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TikTok Mental Health & the Impact of Adolescent Self-Diagnosis Exploration in the Counselling Room: A Reflexive Thematic Analysis of Therapeutic Practice

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Abstract

This thesis explores how therapists perceive and work with adolescent clients who are exploring self-diagnosis of mental health conditions after viewing social media content. Using semi-structured interviews and reflexive thematic analysis, the thesis examines the experiences of six qualified therapists working with young people in Scotland. Two research questions guide this investigation: "What are therapists' perceptions of what a self-diagnosis means for adolescent clients?" and "How are therapists working with adolescent clients exploring a self-diagnosis from social media?" The analysis reveals that therapists perceive social media self-diagnosis as serving multiple functions for adolescents, including identity formation, seeking certainty during a developmental period of ambiguity, and communicating needs. While therapists expressed concerns about algorithmic influence and misinformation, they maintained primarily humanistic approaches in their practice, prioritizing the therapeutic alliance and exploring the meaning of self-diagnosis for each client. The study found that therapists often navigate this phenomenon without specific training, leading to an expansion of their professional roles to include viewing social media content in sessions, providing psychoeducation, and explaining formal diagnostic processes. This research contributes original insights to an emerging field, highlighting implications for therapeutic practice, supervision, and training, while identifying the need for additional resources to support therapists working with this growing presentation in the post-pandemic digital landscape.

Lay Summary

This research looks at how therapists work with young people who think they might have a mental health condition after watching videos or seeing posts on social media platforms like TikTok and Instagram. By interviewing six therapists who work with adolescents in Scotland, I explored what therapists think about this trend and how they respond to it in their practice. The study found that therapists see both benefits and risks in young people learning about mental health online. While social media can help young people feel less alone and give them language to describe their experiences, therapists worry about misleading information and how algorithms might keep showing young people more and more mental health content.

Therapists believe young people might self-diagnose with mental health conditions for various reasons: to understand themselves better, to feel more certain about who they are during the confusing teenage years, or to communicate their needs to others.

When working with young people exploring self-diagnosis, therapists mainly focus on building a good relationship, staying curious about what the diagnosis means to the young person, and sometimes assessing social media content together. They often help clients distinguish between normal difficult feelings and symptoms of mental health conditions and sometimes offer alternative ways to understand their experiences.

The research highlights that therapists are adapting to this new challenge without specific training and suggests that more resources and guidance would help them better support young people navigating self-diagnosis and mental health content on social media platforms. This study adds to our understanding of how social media is changing mental health care for adolescents and therapists.

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Chapter 1: Introduction

1.0 The emergence of social media mental health content

The increasing prevalence of mental health self-diagnosis among adolescents is situated at the intersection of social media consumption, adolescent development, and mental health literacy. It is essential to examine the underlying background to understand how this phenomenon has emerged and the implications for therapeutic practice. During the COVID-19 pandemic, young people reported spending more time on social media (Ellis et al. 2020), which research suggests has reshaped young people's lives and magnified many existing concerns about social media use and mental health among adolescents (Hamilton et al. 2023). One notable change in social media has been the emergence of mental health content on popular social media platforms. Namely, #mentalhealthtok and #therapytok which focuses on mental health have videos with billions of views. Videos with creators disclosing or describing ADHD are extremely popular, with #ADHD being the seventh most popular health-related hashtag on TikTok (Leveille 2024). Additionally, tags such as #DID (dissociative identity disorder), and #bipolar have received billions of views on TikTok (Corzine & Roy 2024).

The presence of social media mental health content has led to a wave of adolescent self-diagnosis with mental health disorders, raising concerns among academics and clinicians about the impacts of inaccurate self-diagnoses (Haltigan et al., 2023; Foulkes & Andrews 2023). While social media has the potential to reduce mental health stigma and enhance health literacy, there are widespread fears about unregulated mental health information available that could lead to misinformation and have detrimental impacts for young people. (Zenone et al. 2021; Suarez-Lledo & Alvarez-Galvez 2021; Yeung et al. 2023).

Consequently, in recent years exploration of mental health self-diagnosis has become a significant phenomenon within therapy sessions (Martin 2023; Nelson 2023; Phillips 2022). At present there is little practice-based research investigating the impacts of adolescent self-diagnosis via social media mental health content in counselling and psychotherapy. In this thesis I aim to investigate the perceptions and lived experiences of therapists working with young people exploring mental health self-diagnosis after watching social media content on platforms such as TikTok.

1.1 Background

1.1.1 Why TikTok Mental health?

Studies indicate that TikTok has an advantage over other social media platforms in engaging the attention of younger audiences and circulating mental health content (Basch et al. 2022). TikTok is the fastest growing social media platform (Schellewald 2023). Some research determines that TikTok is more addictive compared to other platforms, particularly for younger users (Smith & Short 2022).

In a systematic review of the impact of TikTok on adolescent mental health, Conte et al. (2024) analysed available research on TikTok use and concluded that young people discuss and display mental health issues on the platform. Extant research mainly focuses on the overall negative impacts of adolescent TikTok use, such as addiction, spreading of mental illness and low self-esteem.

1.1.2 Adolescent social media use

There is a vast body of research on the impacts of adolescent social media use in connection with mental health. Researchers posit that the proliferation of social media has fundamentally changed adolescent social interactions both online and offline (Nesi et al. 2018). There have been mixed findings on the effects of social media on adolescent well-being (Odgers &

Jensen 2020). However, social media use by adolescents has been described as a "perfect storm" and a "double edged sword", offering both benefits and risks during this stage of development (Choukas-Bradley et al. 2023).

1.1.3 Adolescent Mental Health and Illness

The unique developmental traits of adolescence create a critical convergence for mental health vulnerability and is inextricably linked to the current phenomenon of social media self-diagnosis. During this stage, young people experience significant stressful life events and hormonal changes that can trigger psychological distress (Foulkes 2022). This developmental period is marked by emotional intensity and a heightened risk for the onset of mental health problems (Kessler et al. 2005; Patton & Viner 2007). There is a significant body of research inquiring and defining the stages of development between childhood and adulthood. Further, adolescence is a pivotal time for onset of mental health disorders, with a peak median age of onset is 14.5-18 years across all mental disorders (Solmi et al. 2022). During this stage, adolescents commonly experience anxiety, depression, eating disorders, conduct disorders, substance abuse, and difficulties associated with autism spectrum disorder (Midgley et al. 2017). These normative challenges combined with social media use, create circumstances that lead some young people to seek explanation for their distress through platforms such as TikTok.

1.1.4 Counselling and Psychotherapy with Children and Young People

It is critical to note that the field of counselling and psychotherapy with children and young people (CYP) has a distinct history and framework for practice. In therapy with CYP, there is an emphasis on behaviour and play as communication for the therapist to observe. Kegerreis and Midgley (2014) describe that a therapist's role when working with CYP is to view the client's behaviour, emotions, and responses as communication of their internal experience

and to observe and empathise with their internal world. In counselling and psychotherapy, the therapeutic alliance is seen as the most impactful element in a therapeutic dyad (Cirasola & Midgley 2023).

1.2 The research problem

It has been recognised that adolescent clients are exploring self-diagnosis from social media mental health content in therapy sessions (Martin 2023; Phillips 2022; Nelson 2023). Furthermore, the current body of research offers some clinical perspectives in psychiatry and psychology (Giedinghagen 2023; Lawlor & Kirakowski 2017) which hold adjacent, but distinct roles from CYP therapists in the UK.

Available therapeutic research focuses on self-diagnosis across all age groups and is based in the U.S. (Nelson 2023; Phillips 2022), where therapy has important differences to adolescent counselling and psychotherapy in the UK. Within the UK there are some articles published for practitioners to consider the phenomenon of self-diagnosis from social media in their practice (Martin 2023); however, these are not formal academic studies and do not focus on adolescent counselling and psychotherapy.

Thus, there are few evidence and practice-based perspectives examining this topic and recent studies have concluded that robust clinical research is needed to assess the impacts of adolescent self-diagnosis via social media in therapy and to develop practice guidelines for this presentation (Underhill & Foulkes 2024).

1.3 Research aim, objectives, and questions

Given the lack of research in counselling and psychotherapy exploring therapists' experience working with adolescent clients self-diagnosing after viewing mental health content on social media, this study aims to explore this phenomenon and consider the practice implications of

this phenomenon in the counselling room. I have developed two research questions that this research aims to explore.

- How are therapists working with adolescent clients exploring a self-diagnosis from social media?
- What are therapists' perceptions of what a self-diagnosis means for adolescent clients?

1.4 Significance of this study

This study will contribute to the body of knowledge in counselling and psychotherapy with children and young people and will be an original contribution to the knowledge on therapy practice with self-diagnosis from social media mental health content. This will address the current deficit in research on this topic and will provide practice-based insight from inside practice itself, emphasising lived experiences of therapists through richly illustrated examples. This thesis will contribute to developing a body of research to determine the impacts of this phenomenon and how therapists can work therapeutically with this presentation.

1.5 Reflexive statement

As a qualified therapist, this study was prompted by my practice experience working with adolescent clients exploring self-diagnosis. Between 2021-2022, I was on placement within a school setting. I noticed adolescent clients speaking in clinical psychological terms and self-identifying with psychiatric diagnoses in sessions. I became increasingly curious about the intersection of adolescence, identity-formation, social media, mental illness, and therapy practice. I have continued to work with adolescent clients both in and out of school settings and the prevalence of self-diagnosis and social media mental health content has continued to be an omnipresent element in many of my cases with young people.

As a practitioner, I am aware that my personal and professional experiences are inevitably embedded in this research. My professional training focused on both person-centred and psychodynamic theoretical orientations, learning within this dialogical framework has led me to consider therapeutic modalities through a constructivist lens. I maintain that theories of therapeutic practice are built and shaped within a specific cultural, social, and historical context (Littlewood 2001; Wampold & Imel 2015). Thus, in my view, each therapeutic modality seeks to make meaning of the lived experiences of suffering, uncertainty, healing, and therapy practice from their own narratives and approaches developed within the context of a specific place and time.

I contend that the phenomenon of social media informed self-diagnosis in adolescent clients is also situated within a specific social and historical context. I assert that it is crucial to consider how my approach as a practitioner and researcher is shaped by my training, practice experience, and continuing professional development. Although I was trained in both person-centred and psychodynamic modalities, I practice from a psychodynamic approach. I argue that this is a significant foundation for my practice and this research. These theories underpin my belief that events from the past; as well as unconscious thoughts, feelings, and experiences may play a significant role in present behaviour and relationships (Gabbard 2017; Kealy & Ogrodniczuk 2019). I approach this research from the perspective that therapy and research about therapy require an iterative process of interpretation and meaning making of lived experience (Aleixo et al. 2021; Carlsen 1988; Johnstone 2013; Strong 2003). As I have chosen to centre my subjectivity throughout this research, I reflect that the interpretations, analysis, and conclusions of this thesis are inevitably framed by my psychodynamic perspective on therapeutic practice and lived experience.

Throughout this thesis I have considered myself as a researcher-practitioner and I align myself with Finlay's (1998) work, considering myself as a central figure in constructing,

selecting, and interpreting data. I prioritised self-reflection and viewed my research as dynamic and specific to relationships between myself and the research participants. Throughout this process, I became increasingly aware of how my "practitioner self" was inevitably part of my "researcher self" in the construction of this thesis. Reflexivity has been central to this research, and I have carefully considered my approach as a continuation of my professional practice development both as a researcher and therapist.

Chapter 2: Literature Review

2.0 Introduction

My aim in developing this literature review was to extensively explore published research most relevant to my questions:

- *How are therapists working with adolescent clients exploring a self-diagnosis from social media?*
- *What are therapists' perceptions of what a self-diagnosis means for adolescent clients?*

This research sits at the complex intersection of culture, adolescent development, technology, identity, and therapeutic practice with children and young people (CYP). In the absence of counselling and psychotherapy-based research specifically addressing social media self-diagnosis among adolescents, I draw from interdisciplinary literature to develop an integrated theoretical framework. This framework contextualizes both research questions and provides a foundation for understanding the phenomenon under investigation.

I will begin by examining the developmental context of adolescent identity formation and how it intersects with digital environments. I will then explore social constructionist perspectives on mental illness categorization and self-diagnosis, before examining therapeutic approaches to adolescent mental health. These integrated perspectives provide the theoretical scaffolding for understanding both what self-diagnosis means for adolescent clients and how therapists work with this presentation.

2.1 Key Terms

2.1.1 Young person/ Adolescent

There is a significant body of research inquiring and defining the stages of development between childhood and adulthood. I note that there is ongoing discussion on these categories, including varying definitions geographically. For the purposes of this study, I will use the WHO definitions as follows. The World Health Organization (WHO) uses the term "young people" to define anyone in the age range from 10-24 years and "adolescents" to define anyone in the age range from 10-19 years old (World Health Organization 2024). As the participants in this study work therapeutically with clients from ages 10-18, all clients discussed in this research fall into both the "young person" and "adolescent" categories. I will use both terms to reference clients within the 10-18 age group.

2.1.2 Self-Diagnosis

I define self-diagnosis according to Foster and Ellis' (2024) definition that self-diagnosis describes an individual identifying with a medical diagnosis, which includes mental health condition, illness, or neurodevelopmental difference, without the confirmation of a formal diagnosis from a healthcare professional.

2.1.3 Social Media

Throughout this research, social media will be used to refer to platforms such as TikTok, Instagram, and Facebook. These platforms all fall within what O'Reilly calls "Web 2.0", which is defined as a "network as a platform", which is built on the architecture of participation, where individual users provide data that allows remixing by others (O'Reilly 2010). These platforms are characterized by users sharing and interacting with content which is curated via an algorithm to show users content they are likely to enjoy based on their past viewing and engagement. I make this distinction to highlight that this research focuses on some social media platforms and not others, (i.e. TikTok and Instagram vs. Snapchat etc.)

2.1.4 Mental Health/ Mental Illness

World Health Organization's definition of mental health includes both the absence of mental disorders and "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO 2022).

2.1.5 Psychiatric Diagnosis

I will use the concept of psychiatric diagnosis in reference to the two most prominent frameworks which categorise psychiatric disorders which are overwhelmingly seen as formal definitions of disorder. In the UK, the manuals of terminology and organisation of disorder include the DSM, the Diagnostic and Statistical Manual of Mental Disorders developed by the American Psychological Association (APA) and the ICD-10, the International Classification of Diseases, developed by the World Health Organization (WHO). These two manuals do have some critical differences (Freeth 2021), but for the purpose of this study, I will define psychiatric diagnoses in accordance with the disorders and structures of these manuals, which function clinically as a set of specific symptoms and criteria that serve to name, organise, and classify symptoms within a medicalised mental health setting.

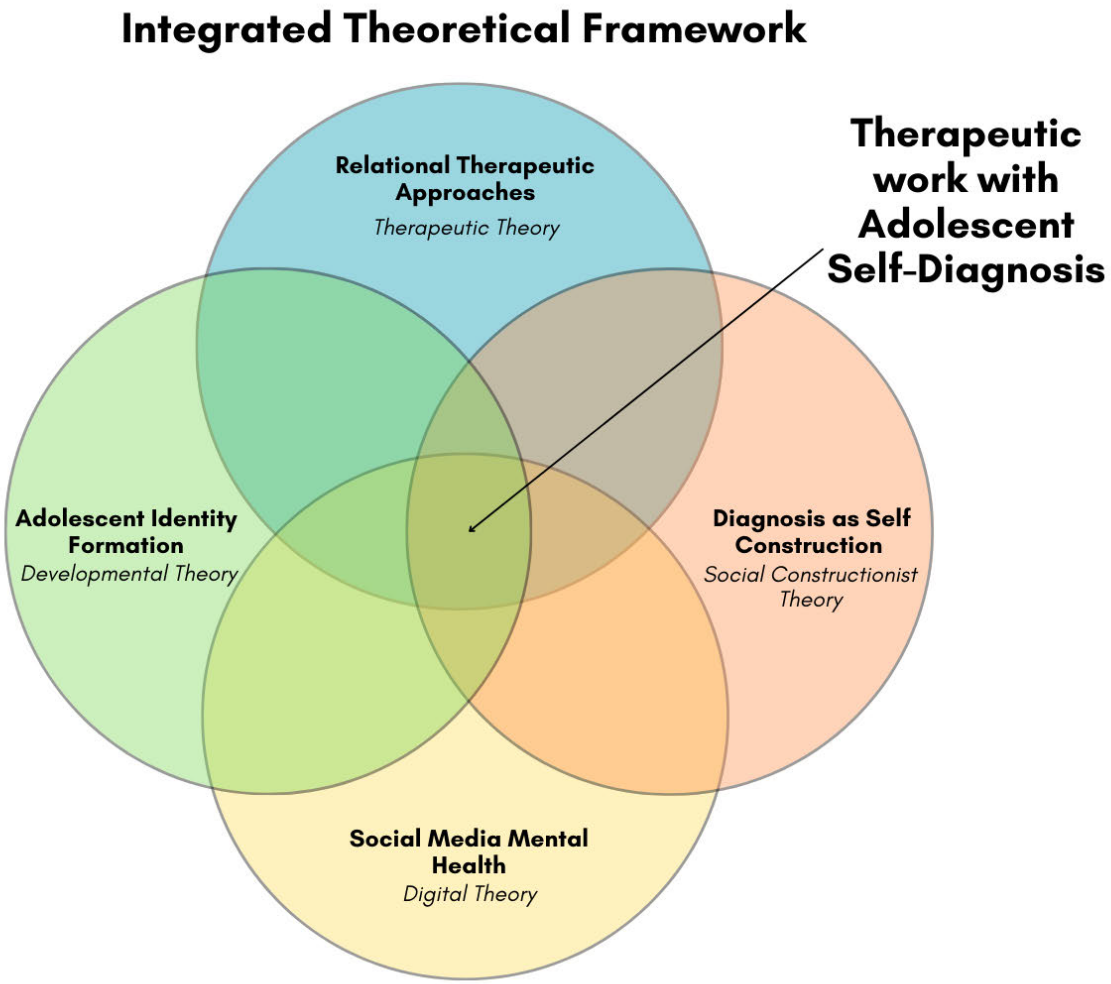
2.1.5 Therapist

The BACP defines counsellors and psychotherapists as qualified persons offering a wide variety of psychological help (BACP 2018). Throughout this paper, I will use the term "therapist" to describe a qualified counsellor or psychotherapist.

2.2 Theoretical Framework: An Integrated Approach to Understanding Adolescent Self-Diagnosis

The phenomenon of adolescent self-diagnosis via social media requires a multifaceted theoretical framework that integrates developmental, social constructionist, and therapeutic perspectives. Figure 1 illustrates this integrated framework.

2.2.1 Figure 1: Integrated Theoretical Framework Venn Diagram



Each of these theoretical orientations contributes unique insights while also intersecting in important ways. Developmental theories help us understand how adolescents form their identities in digital environments. Social constructionist perspectives elucidate how diagnostic categories are created, maintained, and evolve through social processes, including on social media platforms. Literature on relational therapeutic approaches provide frameworks for understanding counselling and psychotherapy with children and young people and how it is impacted by self-diagnosis presentation within the therapeutic space. I have chosen to draw from therapeutic literature from person-centred, psychodynamic, and integrative approaches to mirror the modalities of the participant accounts in this research. I

will draw on these frameworks throughout the following literature review. I have chosen to organise the following research according to my two research questions.

2.3 Literature related to research question 1:

What are therapists' perceptions of what a self-diagnosis means for adolescent clients?

2.3.1 Adolescent identity formation

Adolescence has long been researched as a crucial starting point for the life-long process of personal identity construction at the intersection of personality, self-concept, interpersonal relations and context (Erikson 1968). Over time, researchers in the field of human development have continued to expand ideas of identity development, looking at identity formation as a dynamic cycle where adolescents consider various identities, maintain, reinforce, or revise their identity commitments (Crocetti 2017; Crocetti et al. 2008). Crucially, a sense of self through these models is predicated on a process of exploration and commitment through a process of reconsideration and adjustment toward developing a sense of self-identity (Crocetti 2008). These models offer a guide to the process of adolescent identity formation and can provide a framework to conceptualise the lived experience of young people during this period.

There is ongoing research in adolescent development exploring how the digital space has impacted the process of identity construction and to better understand how social media engagement impacts adolescent identity development (Branje 2022). Raiziene et al. (2022) investigated the associations between adolescent identity formation and online activities and determined that social media serves as the modern context for identity formation and exploration for many young people. Researchers have explored ways that the shift in the setting of identity formation has impacted the ways that young people understand themselves throughout this transitional time between childhood and adulthood.

Perez-Torres (2024) views social media as a digital mirror where self-presentation online is constructed alongside identity development. She posits that to understand the impact of social media on adolescent development, research must take a view of mutual influence, where both the young person and social media are interrelated in identity construction. This study determined that the evolving and interrelated nature of social media identity formation amplifies the identity formation process at an unprecedented rate that is often too rapid for adolescents to comprehend.

Novac et al. (2019) view individual growth and development through a neurobiological lens and argue that identity development is significant to psychotherapy and that the therapeutic process has potential to reshape and repair individuals' self-perception of their experiences. Notably, this study demonstrates the relevance of identity narratives within a psychophonetic context and indicates that in therapeutic spaces, there is the possibility to reshape identity narratives.

Current research in this area is largely cohesive, arguing that social media and online spaces have significant impacts on the process of adolescent identity development. Further, available research asserts that social media is involved in a co-constructive process with the adolescent user throughout the identity formation process. This marks a compelling shift in adolescence as technology is inextricably interwoven into this stage of development.

2.3.2 Self-diagnosis of mental health conditions

It is important to note that on social media platforms, among young people, and in news reporting, diagnoses of mental health conditions, mental illness, and neurodivergence are frequently referred to under an umbrella of "self-diagnosis" (Bobby & Sandhu 2023; Foster & Ellis 2024). Crucially, it is widely accepted that categories of neurodiversity indicate natural variation and difference, therefore, I believe it is important to note that while neurodiverse individuals may meet the criteria for a mental health condition, neurodiversity

itself is not a mental illness. For the purposes of this research, I have chosen to use the term self-diagnosis to reference a broad scope of diagnoses; including neurodiversity, mental illness, and other mental health conditions.

Current psychiatric research indicates that there is an increase in self-diagnosis of mental health disorders after viewing social media content (Haltigan et al. 2023). In Weigle's (2023) study analysing psychiatrists' perspectives, he identified that 74% of participants believed their patients had self-identified a mental illness based on content they viewed online. Additionally, Yeung et al. (2022) in a cross-sectional study of ADHD social media content, assert that algorithmically determined repetition of content about a mental condition on social media platforms may reinforce user's perception that they have a disorder even if they do not meet the clinical criteria. In psychology, Foulkes and Andrews (2023) explored how mental health awareness efforts and growing literacy about mental disorders may have impacts on the prominence of self-diagnosis. This research has led to what they call the "prevalence inflation hypothesis", which draws a connection between increased levels of mental health literacy and the prevalence of self-diagnosis.

Nelson (2023) conducted interviews with mental health counsellors in the United States inquiring how they provide care to clients who self-diagnose. One of the findings in this study indicated that therapists perceive young people today are quicker to self-diagnose than in past generations. Nelson argues that this shift is due to the de-stigmatisation of disorders which may lead people to be more willing to self-diagnose. Current research is largely aligned in noting the increase of self-diagnosis of mental health diagnoses among individuals linking a connection to the availability of online mental health information.

Giles and Newbold (2017) consider that in culture, the idea of "mental-illness-as-stigma" has been inverted. They argue that this may indicate a shift in power, where individual experience and assessment has become more common in society, shifting the power dynamic away

expert knowledge held by professionals. Lupton and Southerton (2024) argue that the emergence of self-diagnosis on TikTok challenges the medical authority, indicating a shift in cultural norms and offering a platform for lay experience. They argue that this shift may have impacts of what is defined as "pathological" and "normal" which serves to add significant complexity to the diagnostic process.

In their study of TikTok content on neurodiversity, Lupton and Southerton (2024) determined that TikTok videos describe the lived experience of neurodiverse individuals rather than explaining medical advice or findings. They posit that on TikTok, influencers are appraised by their ability to articulate lived experience that resonates with users, which offers a contrast to "psy" professionals expressing their credibility through qualifications. They concluded that many people are eager to be "labelled", believing that there are benefits to having a diagnosis, describing that self-diagnosis has been "profoundly life-changing" (2024, 197). For Lupton and Southerton, the popularity of neurodiverse influencers coincides with a cultural concept that having a diagnosis leads to self-knowledge, self-growth, self-compassion, and self-esteem which can be found in "achieving a self-diagnosis, as ways of optimising their lives and finding a sense of authenticity" (2024, 206). They argue that a cultural desire for self-optimisation could be viewed as encouraging people to see themselves within a medicalised framework which individualises society issues.

In digital health, Eagle and Ringland's (2023) ethnography identified that online health communities encourage individuals to self-diagnose and to advocate for formal diagnoses. Their findings indicate that online health communities offer a counter to the gatekeeping of traditional medical services, noting that on TikTok users often encounter health communities in their normal usage, rather than intentionally seeking to find more information or connect with other members of this community.

Literature exploring the prevalence of self-diagnosis largely asserts that the emergence of this phenomenon may indicate a cultural shift towards individual experiences of mental health symptoms and the prominence of mental health information available online.

2.3.3 The algorithmic self

Schellewald (2023) traced and examined the popularity of TikTok among young adult users in the UK through ethnographic fieldwork. Crucially, he argues that users shared awareness of their engagement with the algorithm and expect that their "For You Page" (FYP) will show "an accurate representation of their self" which he defined as "reading for personalisation" (2023, 1574).

Bhandari and Bimo (2022), interdisciplinary researchers in technology and society, sought to understand the emergence of TikTok through analysis of interviews with American university students after systematic use of the platform. They argue that TikTok deviates from other social media platforms where users interact with other users, whereas on TikTok users interact with what they call an "algorithmized self" which emphasises the agency of users in the process of self-making on social media. Bhandari and Bimo define the "algorithmized self" as a "reflexive process of fluid associations with social circles" where TikTok users engage with versions of themselves mediated through engagement with the algorithm (2022, 9).

Users co-create their FYP through their "affective engagement and attention" (Avella 2024,12), which results in them encountering content that matches their emotional experiences. Avella argues that the algorithm appears to access the "unconscious self" of the user. Consequently, individuals viewing diagnostic content on their FYP are primed to view additional similar content as an accurate representation of their identity, potentially accepting characteristics that exist outside their conscious self-awareness. Avella defines this as a

"platformed diagnosis", where diagnosis identities are co-constructed through the process of engaging with social media, specifically TikTok.

The concurrent processes of adolescent identity development and social media engagement add further complexity to the formation of algorithmically-influenced mental health identities, creating a multifaceted interaction between developmental vulnerabilities and digital self-construction.

Current research in this field attempts to contextualise identity-formation on social media platforms. Bimo and Bhandari (2022,11) articulate this process by describing that individual identities are co-created within the "ever-changing" and "extensive ecosystem" of digital spaces.

2.3.4 Critical literature on mental illness and psychopathology

To understand the prevalence of self-diagnosis, I argue that it is essential to situate this phenomenon in the larger history and discourse surrounding psychiatric diagnoses.

There are ongoing debates about the role and power of biomedical frameworks that describe viewing human behaviours through a medical lens (Lupton & Southerton 2024). Biomedical diagnoses are socially constructed forms of knowledge, and some sociologists view expert diagnosis as a form of medical authority that perpetuates a system of gatekeeping that legitimising what constitutes a "disease" or "health condition" (Jutel & Nettleton 2011).

Literature exploring the motivations behind individual self-diagnosis indicates that some individuals may seek certainty through a diagnostic label. In counselling research, Sukmawati et al. (2023) assert that people may be more likely to self-diagnose with a mental illness when they feel uncertain about what is causing their issues. Jutel (2021) contends that when a patient attends a medical appointment with an affliction, they seek the certainty of a medicalised diagnosis. This process requires "temporary uncertainty" in the hope that once an assessment is made and a diagnosis is determined "the uncertainty is quelled" (Jutel 2021, 7).

In a critical review of digital mental health technologies, Stein and Prost (2024) assert that the development of digital mental health technologies is rooted in medical neoliberal interests. In their view, the medicalisation of distress prioritises capitalist incentives, as it seeks to both construct problems and provide products to solve them. They argue that social media provides "a perfect model" to widely collect mental health data. Cosgrove et al. (2020) argue that mental health surveillance tools threaten human rights, where seemingly free resources are mining personal data rather than money in a capitalist exchange.

2.3.5 The changing definitions of mental illness on social media

Knox (2022) describes that the DSM intends to offer an objective and universal scientific framework; however, as psychopathologies are socially constructed and lived experiences, it may be impossible to achieve an objective framework to capture the shifting nature of mental illness. I argue that these shifts can be viewed through a lens of Haslam et al.'s (2016) theory of concept creep, which characterises the "conceptual expansion" of pathological concepts and psychological categorisations. This theory posits that the expansion of harm and pathology takes both "horizontal" forms, which capture qualitatively new phenomena and "vertical" forms, which capture quantitatively less acute issues. Thus, the semantic shifts in psychopathological language affect the way that people use language and their understanding of these terms and categories.

Hacking's theory (1999) sees pathology and mental illness as interactive and thus more complex than being socially constructed or biological alone. Significantly, Hacking (1998) describes mental illnesses as "transient", which he defines as existing in a specific time and place. Hacking posits that from a social constructionist view, a pathology is associated with the name of a disorder itself, and there is the social construct that relates to the dynamics of this social construct in society. He argues that there is a "looping effect" where the term is

malleable and changes because the people categorised with a mental disorder add additional meaning through their lived experiences.

As Chevalier (2024) interprets Hacking, he states “it is not as important what the term means now, but how the term changes meaning.” (2024, 164).

> With the aid of an algorithm, like the one TikTok uses, someone's proposal for a new term or revision of a term is sent to people who may be interested. These other TikTok users then loop with the new/revised term by applying it to themselves and by offering further revisions. Given the simplicity with which users create and engage with content on the platform, this process is often unconscious (2024, 172).

Thus, Chevalier argues, that viewing TikTok and social media content about psychiatric disorders through a lens of Hacking’s “looping effect” offers a framework to explore the process where algorithms interpret user activity to form a label, to then categorise users and show them advertisements. Chevalier acknowledges the complex motivations behind creating and consuming psychopathological content online, he emphasises that the resulting semantic shifts in terminology have substantial impacts on both theoretical concepts and individuals’ perceptions of mental health conditions. He describes that this phenomenon is a piece of a complex picture and that the construction of meaning in psychopathology is situated within the rapid context of social media where terms can be “redefined overnight” and rely on “viral whims” of social media all within platforms where many content creators are looking to sell products (2024, 171).Within this web of motivations and rapid shifts, he argues that it is not clear how to distinguish between “genuine patient testimony” and “algorithmic noise” (2024, 171).

Across psychiatry and psychology research, many terms and theories seek to make sense of the evolving nature of diagnostic categories on social media. In psychiatry, Haltigan et al. (2023) consider that social media may act as an “incubator” for a different form of self-labelling consistent on social media while being inconsistent with diagnostic criteria. These

theories are in dialogue with both Haslam's "concept creep" and Hacking's "looping effect" and aim to analyse the specific impacts of psychopathological information on social media platforms.

Thus, the critique of disinformation on social media may be more complex than it initially appears, as according to these theories, the meaning of psychiatric categorisations has always been in flux. Social media mental health provides an introduction of lay perspectives on a mass scale and serve to disrupt the power dynamics of experts and patients, leading to more accounts of individual lived experiences of mental disorders. These perspectives may expedite the expansion and shifting of psychopathological terms through rapid communication and dissemination on platforms like TikTok, which may lead to consistently evolving meanings that further muddies the boundaries between what information is seen as valid or false.

2.3.6 Young peoples' perceptions of mental health content and influencers on social media

There is a growing field of research in public health examining the role of social media influencers in disseminating health information to young people globally. Engel et al. (2024) conducted a cross-sectional study in digital epidemiology examining Australian youth perceptions of influencers. This study indicated that social media influencers are seen as trusted sources for health information and product recommendations.

In health communications research, Pfender and Bleakley (2024) conducted a qualitative study about youth beliefs about seeking health information from social media influencers. Their findings indicate that youth are widely accepting of learning about health from social media influencers. However, this study indicated that these beliefs are not shared by parents or older family members. Further, young people discussed concerns about influencer

credibility but explained that these are eclipsed by the accessibility of social media health information.

Harris et al. (2021) conducted a qualitative study of young people's views of YouTube-produced health content. In this study, a subset of participants expressed concerns that some health content generalises personal experience that could lead to inaccurate self-diagnosis. Interestingly, this research indicated that younger participants may be more likely to trust information they viewed and were less able to evaluate the accuracy of mental health information. Crucially, they concluded that young people evaluate the quality of health information by appraising the content creator's authenticity and motivations for sharing health information.

In addition, there is a growing catalogue of research specifically investigating impacts of influencers disseminating mental health information on social media. In psychological research, Adeane and Stasiak (2024) qualitatively analysed in-depth interviews of youth perceptions of influencer mental health content in New Zealand. This dialectical study found various perspectives and some youth found content normalising mental health issues helpful, while others described their concerns that some depictions of mental illness online "unintentionally glorify mental health issues." Young people discussed mental health content following trends and they perceived that some young people model their mental health identities on influencers they follow. This study offers a nuanced approach, illustrating young people's complex feelings and preferences about mental health information on social media platforms.

2.3.7 Online illness identities: what is accurate and what is performed?

Despite having many challenging symptoms and effects, Giles (2006) found that members of some online communities celebrate receiving a psychiatric diagnosis. Conversely, in the view of some researchers, illness identities raise significant concerns, particularly when a person

has self-diagnosed with a condition that mental health providers assess as inaccurate. Suhr and Johnson (2022) collected data from American university students about their self-identified mental disorders. In their analysis, they assess that in some cases, self-diagnoses can result in pathologising normal behaviour. For Suhr and Johnson, self-diagnosis could lead individuals to be misdiagnosed, develop maladaptive symptoms, receive unsuitable treatment, or add unnecessary strain on the mental health care system.

In the field of psychology, some researchers consider certain self-identified diagnostic labels through the lens of "Munchausen by Internet", where individuals identify with a diagnosis due to the perceived benefits of having a disorder (Corzine & Roy 2024). Lawlor and Kirakowski (2017) describe phenomenon as a "factitious disorder" where an individual feigns an illness or symptoms to identify with an illness. According to Lawlor and Kirakowski, individuals who inaccurately adopt a diagnosis may be more likely to have early childhood trauma, low self-esteem, or poor self-concept, as these factors may lead individuals to look for positive attention and identity cultivation through a diagnostic label.

In a review of current research, Giedinghagen (2023) considers the prevalence of reproduced illnesses such as Dissociative Identity Disorder (DID) and Tourette's Syndrome in adolescents and argues that in these cases symptoms are assumed "whether with conscious intent or not" (2023, 271). She considers that young people may be motivated to reproduce illness symptoms because of a deep desire to be "seen." She views this within an algorithm-driven social context that "rewards the most extreme symptoms with views" (2023, 275).

2.3.8 Stigma and scepticism of adolescent self-diagnosis via social media content

Although there is research available that indicates a diminishing level of stigma around mental health diagnosis and self-diagnosis, among peer groups and in wider culture, adolescent mental health and illness hold complex nuances.

According to a study analysing interviews with Swedish young people, Hermann et al. (2022) reported that young people described feeling "mentally unwell" as the "new normal." Adolescents identified that although it is widely viewed as acceptable to have a mental illness or self-diagnosis, there is a risk of being seen as falsely identifying with a mental illness, which holds significant stigma in peer groups (Hermann et al. 2022).

Concurrently, Dixon-Ward and Chan (2022) used qualitative methods to analyse adolescent subreddits and found that there is significant stigma for young people diagnosed with depression. This study emphasised that there is scepticism and hostility directed towards young people who are seen as "faking it." The idea of "faking" a mental illness and the social stigma attached was also explored by Teng et al. (2017) in a study of Australian young people speaking about their experience and perceptions of mental health and illness. Significantly, the empirical data in this area is based on the perspectives of adolescents and young people, which marks a difference from other elements of available research, which primarily consider adult interpretations of this phenomenon.

Underhill and Foulkes (2024) used reflexive thematic analysis to analyse discussions of self-diagnosis of mental disorders on Reddit. They conclude that self-diagnosis is a "highly contested issue" with the discussions highlighting a variety of both positive and negative views of self-diagnosis. This study found that adolescents were frequently met with scepticism and users believed that many adolescents were self-diagnosing incorrectly by inaccurately labelling or intentionally misrepresenting themselves for attention. Interestingly, Underhill and Foulke's research complicates the views of some research, namely research from adult perspectives, that suggest self-diagnosis leads to social acceptance for adolescents. Crucially, they conclude that responses to self-diagnosis may be multifaceted and are possibly impacted by different contexts, such as self-diagnosis on social media versus in peer groups.

2.4 Research related to research question 2:

How are therapists working with adolescent clients exploring a self-diagnosis from social media?

2.4.1 Psychiatric diagnosis with CYP in Counselling and Psychotherapy

There is a long and rich history of debate within the fields of counselling and psychotherapy about the value and role diagnosis could or should play in therapy. Significantly across mental health fields, there is a troubled relationship between psychiatry and psychotherapies, which can be in part attributed to an increasingly siloed field where psychiatrists prescribe, psychologists diagnose, and non-psychiatric mental health professionals conduct psychotherapy (Gabbard 2009).

This debate continues and holds further nuance in the field of CYP's counselling and psychotherapy. To detail this history would be outside the scope of this study, however, I believe it is important to bring elements of this discourse into the context of how therapists may encounter a self-diagnosis presentation when working with adolescent clients. It is significant to acknowledge that many therapists in the UK hold a critical view of pathology and question the reliability of the diagnostic system (Cooper & McLeod 2011).

In practice, therapists tend to align more with a humanistic lens, which sees beyond pathology to view the client holistically (Remley and Herlihy 2020). This view aligns with the person-centred perspective, as Carl Rogers states, "…we shall deal with the child, not with behaviour symptoms…" (Rogers 1939). Focusing on how it is the child or young person that the therapist is looking to empathise and connect with holistically, rather than through a lens of pathology. Rogers believed that psychological diagnosis could lead to a client abdicating their personal power and positioning the therapist as a professional expert of the client's experience, possibly inhibiting the therapeutic endeavour (Rogers 1951).

This holistic approach can be viewed as therapists centring the therapeutic alliance, even in cases where diagnostic labels are present. Cirasola and Midgley (2017) analysed existing literature and determined that the following approaches are consistently proven to be effective to foster a strong therapeutic alliance with adolescents.

> (a) validating the feelings and experiences of young people, (b) actively nurturing trust, (c) demonstrating genuine interest and curiosity in adolescent clients, (d) respecting their autonomy and identity, and (e) acknowledging and praising their efforts and engagement in therapy… (Cirasola & Midgley 2017, 308).

Johnstone (2013) argues that therapy offers an alternative approach to pathologization to make meaning of people's suffering and that by using psychological formulation, it is possible to define the same experience through different models. Hence, symptoms which could be viewed through the lens of psychiatric diagnosis could also be defined through other formulations. Following this position, Johnston posits that viewing formulations as "correct", "true", or "accurate" poses a binary where other formulations are necessarily false or inaccurate. Johnstone considers therapy as a space where therapists and clients come together to engage in an iterative and collaborative process of formulating and re-formulating the client's experience. She posits that therapists must consider the power in their role and prioritise reflexivity in their views, feelings and experiences when exploring formulations with clients.

It is important to note that in the UK, it is not common for counsellors and psychotherapists to train in psychiatric diagnosis or diagnostic processes. This skill is not required for qualification or membership to prominent professional bodies (BACP 2018). Therefore, many therapists working with CYP are not formally trained in diagnostic frameworks and processes within the CAMHS and NHS services. As Cooper describes, in the UK counselling comes from a "pastoral tradition" which has epistemic impacts, particularly when

compared with the United States, where psychotherapy “is grounded in psychology” (Cooper 2008).

In a qualitative thesis in counsellor education, Nelson (2023) analysed interviews from mental health counsellors in the United States about their experiences providing care for clients who self-diagnosed through the internet. Interestingly, training for this role in the United States requires therapists to learn about psychiatric diagnosis and diagnostic procedures to become qualified practitioners. Hence, in Nelson’s study, therapists hold training in diagnosis, and some practitioners are qualified to diagnose.

Connor (2022), a UK-based adolescent psychotherapist explores practice-based vignettes as a guide for CYP practitioners. In her view, many young people and parents view the adolescent experience through a pathological lens, which she works to normalise in her practice. Connor argues that one of the goals of therapy is to work with the client to explore their struggles and develop alternative narratives for the young person to understand their sense of self within the context of their life and experience.

2.4.2 Research on the impacts of therapist attitudes

At present there is little relevant research available investigating the impacts of therapists’ attitudes about adolescent social media mental health content or self-diagnosis. I contend that individual beliefs and attitudes are developed within a social constructivist paradigm. I argue that it is essential to consider this thesis, and the perspectives of therapists in relation to culture, geography, generation, and lived experiences. Thus, in my view, it is crucial to situate therapists’ attitudes on adolescence, social media, and self-diagnosis within a specific context. Throughout the following section, I draw on literature that considers how therapists’ biases and attitudes are inevitably woven into the individual attitudes and professional practice approaches of therapists working with children and young people exploring self-diagnosis from social media content. In the absence of specific literature on this topic, I have

chosen to draw on research focused on therapists' reflexivity about personal biases and attitudes and in the follow section on the elements of this phenomenon.

In counselling and psychotherapy training the development of self-knowledge and reflexivity are key components to building ethical practice (McLeod 2011). Willig (2019) states that it is essential for therapists to continually engage in self-reflection and to be aware of how their personal experiences may impact how they view and work with clients and their issues. Further, Willig asserts that it is crucial for therapists to recognise their assumptions and how they may impact their ways of relating to others.

Across literature in mental health professions, clinical supervision is seen as an essential space for therapist reflection. In social work research, Rankine (2017) concludes that it is essential for supervision to be a trusting and open relationship to allow for the supervisee to explore their assumptions and challenges. Harries (2024) research in school-based counselling maintains that it is crucial for supervisees to feel able to examine their relevant attitudes and biases within the supervisory relationship.

In qualitative counselling and psychotherapy research, Yager et al. (2021) examined psychotherapeutic vignettes based on the authors' clinical experiences. They argue that the impacts of psychotherapists' cognitive and affective biases influence clinical assessment, reasoning, and decision-making. They conclude that therapists' biases are likely to play an important role in therapy and, in some instances, can lead to therapeutic rupture, particularly when therapists "failed to see or acknowledge their own roles in the difficulty" (Yager at al. 2021,123). Further, they argue that as most personal biases result from various contributing factors and may be deeply entrenched, there is no single way for therapists to expand their awareness of their biases, however, the urge that supervision and reflexive review may support therapists to become more aware of how their biases may impact their psychotherapy practice.

2.4.3 Attitudes and biases about adolescence, self-diagnosis, and social media

2.4.3.1 Adolescence

Crucially, therapists working with CYP clients may have additional attitudes and biases to consider as therapists views on young people that could impact therapy. In my view, as therapists working with adolescent clients often have varied life experiences and perceptions on youth, social media, and self-diagnosis, it is crucial to consider therapists' biases as present in the therapeutic relationship to understand their practice for this thesis.

Across disciplines in psychological research and human development, there are ongoing discussions about the capacity and competency of CYP. Bakhtiar et al. (2022) assert that research about or involving CYP is necessarily framed by adult perspectives on CYP's subjectivity and agency. Wood (2022) in her research on youth citizenship, highlights the ongoing discourse regarding how professionals conceptualise young people. This discourse draws on Uprichard's (2008) influential distinction between children as either 'beings'- fully formed individuals in their own right- or as 'becomings'- incomplete individuals defined by their potential as future adults. Wood (2022) asserts that a "becomings" view of youth is has come under significant critique in recent years, and views on youth have shifted more towards a complementary approach which considers the temporality of youth and stages of development, while also valuing the young person's perspective and autonomy.

2.4.3.2 Self-Diagnosis

In the absence of empirical research on therapists' attitudes towards self-diagnosis, I have drawn from professional resources developed to guide therapists' work with clients who have a psychiatric diagnosis. In a 2021 article, Freeth, who brings dual experience as both a trained psychiatrist and practising person-centred therapist, published a guide for therapists working with clients who have received psychiatric diagnoses. She emphasises the importance of

therapist self-awareness about their views on diagnosis as these underlying attitudes may impact therapy with clients.

2.4.3.3 Social Media

At present there is limited research on therapist attitudes about social media. However, there is a significant body of research in technology studies, psychology, and human development exploring the impacts of adolescent social media use. To delve into this topic fully is beyond the scope of this study; however, I will briefly discuss the impacts that these debates have on this thesis. For this literature review, I will focus on adult attitudes towards social media content and adolescent social media addiction.

One of the consistent concerns about social media use is the fear that young people would engage with harmful content, including pro-eating disorder content (Custers 2015; Juarascio 2010) suicide-related internet content (Bojanić 2024), and self-harm-related content (Dyson et al. 2016).

Additionally, there is a breadth of research on adolescent social media addiction and the potential impacts and interventions to moderate social media use (Al-Samarraie 2021; Hou 2019). Research in information science by Adiele and Olatokun (2014) and in health sciences by Caner et al. (2022) contend that developing self-control is a key component of adolescent development, which may lead young people to be more drawn to social media and susceptible to social media addiction during this stage of life.

Chao et al. (2023) analysed the mental health of Chinese adolescents using short video platforms such as TikTok, marking the mental health of non-users, moderate, and addicted users. This study showed that 40.2% of participants were “addicted” to using short video social media platforms and findings indicated that those addicted to short video platforms had significantly worse mental health compared to non-users and moderate users of these platforms. Crucially, this study notes that it is possible that adolescents with poor mental

health and negative environments may be more likely to use these platforms and may be more susceptible to addictive use. They argue that as adolescence is a pivotal developmental stage, addictive use of platforms such as TikTok may pose a significant threat to the mental health of adolescents.

Walsh (2020) characterises the prevailing negative attitudes toward adolescent social media use as a form of 'moral panic.' This concept refers to collective societal behaviour that views phenomena through disproportionate alarm through emotionally charged discourse and media coverage, often without empirical justification.

For Walsh, this panic is unfounded as he argues that available evidence shows that popularised fears inflate the risks of social media use and ignore the complexity of the role of social media in the lives of users and across cultures. Livingstone and Third (2017) in a study on the rights of children online, identify an ongoing debate among researchers and practitioners, where some call for the protection of adolescents arguing that they are more vulnerable to harm online, whilst others believe young people's digital skills are underestimated by adults and that CYP should be trusted and empowered to navigate their online lives.

2.4.4 Research on mental health professionals working with self-diagnosis from social media

In healthcare research, there is empirical research that indicates an increase in patients self-diagnosing themselves from online resources (Jutel 2017). In psychiatry, Monteith et al. (2024) explain that online self-diagnosis has risen rapidly in clinics and assert that psychiatrists must be aware of the potential risks of misdiagnosis. Some individuals who self-identify with a disorder have expressed a sense of self-understanding and community from online groups, citing that this led them to seek a specific diagnosis (Milton et al. 2023).

From a psychological perspective, Corzine and Roy (2024) analysed existing literature on self-diagnosis of mental health disorders and self-diagnostic behaviours on social media. They acknowledge that individuals may feel protective of a self-diagnosis and may view this as an element of their constructed identity, which could lead some individuals to feel judged by professionals who disagree with their self-assessment. Notably, they assert that as this is an emerging phenomenon, particularly among adolescent populations, it is difficult to determine whether adolescents will maintain self-diagnosis identities into adulthood and in future research, adolescent perspectives are necessary to clarify the underlying interests and motivations of young people self-identifying with a diagnostic label. They emphasise that professionals must consider ways to approach these clients without encouraging further alienation and mistrust in the clinical process.

Giedinghagen's (2023) research in child and adolescent psychiatry, explores the phenomenon of adolescents presenting reproduced illnesses which appear to be acquired from viewing social media posts. She argues that as these presentations are complex, it is essential to develop guidelines for mental health professionals to work with these patients. In her view, professionals need to prioritise building rapport with self-diagnosing clients and develop an understanding of biological, psychological, social, and cultural contributions to the presentation.

2.4.5 Therapy in the age of TikTok

In counselling and psychotherapy research, some studies are seeking to understand how therapy has been impacted by the growing presence of mental health content and self-diagnosis. At present, research in counselling and psychotherapy has focused on how CYP access and engage with virtual therapies and mental health interventions (Ridout et al. 2021; Stasiak et al. 2016). However, these studies are primarily concerned with the effectiveness of

online mental health interventions for CYP and do not consider the impacts that social media mental health content or self-diagnosis has on clients or therapeutic practice.

2.4.6 Research on social media in the counselling room

There is an emerging field of research that explores the presence of social media in therapy. Zeavin (2021) researches the history of therapy and developed a concept of "mediated therapy", where she argues that therapy is triadic. Zeavin's work focuses on teletherapy and the evolution of media and psychoanalysis across history. In her view, the patient, therapist and media are always involved in the therapeutic encounter. Thus, the presence of social media, either being shown or spoken of during sessions could be viewed as a third in Zeavin's triadic concept of mediated therapy. Avella (2024) argues that Zeavin's concepts, although they do not precisely map on to TikTok and social media mental health, can serve to understand the role of TikTok as an emergent form of therapy, which can influence conceptions of mental health care. These theories contend with the shift in therapy and mental health concepts as mediated by growing technological presence and mental health phenomena. Although this research remains adjacent to therapeutic practice with adolescents, in my view, these ideas shed light on the ways that the presence of social media may impact therapy.

White and Chen-Wilson (2024) conducted a qualitative study interviewing UK-based CYP therapists on their social media use and understanding. They highlighted that participants had not received any specific training on working with issues related to clients' social media use. They argue that this shows a significant gap in training and counsellors should be given ongoing and continually updated guidance and training on how to support young people with social media issues. Additionally, their study suggests that counsellors also experienced obsessive use of social media, but perceived when social media use impacted their mood, they were more able to hold boundaries for themselves compared to the adolescent clients.

Derges et al. (2023) conducted a qualitative study with adolescent clients and practising CYP therapists in the United States that focused on discussions of social media and web-based activities in therapy sessions. Young people expressed a desire for practitioners to understand social media and web-based activities to feel comfortable discussing social media related issues without feeling judged or misunderstood. Notably, some therapists described using their ignorance of social media and web-based activities as a tool for rapport building, however, according to the young people interviewed, this could deter them from speaking about these topics with their therapist. The findings of this study evidenced that practitioners gained most of their knowledge and skills about social media and web-based activities informally, sometimes from colleagues or younger clients. Hence, some therapists may be unfamiliar with social media and the kinds of information that clients view about mental health on popular platforms.

Conversely, in Nelson's (2023) study exploring therapists' experience of caring for clients with a self-diagnosis via social media, based in the United States, she notes that it is an ethical obligation for therapists working with CYP to be familiar with social media platforms and their purposes (ACA 2014). However, from Nelson's view, it is not enough for therapists to know about social media, she argues that there should be ethical guidelines for therapists to work with clients who present in therapy with a self-diagnosis from social media. Nelson's research poses an interesting comparison to therapy practice in the UK where CYP therapists do not have a social media literacy requirement in their qualification (BACP 2022).

2.4.7 Practice-based literature on social media self-diagnosis

Literature in counselling and psychotherapy tends to focus on practice experience and is often published in monographs, practice-based periodicals, and handbooks for therapists rather than empirical research in academic journals. In publications from professional bodies, there have been multiple pieces written for practitioners about the presence of self-diagnosis from social

media in therapeutic relationships. In one article Martin (2023), an integrative psychotherapist based in the UK, wrote about the presence of TikTok mental health information in therapy sessions. In this piece, he focuses on the accuracy of information about mental health on social media, noting that this content disproportionately impacts CYP. This article frames self-diagnosis as a presentation of possible underlying experiences and describes that when a client discloses a self-diagnosis, they may be articulating symptoms they have had all along and seeing videos on TikTok could have helped them know how to express them. Alternatively, he poses that some young people may be misdiagnosing themselves but have "genuine feelings or anxiety and identity disturbance" that the therapist should attune to. Martin advocates that therapists should "counterbalance misinformation on a one-to-one basis" while simultaneously "encouraging curiosity" in their clients. Specifically, he recommends inviting clients to explore whether their experiences might be explained by factors "other than the condition they've decided on." According to Martin, the best practice approach involves validating the client's self-diagnostic process while maintaining what he describes as "a little scepticism about taking what we hear at face value."

In another practice-based article, Phillips (2022) interviewed therapists about their experience of self-diagnosis from social media for the American Counselling Association magazine, in this article, Phillips describes therapists watching social media posts with clients in sessions and offering psychoeducation around when symptoms are "normal" or "disordered." Therapists stated that, in their view, clients are looking to understand their experiences and the ways that mental conditions are depicted on social media seem to explain. Phillips posits that it is particularly important for therapists "to create a safe, welcoming space for young clients and avoid dismissing their thoughts and feelings around self-diagnosis". In some accounts, therapists reported having an initially negative reaction to social media self-

diagnosis and feeling concerned about how to navigate a client who has identified with what they view as an inaccurate diagnosis. Phillips argues that counsellors can engage with self-diagnosis collaboratively by exploring what elements of a diagnosis resonated with the client and asking about their reasoning behind identifying with a particular condition.

Nelson's (2023) thesis provides distinctive practice-based insights into counselling approaches for self-diagnosed clients. Her research with U.S. mental health counselors reveals that most employ humanistic perspectives when addressing client self-diagnoses, emphasizing therapeutic alliance and client expertise. Though some counselors initially responded negatively to client-determined diagnoses, Nelson emphasizes the importance of therapist self-reflection regarding biases toward self-diagnosis and social media.

Her findings suggest that therapists view self-diagnosis—even when inaccurate—as an opportunity for therapeutic exploration. Counselors provided psychoeducation while validating clients' experiences, sometimes offering alternative perspectives such as trauma history. The study noted that clients frequently shared social media content during sessions, with therapists sometimes evaluating online information and recommending reliable resources.

Particularly relevant to this thesis, Nelson identified that adolescents and young adults were more likely to self-diagnose and discover mental health conditions via TikTok, possibly influenced by developmental identity formation processes. She concludes that clients use self-diagnosis as a tool for self-understanding, and that therapists applying humanistic principles achieve better outcomes with these presentations.

While Nelson's research aligns with the aims of this thesis, there are key differences. Nelson examined all age groups rather than focusing on adolescents specifically, studied internet sources broadly rather than social media platforms like TikTok, and operated within the U.S.

context where therapists receive mandatory diagnostic training which is a requirement absent in UK counselling and psychotherapy practice.

2.5 Gaps in research

There is a growing interest and desire to understand the phenomenon of self-diagnosis from social media mental health content. Further, as some of the literature indicates, there is awareness that this phenomenon may have specific impacts on young people.

Many studies look to make sense of the emergence and prevalence of mental health content on social media, placing this phenomenon in the context of critical psychiatric and capitalist discourse. Further, there is an extensive body of research investigating adolescent social media use and mental health impacts alongside cultural attitudes and stigmas. However, these studies have limitations as they do not focus on clinical populations (Fassi et al. 2024). This is one point that this thesis seeks to consider.

> *What are therapists' perceptions of what a self-diagnosis means for adolescent clients?*

Additionally, there is limited research investigating how self-diagnosis by social media mental health content impacts on therapeutic practice in counselling young people. Further, there is no available research on therapist's perspectives on self-diagnosis with mental health conditions in either adult or CYP populations.

There is an evident gap in knowledge regarding practice-based perspectives of adolescent self-diagnosis from social media. Additionally, there is an absence of research regarding therapists' experiences of this phenomenon in the UK. Thus, this thesis seeks to address the additional research question.

> *How are therapists working with adolescent clients exploring a self-diagnosis from social media?*

This thesis aims to address some of these gaps by exploring UK-based therapists' experiences and perspectives on working with adolescents who are exploring self-diagnosis after viewing social media content. By examining both what therapists perceive self-diagnosis to mean for adolescent clients and how they work with this presentation, this research will contribute to developing a more comprehensive understanding of this emerging phenomenon in therapeutic practice.

Chapter 3: Methodology

3.0 Introduction

This chapter details the methodology and methods to explore the questions:

> *What are therapists' perceptions of what a self-diagnosis means for adolescent clients?*
>
> *How are therapists working with adolescent clients exploring a self-diagnosis from social media?*

In this chapter, I discuss the methodology and methods along with the reasons I have chosen to use a qualitative approach, establishing constructivist hermeneutic phenomenology, which led me to choose reflexive thematic analysis to conduct this research. This chapter outlines my research design, ethical considerations, data collection, and analysis for this thesis.

3.1 Research Paradigm

3.1.1 Ontological and Epistemological Assumptions

As outlined in my literature review, the nature of this research is firmly situated in a historied and complex sociocultural context. As this research is practice-based and culturally situated, I was drawn to Finlay's description of "reflective enquiry", where she states that "both therapy and phenomenological research involve a journey of evolving self-other understanding and growth" (Finlay 2011, 7). I find that this journey of evolving understanding and growth throughout this research has supported me to hold my roles as both researcher and therapist dialogically, at times enlisting skills and frames from one role to engage with the project of the other.

I chose a qualitative framework for this research as my study aims to make sense of and capture the richness and depth of the data (Willig 2008). Therapy is a nuanced process of meaning-making and reflections on therapeutic practice are necessarily complex and

informed by each therapists training, experience, and point of view. Thus, I believe that using a qualitative method of enquiry aligns with the research aims to acknowledge the value of subjective experience and multiple perspectives (McLeod, 2011). Research paradigms are fundamental to providing the appropriate "tool" for gaining insight while reflecting the values that motivate the researcher (Pilarska 2021). As such, this study is ontologically oriented within a relativist paradigm, which acknowledges the existence of multiple, equally valid realities developed on what they perceive of their environment (Ponterotto 2005).

As Pilarska (2021, 64) describes:

> All constructivist approaches acknowledge that there are no universal 'truths' or valid categories for human experience; hence knowledge is the production of social and personal processes of meaning-making.

The constructivist position holds that meaning is hidden and must be brought to the surface through deep reflection, which can be fostered through the researcher-participant dialogue (Ponterotto 2005).

Aligning ontology and epistemology is crucial to coherent foundations for research, therefore, this ontological position requires an epistemological approach to knowledge generation, which aligns with the dialogical and constructed nature of reality.

Ponterotto (2005, 129):

> The researcher and her or his participants jointly create (co-construct) findings from their interactive dialogue and interpretation.

Thus, this epistemological position views reality as both constructed and contextual. This lens embraces an interpretivist theoretical perspective to emphasise the subjective and interpretive nature of human experience (Cresswell et al. 2007). Taking a constructivist epistemological position recognises that the researcher is actively (co-) constructing meanings, fluidly accepting that participants' stories reflect their own subjective perceptions (Finlay 2021,

105). Adopting this stance required me to engage dialogically throughout this research, generating data through a process of reflection and interpretation.

3.1.2 Methodology: Hermeneutic phenomenology

Methodological integrity in qualitative research relies on thoughtful research design and procedure that supports research goals and explicitly states the researcher's approaches to inquiry (Levitt et al. 2016). As such, considering my knowledge assumptions of interpretive intersubjectivity, I chose phenomenology as a methodological approach.

Phenomenology is not only a description of an interpretive framework, but a process where the researcher "mediates" different meanings of the lived experiences (Van Manen 1990; Cresswell et al. 2007). Rather than attempting to hold an objective perspective, I align myself with Willig and Billin (2011), who believe that the subjectivity of the researcher inevitably impacts the research and that intersubjectivity is an important dimension of hermeneutic phenomenology.

I acknowledge that there are various approaches to phenomenology, underpinned by different philosophical standpoints. I have chosen to use Husserlian hermeneutic phenomenology, where the researcher works from the participants' specific statements and experiences (Cresswell et al. 2007). In contrast to Moustakas' transcendental or psychological phenomenology (Moustakas 1994), hermeneutic phenomenology emphasises the interpretive process where the researcher makes meaning of the lived experiences of the phenomenon (Cresswell et al. 2007). I felt that this methodology's emphasis on interpretation and researcher involvement aligns with the ontological and epistemological foundations of this research.

Finlay summarises Husserl's philosophical approach to phenomenology as built on the intention "to bring out the full richness of our subjectivity as ways of discovering the world" (Finlay 2011). This methodology aims to honour the participant's and researcher's

subjectivity as interrelated and situated in the world. Therefore, epistemologically this methodology is hermeneutic and dialectic. This project is reflexive by nature, as a researcher-practitioner, engaging in practice-based research with participant-therapists, as Pilarska states, “I became a part of the reality that was being researched” (Pilarska 2021, 66).

As a practitioner and researcher, my perspective is inevitably situated within my personal and professional experiences. I argue that it is important to emphasize how my theoretical orientation provides a foundation for my interpretations throughout this thesis. In my practice, I make meaning and interpretations through a psychodynamic lens, which is built on the idea that lived experiences are situated in dynamic relationships with oneself, others, and the world. This orientation has significant influence and grounds my interpretations and analysis of participant’s perspectives. Throughout my analysis and interpretations of participant accounts, I draw from psychodynamic theory and consider the conscious and unconscious processes that are being ‘acted out’ within participant interviews and participants’ accounts of their therapeutic work with clients. Additionally, this orientation led me to remain curious about both explicit and implicit communication, as aligned with psychodynamic theories which consider both apparent and deeper meaning of what is expressed (Jacobs 2024).

I argue that my psychodynamic orientation further aligns this research with hermeneutic phenomenology, as both view interpretation as a subjective and iterative process that links our external and inner worlds within the discourse of our experiences and context.

As my research is concerned with deepening research of therapists’ practice with the phenomenon of adolescent self-diagnosis from social media, highlighting my theoretical orientation and adopting a constructivist lens alongside phenomenology has supported me to engage with my research questions ethically and reflexively.

3.2 Data generating methods

Embracing my ontological perspective that reality is constructed and dialogical, I chose to generate data through semi-structured interviews. This method opened the opportunity to enter a dialogue with participants about their experience and to facilitate space to produce rich data. I developed a set of open-ended questions (see appendix 5) that I felt would invite participants to engage in reflective and exploratory dialogue about their experiences.

For this research project, I decided to conduct semi-structured interviews with therapists working with young people aged 10-18 who had experiences of self-diagnosis exploration in their practice across Scotland. In the creation of my research design, I investigated roles and settings of CYP therapists. I became aware that in Scotland many practitioners working outside of NHS settings, were based in upper primary and secondary schools, or within adjacent charity settings which aligned with school programmes. This led me to develop inclusion criteria, which focused on therapists working with young people aged 10-18. Additionally, as this research seeks to understand an emerging phenomenon, I decided to include a wider age range to accommodate the prevalence of self-diagnosis across CYP populations.

Due to the nature of this research and my investigation into how therapists are practising with social media informed self-diagnosis, my aim was to explore the experiences of therapists who were not placed within a diagnostic setting, such as CAMHS or NHS services. Therefore, I developed crucial exclusion criteria of therapists working outside NHS settings. Furthermore, I sought to gather data from therapists who had completed a recognised qualification through a professional body. This decision was twofold, I was seeking therapists who were experienced in their practice and, who practiced in line with the ethical guidelines of a professional body such as BACP, COSCA, or UKCP.

I contemplated my research questions and goals to explore in-depth practice experiences with my research supervisor; these discussions led me to decide on a sample size of 6-10 participants. I decided on this sample size by recognising the limits of this thesis, which adheres to a lower word count than a PhD, and the complexity of this topic, which spans across disciplines. The intention of this research is to delve into the lived experiences of therapists; therefore, I decided to prioritise a smaller sample size to allow sufficient space for in-depth explorations of participant data. Hermeneutic phenomenology tends to use smaller sample sizes to facilitate intensive engagement with data (Willig and Billin 2011), thus I made this decision by considering the methodology, research aims, and scope of this research project.

3.3 Ethical considerations

The current study as well as all materials used were reviewed and approved by the University of Edinburgh board of ethics. I considered that participants were all qualified and experienced therapists under clinical supervision and the practice issues discussed were on a par with the kind of issues that they would normally discuss in supervision. Additionally, this study did not recruit participants from the NHS but due to the nature of this project and its exploration of mental health diagnosis, this research proposal was also considered and approved by the University of Edinburgh Sponsorship Board (see appendix 7). The process described below was developed and approved in accordance with the University of Edinburgh Research Ethics Committee (see appendix 8).

Key ethical considerations for this research include maintaining confidentiality for both participants and their clients, navigating potential dual relationships within a small therapeutic community, and managing my position as a practitioner-researcher. I took careful measures to anonymise all data, paying close attention to the confidentiality of client information discussed by participants. Throughout the recruitment and interview processes, I

discussed my role as a researcher with participants and outlined the boundaries of confidentiality within our potential dual roles in a shared community of therapists. I prioritised transparency about my research aims while being mindful of how my power and position as a researcher might influence participants' responses. Additionally, I provided both verbal and written opportunities to discuss any concerns about confidentiality or professional implications of participation.

Throughout this process, I held in mind Willig's words, "With the power to transform meaning comes responsibility" (Willig 2017, 509). As a researcher, my attempts to make sense of and analyse the accounts of participants, I hold the power to shape and portray these experiences within the context of this thesis. In my dual role as a researcher-practitioner, I continued to reflect on and navigate the boundaries between my therapeutic practice and my role as a practitioner and researcher. During the process of this research, I drew on both clinical and research supervision to reflect on my positionality whilst holding space for the complexity of engaging in practice-based research.

3.4 Participant recruitment

Participants were recruited by contacting counselling and therapy services working with CYP throughout Scotland. I created recruitment materials (see appendix 1) and requested that the services share these materials with their team. These services were given my email and encouraged to reach out with any questions. This recruitment process generated interest and I was in contact with 8 individuals considering participation in this study. I then sent interested individuals a Participant Information Sheet (see appendix 3). Following, their viewing of the participants' information sheet I liaised with potential participants to discuss the project and field queries before arranging an interview. At this stage, 2 participants disengaged and did not respond to my email to schedule an interview. Interviews were scheduled in confidential

spaces either at the participant's place of work or online through a Microsoft TEAMS meeting in a private space.

3.5 Pilot interviews

To test the flow and efficacy of my draft interview schedule, I first had a colleague conduct and record the interview placing myself in the participant role and answering questions as a practitioner. I chose to start this way, to begin the participant portion of this research from a place of reflexivity. This process helped me to understand my perspective and ideas before starting interviews with research participants, while also enabling me to occupy the position of interviewee. After this practice interview, I made minor adjustments to the interview schedule, these adjustments included shifting the wording of questions for clarity and the inclusion of a question about the practice setting of therapist-participants. Next, I organised a practice interview with a colleague who met the inclusion criteria for this study. I recorded this interview and had an informal discussion with my colleague about their experience as a practice participant. After this interview, my colleague offered feedback, and we discussed the order of questions and wording of the interview schedule. This practice interview allowed me to step into the role of interviewer and to assess the flow and clarity of the interview schedule from that position.

3.6 Recruitment sample and participants

Holding in mind the scope and aims of this research, I chose to design a research project with the goal of facilitating longer interviews with a smaller pool of participants.

All participants met the inclusion criteria below:

- A qualified counsellor or psychotherapist recognized by a professional body such as COSCA or BACP or UKCP
- Currently providing talk therapy to young people in a non-NHS counselling service or private practice

- Experienced for a minimum of 6 months in this work
- Currently working with young people aged 10-18 in Scotland

3.7 Interview participant demographics

There was a total of 6 participants who completed interviews for this study. The survey participants (see Table 1) represented a mix of theoretical orientations, years of therapy practice, practice settings, and additional relevant experience. I chose to include participants' theoretical orientations as a therapist's modality can have significant impacts on their approach and meaning making throughout their practice and reflections. Notably, individuals that responded to the recruitment for this study were overwhelmingly registered with BACP and COSCA professional bodies and practice with Person-Centred and Psychodynamic theoretical orientations.

3.7.1 Table 1: Participant demographics

Pseudonym	Gender	Nationality	Modality	Years of therapy practice	Practice Setting & Additional relevant experience
Caroline	Female	British	Person-Centred/ Psychodynamic	5 years	Primary and Secondary School, charity, experience as a counsellor in a GP practice
Jacqui	Female	European	Psychodynamic, supervisor	12 Years	Primary and Secondary School
Ellie	Female	European	Person-Centred	3 years	Primary and Secondary School and Private Practice, background in youth work
Alex	Female	British	Existentialist, supervisor	16 years	Community agency which provides counselling, youth work, and family work in both school and community settings
Ana	Female	European	Psychodynamic (background in art therapies)	7 years	Secondary School and Private practice, studied psychology and internship experience with psychiatry
Dan	Male	British	Person-Centred, supervisor	10 years	Primary and Secondary School background in youth work and social work

3.8 Conducting the interviews

Interviews were arranged over the course of 6 weeks. Interviews were a mix of in-person and virtual meetings. There were two interviews arranged in-person and four interviews held virtually on Microsoft TEAMS.

At the beginning of the interview, participants were given the opportunity to discuss any further questions about the Participant Information Sheet (see appendix 3) and any possible risks involved in partaking in the research. In-person participants then completed a Consent Form (see appendix 4), participants who attended interviews online were asked to complete the consent form through email prior to the scheduled meeting. In both circumstances, I confirmed the participant's consent to be interviewed and to be audio-recorded.

I then began a semi-structured interview following the Interview Schedule (see appendix 5).

At the end of the interview participants were thanked for their time and I provided all participants with a Participant Debrief Form (see appendix 6) outlining the aim of the research, the next steps of the project, and how their data would be held.

Audio recordings of interviews were then saved on OneDrive and on a password protected external hard drive.

3.9 Method: Reflexive thematic analysis

Having chosen to work with hermeneutic phenomenological methodology, I considered coherent methods to conduct my analysis. I explored interpretive phenomenological analysis, grounded theory, and reflexive thematic analysis. As I considered my research aims, purpose and positioning, I decided that using reflexive thematic analysis was the best fit for this study and would provide a coherent and flexible set of methods. Reflexive thematic analysis offers an accessible and robust "family of methods" (Braun & Clarke 2022), through which I was able to bring myself as a subjective and reflexive researcher.

Reflexive thematic analysis is characterised by an iterative process of coding and theme development where researcher subjectivity is seen as "not just valid, but a resource" in the generation of codes, themes, and interpretations (Braun et al. 2019, 848).

As with any research method, reflexive thematic analysis is not without critical discourse. As a method that is widely used in qualitative research, there are varying degrees of rigor and quality when using this "family of methods" (Braun & Clarke 2022). The dominant critique of reflexive thematic analysis is that some research using this method confuses epistemological and methodological commitments and lack coherence throughout creating "bad" and "ugly" results (Finlay 2021). Braun and Clarke emphasise that although reflexive thematic analysis is characterised by its flexibility, it is essential that this method is underpinned by robust engagement with theory (Braun & Clarke 2018, Finlay 2021)

Braun and Clarke (2018) emphasise that the researcher must choose theories that inform their reflexive thematic analysis and explain exactly how they implement the methods in their research. Adopting this method, I used an inductive, data-driven approach (Braun and Clarke 2013). Meaning that the research is developed from the data and themes are determined through the subjective process of coding and organising the data from the perspective of the researcher. This thematic analysis is ontologically grounded within an interpretivist paradigm and philosophically underpinned by hermeneutic phenomenology.

3.10 Working with the phases of reflexive thematic analysis

Coding and analysis were guided by Braun and Clarke's (2022) framework for Reflexive Thematic Analysis, which involves an iterative process of data familiarization, code, generation, theme development, theme review, theme definition, and finally writing up these findings for this thesis. Throughout this process, I kept thorough notes of the development of codes and themes to allow for coherent and traceable research.

These phases are an iterative process, outlined by the structure but are described as a process of mapping, using these methods as a guidebook as one would use a travel book or map on an adventure (Braun and Clarke 2022). Researchers are explicit that they make use of these phases and moving between them fluidly throughout the process of data analysis and theme development (Finlay 2021). Throughout the data analysis and theme creation in this research, I often returned to previous phases to refine, adjust, or reflect on the process and my changing perspective. Reflexive thematic analysis encourages the researcher to immerse themselves in the data to become deeply familiar with the details of the data, paying close attention to the details of language, tonality, and possible meanings (Braun & Clarke 2022). The next steps in the process require the researcher to take a step back and look at the data thematically or to "critically engage" with the data from a bird's eye view (Braun & Clarke 2022). I have frequently thought about these processes of "immersion" and "critical engagement" as *zooming in* and *zooming out*. Throughout this study, I found the process of moving between a *zoomed in*, more detail-oriented and a *zoomed-out*, more broad-viewed perspective challenging. In phenomenology, researchers examine a phenomenon, reflecting on essential themes of the lived experience, and write a description "balancing the parts of the writing to the whole" (Cresswell et al. 2007, 253). Throughout the process of generating themes and developing an analysis of this data, I have been challenged to find balance between the individual participant parts to the whole making meaning of this study from a phenomenological perspective. In this process, I have grown and developed as a researcher learning to embrace the uncertainty and sticky points of the research and staying with and between each phase of the analysis.

3.10.1 Phase 1: Familiarisation with data

After conducting the six interviews, I used the software Transcribe (Routes 2023) to create initial transcriptions of each interview. I then read through the transcribed interviews and

cleaned the data by listening to each interview whilst reading the transcriptions and making corrections to improve accuracy.

I familiarised myself with the data by annotating the transcripts in Microsoft word using the comment function alongside the transcripts. In these annotations, I intended to stay as closely to the participant's words to best capture each therapist's perspective. After this process, I wrote up individual interview summaries, which included key quotations, client examples, and overarching practice methods for each participant. I used the process of writing these summaries to *zoom in* and familiarise myself with the interviews as a data set. These transcript summaries supported me to delve into the data and to begin to see similarities and differences amongst the six interviews. At this point, I began the process of entering into dialogue with the data. During this phase, I moved away from simply summarising the data and began "asking deeper questions about the data" (Braun & Clarke 2022, 43).

After looking at these interview notes, I returned to my research initial question, *What are the experiences of therapists working with young people who are exploring mental health self-diagnosis after watching social media content?* I noticed that participants had shared their practice experiences, however, participants had also described what they believed was happening for young people and social media. As I began, I then decided to develop a second research question to capture this aspect of the data. *What are therapists' perceptions of what a self-diagnosis means for adolescent clients?*

3.10.2 Phase 2: Coding

Once these summaries were complete, I began the coding process. I uploaded the cleaned transcripts into NVivo and began coding the transcripts line-by-line. I began coding, using primarily semantic codes to stay close to participant's descriptions of their own experience. At the outset of this phase, I considered my research orientation to interpretation and

reflexivity. I chose to take a latent approach to coding, focusing on deeper more implicit meanings that may be hidden or concealed (Braun & Clarke 2022).

As I went through the interview data, I created a bank of codes within Nvivo (Lumivero 2023). I went through line-by-line, marking significant statements generating codes and drawing from the bank of codes I had created. I frequently labelled lines or statements with multiple codes to capture the full meaning of the statement. This process categorised the data into just over 300 codes. Each interview lasted between 60 and 90 minutes and produced transcripts between 15-25,000 words. Due to the amount of data and cultural context of this research, I spent days delving into the data and would take time away from the data to refresh my perspective.

After this first set of coding, I returned to the original bank of codes and refined them for clarity and duplicates. I then looked at the groups of data associated with each code and considered the frequency and representation of individual codes across the total data set. I noted codes that were represented across multiple interviews and codes which were concentrated to one or two participants.

Shaping the data set into small statements and phrases was a hermeneutic and cyclical endeavour. Over a period of weeks, I came back to the data, reflecting on the codes I had created and wondering about the many stories that could be told from this set of data. I began thinking about the codes in relation to one another, I found myself excited to notice the frequency or the richness of some codes. At this stage of the analysis, I was *zoomed in*, immersed in the details of the data, thinking about the specific words, tones and client examples that were given.

At this point I felt bound-up in the messiness of the research. This part of the process was intense for me, I felt as though I was swimming through the words and all of their possible meanings, and the larger picture felt far from sight. I worked to stay in the uncertainty and

possibility of the data. I hoped that with more time and engagement with the data, I would start to form a story with the abundance of threads I had begun to notice.

3.10.3 Phase 3: Generating initial themes

Starting the phase of generating themes felt like my first foray into *zooming out* and adjusting my vantage point away from the trees and towards the forest. At first, the process of zooming out felt blurry, foggy, and unclear. In the hopes of starting to shape the blurred image, I decided to organise codes into groups according to my 2 research questions. As I looked at these groups, I felt that these categories limited the ways that elements of the data were connected. As if placing a code into one research question or another restricted the lines of connection I noticed across the codes and the research questions.

To expand my thinking, I hand-wrote codes onto strips of paper and laid out pieces of coloured paper to create a malleable diagram (see appendix 10). I placed codes onto different colours of paper and moved them into different groupings to explore their points of connection and disconnection. I felt that this process brought a more embodied approach, and This process helped me to consider other ways of organising my thinking and I began to consider different conceptual shapes that these codes could make. At this point in the analysis, I started to develop some rough themes and subthemes.

3.10.4 Phase 4: Developing and reviewing themes

Although these interviews felt representative of the diversity of participants and their clients, I quickly noticed that there were many points of convergence within the data, particularly around the ways that therapists responded to and practised with young people exploring self-diagnosis within therapy sessions. Further, I noticed a common description of therapists working alongside other adults, professional and familial to support their clients. I felt that it was important to balance the diversity of participant responses alongside the holistic aims of this phenomenological study.

At times, I found it difficult to step back or *zoom out* from the details of the data and engage in critical engagement to gain perspective on the bigger thematic picture I was building. I found it challenging to extract themes from the rich, descriptive and relational text of the interviews. During this process, I continually returned to the themes and subthemes I had initially generated, considering how different configurations and frames could impact the story I was developing from the data.

At times I felt overwhelmed trying to express all the aspects that felt significant and overlapping to me. I chose to draw diagrams of interconnected circles, looking at how the data could be shaped differently according to which element was placed in the centre (see appendix 11). I played around with these connected circles and placed elements that I felt were core to the research in the centre, such as the therapist, client, social media, and self-diagnosis.

3.10.5 Phase 5: Refining, defining, and naming themes

Using these processes, I initially developed a set of 9 themes and 22 sub-themes (see appendix 9). Following the creation of these initial themes, I continued to further play with the themes and subthemes. I actively searched for connections between them and considered how my choices in interpretation and organisation could shape the story that I was aiming to tell in this research.

I went back through each transcript looking through the lens of my themes and identified examples, ideas, and elements of each interview that linked to each theme and subtheme. At this stage, I listened to recordings of each interview to refamiliarize myself with the context of codes and themes that I have created. This felt crucial to holding the uniqueness of each interview in balance with connecting each individual participant to the whole of the research themes.

I continued to refine my themes and gave them names which I felt captured their essence (Braun and Clarke 2022). In the end I was left with 10 themes and 29 subthemes (see chart in chapter 4).

3.10.6 Phase 6: Writing matters for analysis

Finally, I began writing. I started engaging with the excerpts, thinking about how I would present the data and form a coherent story. I continually re-adjusted and organised where and how I would use different aspects of the data. I often felt uncertain about where to situate examples, as I have mentioned, I was challenged to untangle elements of examples of practice, which often touched on many aspects of culture, practice, and relationality.

The more time I spent writing, the deeper my reflections became. At this stage, I felt immersed in the intersubjectivity between myself and the data. I chose to present the data alongside my analysis, weaving my subjectivity and reflexivity amongst the participant excerpts. Throughout the revision process, some of the fog began to lift, I became aware of the story I was writing with this data set and felt more confident in my choices as a researcher. At last, I felt as though I was zooming out and engaging critically with the data as a balance between the individual and the whole.

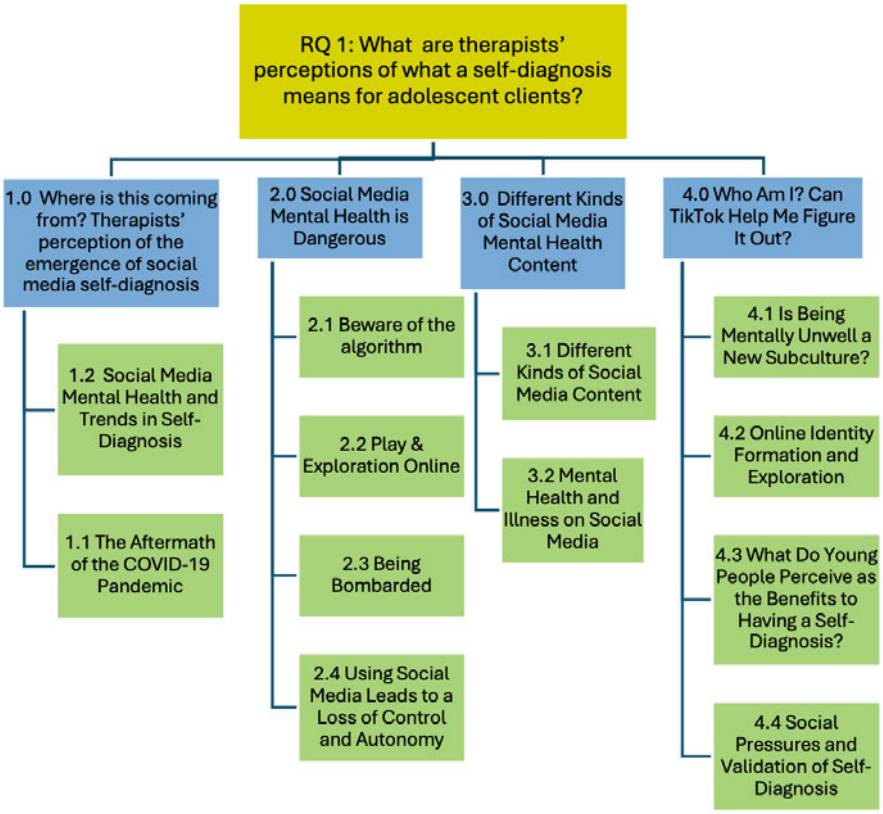
Chapter 4: Analysis

4.0 Introduction

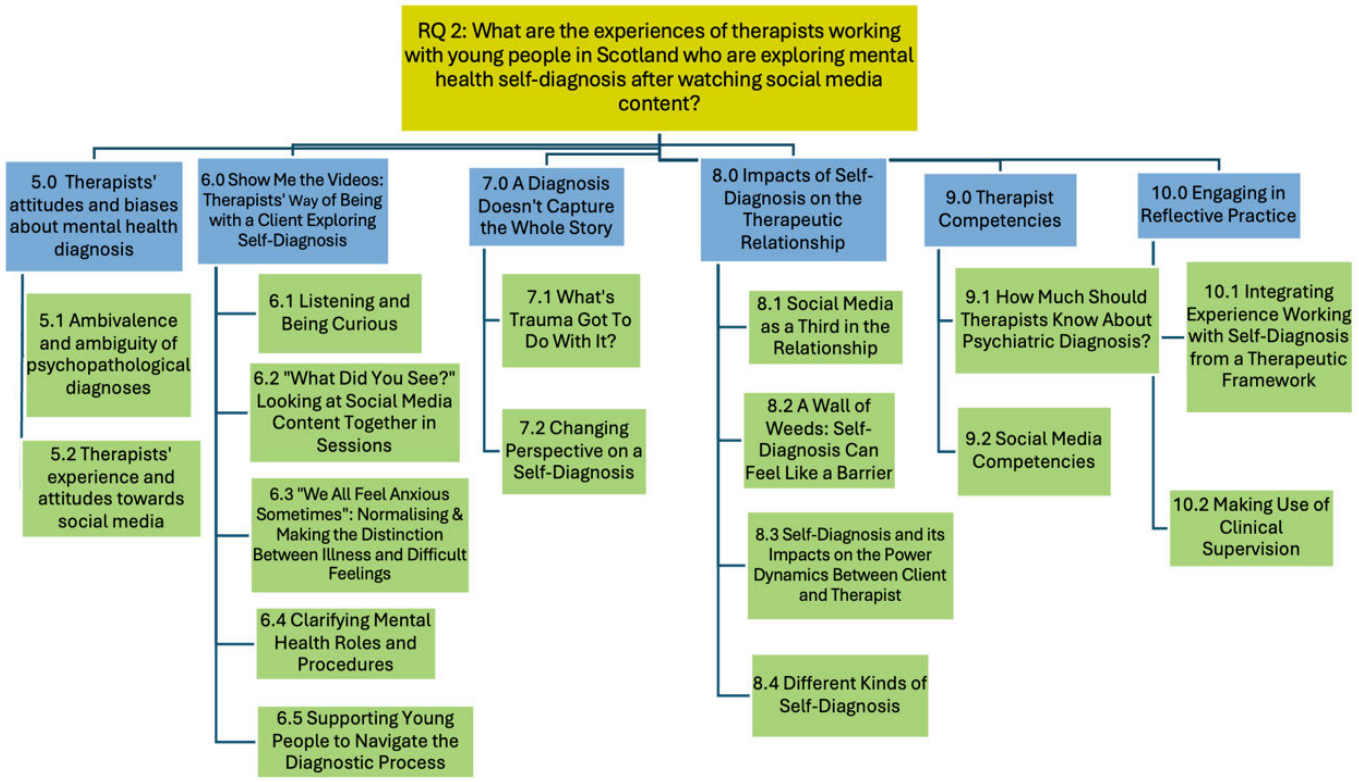
In this chapter I will show how I have chosen to synthesise and contextualise participant data by conducting a reflexive thematic analysis. I constructed 10 themes and 29 subthemes during the research process I outlined in Chapter 3. In Figure 2 I have presented the themes associated with the research question, *What are therapists' perceptions of what a self-diagnosis means for adolescent clients?* In Figure 3, I have presented the themes associated with the research question, *How are therapists working with adolescent clients exploring a self-diagnosis from social media?*

Together these themes aim to illustrate relevant and evocative practice examples across the data to answer my two research questions. Although themes are presented separately, I note that they are interconnected illustrating the complexity and richness of therapists' perceptions of their adolescent clients and their practice. I chose to write this chapter as an analysis to emphasise the interpretivist nature of this research and to draw deeper insights related to my research questions. Throughout this chapter I have woven my interpretations and reflections throughout participant data. In these instances, I use the first person to signify my analysis.

4.0.1 Figure 2: RQ 1 themes and subthemes



4.0.2 Figure 3: RQ 2 themes and subthemes



Themes related to research question 1:

What are therapists' perceptions of what a self-diagnosis means for adolescent clients?

4.1 Where is this coming from? Therapists' perspectives on the emergence of social media self-diagnosis

4.1.1 In the aftermath of the COVID-19 pandemic

The impact of the COVID-19 pandemic was a thread that appeared across conversations with several participants. Therapists described that before the pandemic it was rare for young people to bring self-diagnosis explorations into sessions. In the years following the COVID-19 lockdowns and ongoing social distancing policies across the UK, participants started to notice young people struggling more frequently with social situations and learning more about mental health conditions on social media platforms.

Each therapist mentioned the impact of the pandemic at some point in the discussion. Jacqui described that there, "has been a boom" of young people self-diagnosing with mental health disorders and that, specifically, "TikTok had a bit of a boom during Covid." She also noted that TikTok videos started to shift to content about mental health diagnoses such as ADHD or bipolar disorder. She believes that this "boom" in social media use and the change in content has led to more young people self-diagnosing and thinking about their experiences through a lens of psychopathology.

Ana spoke about noticing a delay between the end of the pandemic and the emergence of social media self-diagnosis in her practice. From her perspective, the prevalence of self-diagnosis exploration correlated with the return to "normal life" after the pandemic. She started noticing self-diagnosis, "definitely after the pandemic" and identified that the examples she referenced throughout our interview were between 2022 and 2023, when self-diagnosis became prevalent among her clients.

Caroline noted that her experience working with young people throughout the pandemic differed from her experience after. She believes that "the pandemic influenced things a lot", explaining that she "started to notice social media use changing." She elaborated, describing that after the pandemic, young people began speaking about mental health content and relationships that were social media based.

Across interviews, participants considered how the pandemic was a significant marker of change in the lives of the young people they work with. I argue that placing this research within this historical context is essential to exploring the emergence and impacts of this phenomenon.

4.1.2 Social media mental health trends

Social media is characterised and organised by trends, such as hashtags, memes and music clips; it follows that content about mental health diagnoses would exist within this framework. Therapists spoke about noticing trends in diagnoses, neurodiversity and ADHD were mentioned repeatedly. Participant's accounts described self-diagnosis as emerging rapidly among their client base and with multiple clients self-diagnosing with the same condition at a given time.

Dan first noticed self-diagnosis when "so many kids talked about depersonalisation" after they had "learned about it online." Dan explained that he was surprised by the popularity of this diagnosis as he wasn't familiar with it and had never heard it spoken about before. This example diverged from other participants as it was the only account where clients had self-diagnosed with a condition that was not previously known to the therapist. This could be in part due to the diagnosis itself or could be attributed to Dan's approach to both social media and diagnosis which he self-describes that "he doesn't know much about these things."

Ellie also shared that she first noticed self-diagnoses becoming more prevalent with clients exploring gender identity. Ellie said that she noticed that clients were questioning their

gender identity and simultaneously exploring a diagnosis such as ADHD or ASD. She observed that once a young person has felt validated in one element of themselves, in this case, gender identity, they may also continue to consider other aspects of their experience that might be recognisable on social media, such as categories of neurodiversity.

I argue that these accounts point towards a rapid emergence of self-diagnosis in the years following the COVID-19 pandemic. Crucially, therapists described noticing that multiple young people explored a self-diagnosis of the same condition simultaneously, seemingly in waves. I consider how the structure of trends on social media may impact the prevalence of specific self-diagnoses at a given time and how this view aligns with my psychodynamic practice approach and understanding of mental health from a contextual and historical perspective. These accounts lead me to wonder how or if self-diagnosis presentations may be directly related to trending content on social media platforms.

4.2 Social media mental health is dangerous

4.2.1 Beware of the algorithm!

Although this research is focused on therapists' practice alongside adolescent self-diagnosis, these accounts point to a core belief in therapists that social media cannot be trusted in relation to mental health information. This belief was expressed about many elements of social media mental health, some therapists highlighted the usage-focused design and motives of social media platforms to engage users and make a profit rather than to disseminate accurate information.

There were many elements of social media algorithms that participants mentioned feeling concerned about. Across all but one interview, participants described the risk of losing autonomy on social media and concerns about it being "addictive", "dangerous", and "traumatising." These accounts indicate a fundamental fear of the dangers of social media being used for mental health information and I argue that understanding therapists' beliefs

about social media is crucial to understanding the ways that therapists practice and engage with young people exploring self-diagnosis after viewing mental health content on social media platforms.

Alex stood out as a participant who emphasised her fears about the impacts of social media.

> I mean social media is, it's just, I think it's, it's quite scary and I don't think, you know, the uptake in social media and the mental health crisis, I don't think they've happened unrelatedly.

Above, Alex makes a direct correlation between the "mental health crisis" and social media use. She believes that social media is detrimental to mental health and that the continued prominence of social media use is a contributing factor to the increase in mental health issues that young people are experiencing.

Algorithms serve corporate interests

Participants expressed concern with the way that social media algorithms are integrated with marketing and data collection. Three participants expressed fears about the ulterior motives of social media companies and how marketing is embedded in social media use.

Ellie stated that she feels uncomfortable with the ways that devices and websites are integrated with advertisements, "…if I look at something on Google or a website and then suddenly it pops up on my Alexa or it pops up on your Facebook page…" She extends this experience to consider how this impacts young people who are constantly marketed to by social media platforms for both content and products. She is fearful of how that would be for a child or young person who has searched for content that could be connected to mental health issues such as low mood, restrictive eating, or self-harm. Ellie's considerations of CYP seem to indicate that from her view, this would be more impactful for younger people than it would be for adults, such as herself.

Alex spoke specifically about the monetisation of online resources relating to mental health conditions. She mentioned the prevalence of online checklists and resources to seek out a psychiatric diagnosis.

> …if you just Google autism, the first thing that comes up is usually a quiz. So, is there any wonder that young people are self-diagnosing?

She notes that these resources often require an email address to view the results from an assessment.

> …and then you do the quiz and you have to put your email in to get the results and then it's out there and it's like you're bombarded. So, for your monthly amount, you get regular emails and personalized this and that…

She refers to the increase of online services offering a paid private diagnosis. Alex believes that companies have ulterior motives for people to be curious about a diagnosis, as there are material benefits from paid assessments, content, and resources to manage mental illnesses which are both linked by some influencers or marketed through advertisements which are curated according to the content that users view.

It is clear from the quotes above, that both Ellie and Alex are concerned about the presence of marketing that for-profit companies have within social media platforms and how that integrates with potential mental health conditions. I interpret that they both feel that some social media content and companies are leveraging the vulnerabilities of young people who are struggling emotionally by marketing paid solutions such as diagnostic assessments or resources to manage a mental illness. I argue that from the viewpoint of these therapists, the trend of social media content about psychiatric diagnoses could be seen through a lens of for-profit interests. I consider that from these accounts, therapists express concerns about young people being influenced to identify with a self-diagnosis for the benefit of companies profiting from mental health resources such as assessments.

4.2.2 Play & exploration online

Caroline thinks about young people exploring social media content in terms of play. I believe here she is using the term "play" from Winnicott's (1971) idea of play, which for him is a goal of psychotherapy where the individual is open to be free and creative, although "inherently exciting and precarious." Here, Caroline draws on her psychodynamic training to interpret how young people are using social media platforms. Caroline uses this term to describe online play and how social media is a domain that can create space for exploration.

> I think play is dangerous and scary at times, but I think that Al that's where the algorithm gets me. 'Cause it sucks you out of the bit where you're exploring the dangerous and the scary and sucks you all the way in. But in some ways otherwise, if you're playing a scary game with your friends, you can just walk away. It is not like you're gonna be reaching back at you. To show you more and more. It's that loss of control really. The loss of control.

Caroline personifies social media using terms that grab and take away control from the user. She contrasts play offline and online, describing offline play as something that the individual can choose to end by walking away. However, she sees online play as personified, "reaching back at you" and "sucking you all the way in." I highlight these terms in my analysis, as I interpret that they illustrate the algorithm and AI as a predatory being that captures social media users and takes away elements of their control.

> Like it angers me actually. Yeah. But 'cause they are children at the end of the day, they can't necessarily make the choices that an adult would make and have the self-control to say, actually, I don't wanna see that.

She expresses anger and separates the abilities of adults and children to use self-control. I understand her anger as a response to feeling that these children are being taken advantage of in some way or that they are not being adequately protected from pernicious forces. Caroline emphasised that "they are children", this statement stands out as throughout the interview, as this excerpt is the only place where she speaks about young people or clients as children. I

interpret that because she is speaking about the risks of social media and what she perceives as predatory elements of using these platforms, Caroline is focused on the vulnerability of young people, which she communicates by shifting her language to use the term children. This change in terms seems significant as the role of adults, legislation, and autonomy is widely seen as different for children vs. adolescents or young people.

Caroline also spoke about online forums where people share ways to develop disorders. She spoke at length about people that were able to "deliberately induce DID."

> …something that had kind of started as a fun little silly thing…actually messed them up and now they had a genuine diagnosis of DID and were really struggling.

She described this as a cautionary tale and with genuine concern for young people who may find these kinds of forums. In this example, I gather that Caroline is grappling with the line between play and danger. Here, she describes that online something which may seem innocuous or playful, may lead to severe or irreversible shifts in a person's mental wellbeing.

> I think that really scares me. Because there's so much we don't know about our brains and our sense of self.

Here, Caroline depicts her fear that it is possible to develop a mental health disorder and that in her view some young people may want to do this or play with this idea but it may have lifelong impacts. She ends this quote thinking, "there's so much we don't know", and holding in mind that in this uncertainty, there is a risk of significant harm.

It feels that she is connecting the choices that a person can make at a young age which may have lifelong effects without realising. As we discussed this, I felt aware that we were two adults speaking about the experience of teenagers. I was reminded of my own experience as a young person and the ways that I couldn't conceptualise the possibilities of how my actions or decisions may impact my life or others. I wonder about Caroline's perspective here- for me, her considerations bring up a lot of questions about autonomy, ability, and consent about adolescence and social media.

4.2.3 Being "bombarded" by mental health content

Participants expressed fears about the structures of social media platforms and how algorithms are designed to compile content similar or related to content that the user has viewed. Five out of the six therapists interviewed mentioned apprehension that a young person would continue to see content based on what they have watched previously. This concern was most frequently described in terms of if a young person had viewed potentially harmful content such as videos on suicide, self-harm, or disordered eating; they would continue to view more content on this topic, which could lead to them to pursue these behaviours, potentially causing physical and emotional harm. In these statements, participants expressed a sentiment that young people need to be protected from dangerous content and malign forces.

Alex spoke of her concern about algorithms on social media platforms and the ways that viewing content on a topic leads to further content on the same topic.

> You open that up. Yeah. Then that's, it's just a total rabbit hole that young people fall into because, you know, and it, it's all algorithms. So, you click on one and then the next thing you're getting more and more and more. And so, it's almost like once you've ticked that box, then that whole world opens up. So, if you've got a young person who has low mood, it can be very, very dangerous.

In this excerpt, Alex conjures up a sense of powerlessness of young people who may inadvertently be going up against poisonous and corrupting forces. She repeats words emphasising the impact of the content and the potential danger that lurks.

She alludes to strong imagery, such as the myth of Pandora's box, expressing how once the world of dangerous content is opened, it is seemingly endless and inescapable. She also characterises the experience of using social media as a "total rabbit hole" where the user is entangled in a time-consuming and confusing tunnel.

She goes on to describe how a young person engaging with content about low mood can quickly lead to content about suicidality, including information about methods and plans to complete suicide.

> I think sometimes you can just click on something that is maybe a bit about, you know, low mood, and then it's about suicide. And then before you know it, there's like, it's taking you down a hallway of 'Oh, these are ways that you can actually end your life.' Yeah. And it can be, you know, it can be four clicks away. Yeah. And that's, that scares the Jesus out of me, I have to say.

Above, she describes a scenario where content about how to complete suicide is just "four clicks away." This description depicts a rapid journey from innocuous to pernicious content, which can happen in seconds. Crucially, Alex paints an illustration of how the platform leads the user through the curation of more content, which can begin as a benign curiosity and can end with materially damaging influences. I interpret her view as highlighting the vulnerability and powerlessness of young people who are led towards danger lurking just a couple of videos away. This description evokes a submissive and dark power dynamic between the user and the platform.

Ellie accentuates a sense that young people are trapped by the content they are viewing on social media. She stated, "it becomes really hard to get out of that as well", indicating that for young people there may be a loss of power or control which makes it more difficult for them to break away from looking at the images and videos on their feed. Ellie specifically named that she fears for adolescents using social media as they are "at a time of development and identity" and that it would be more impactful for them to be "inundated by such a bombardment of information" at this time of life.

Ellie uses potent language about young people being "bombarded*"* and "inundated*"* by information. These words evoke images of warfare, violence, and lack of control. This implies that when young people are in a way being attacked and overwhelmed by social

media content. From this view, they have little autonomy or power to intervene or to defend themselves against the destructive consequences.

Jacqui described an experience of a client who described their social media use to her, "I choose content and then I get more and more and more content." Her client explained noticing that they didn't feel they always were making a choice to watch videos on TikTok.

> I got stuck, I stayed there for two hours watching all these videos and I'm not really sure if I really wanted to.

In this example, Jacqui depicts a young person feeling inundated and frozen by the content they are viewing. She emphasises the amount of content by repeating "more" to highlight that it feels like the inundation of content continues indefinitely.

What stands out for me in this excerpt is Jacqui's perspective that the client was "stuck." This framing elicits a feeling of powerlessness to leave or change the content they are viewing. She continues to explain that client reported that they had lost a sense of agency in continuing to stay on the app for two hours. Jacqui, like other participants in this section seem to be questioning the impact of choices that young people have within the context of social media platforms and whether these choices function to facilitate the autonomy of adolescent users on platforms such as Instagram and TikTok.

Significantly, Caroline also had a similar description of social media algorithms as a "kind of tunnel" and that viewing disturbing content may lead a user "into a freeze state" which algorithms would likely interpret as positive interest and continue "to get more of the thing that is stressing you." She shared an example where one client who decided to attend therapy after viewing something they found upsetting on TikTok.

> …after a couple of weeks it turned out that they'd seen something that really disturbed them on social media related to mental health they hadn't felt able to tell anybody and they hadn't known what to do, like how to report it or do something about it…they had seen something

> they didn't know how to talk about and felt ashamed to share with other people what they'd seen.

She explained that this was an "extreme instance" where she felt that this client had felt traumatised by this content and entered a "freeze state" where they were unable to look away. Caroline expressed her concern for this dominant structure of algorithmic curation, particularly for young people who may be traumatised or significantly influenced by images and ideas they are consuming.

She went on to lament that in cases where a young person is led toward the tunnel of dangerous or harmful information, they "miss out on the whole rest of social media that might be quite helpful and supportive…" Here she diverges from other participants on the topic of algorithms, as she highlights the potential for social media to be a positive and supportive environment for young people. She speaks about two sides of a coin asking, "is it gonna relieve trauma?" or "is it gonna create trauma?"

I argue, that from these accounts, young people are depicted as being vulnerable to having a passive curiosity which could lead to a bombardment of progressively dangerous content that may be inescapable for them. Thinking with Caroline's view, a pathway towards viewing helpful or supportive content versus dangerous and overwhelming content may be unpredictable. I argue that these views from participants illustrate young people as caught within social media algorithms with limited agency to alter the algorithmic trajectory they are on.

4.2.4 Using social media leads to a loss of control and autonomy

Participants perceived that being a social media user led to a lack of autonomy and control. Multiple therapists mentioned the difference between using different social media platforms such as TikTok and Instagram. They note that different platform structures and algorithms

could lead to varying levels of autonomy. Participants explained their concerns about the addictive nature of social media.

Ellie referenced learning about social media through a documentary which left her feeling pessimistic and uncertain about the impacts of social media diagnosis and social media use in teenagers.

> I don't think we know the dangers of social media diagnosis, the kind of like the addictive side of, you know, how much young people are entrenched in social media and their phones and their devices. Yeah. I just don't think we're, we're gonna know the dangers of it for a long time and then we'd be thinking, what the hell?

Ellie explains her fear of the unknown effects that social media diagnosis and social media use may have. She predicts the impacts of social media diagnosis with the words “addictive”, “dangers”, and “entrenched”, each of these terms evokes a lack of safety and personal power. Ellie posits that at present it is difficult to see the impacts of social media self-diagnosis, but she imagines a future where it is apparent that this growing phenomenon is detrimental to young people.

Caroline notes differences in social media platforms TikTok and Instagram, the two platforms where participants reported young people most frequently engaging with content about mental illness and wellbeing.

> *C:* “I think particularly on Instagram, it's a bit easier because they perhaps find one account and they follow it and then if they're on their homepage they see more of that one account that they've liked in a genuine way. Yeah. I think TikTok’s a bit difficult because it's more scattering, otherwise you've got a bit more control of Instagram.
>
> *M:* Yeah. Well, I guess yeah, that's exactly it, on TikTok is just whatever comes next.
>
> *C:* It's the control, isn't it? Yeah. Like yeah. And you do lose control.

Caroline reflects on TikTok and the algorithm driven “For You Page” (FYP). She notes that it is designed to continuously provide more content that the user may be interested in. Here,

Caroline and I speak together about the distinction of a social media user choosing what to view in contrast with being given something to view. She argues that the crucial difference is the amount of control that the user holds on different platforms. When she discussed Instagram, she described that the user actively creates their preferences by choosing who to follow. In contrast, she defines TikTok as "scattering", depicting a sense of disorder. I interpret her statement on control to communicate her sense that on TikTok, the user abdicates their autonomy to the algorithm, willingly relinquishing control to the platform. Alex, illustrates an example of a young person who feels a lack of control when using social media. Alex and this client began to notice a pattern where his use of social media during less busy times in his life, often led to a return to restrictive eating behaviours.

> *A:* …if you're, if you're bored and you just flick onto [TikTok] and because he's a previous user, then, you know, all the usual flags are there. Yeah. And the click bait kinda stuff that he's just, where if he was having his therapy, if he was working, if he had all the other distractions. Then he wouldn't be looking at that…right okay, can we spot the pattern here?
>
> *M:* It's almost as if it's waiting for him where he was last time he was using it.
>
> *Alex:* Absolutely.
>
> *M:* Like it's queued up from exactly where he left off…it's quite sinister.
>
> *A:* Really. So, it's a stalker in your pocket. Yeah, just waiting for you.

From her perspective, this client's use of social media is a direct link to his relapse into disordered eating. Alex and I both consider how a social media platform maintains records and data from the last usage, therefore when the client returns to the app, there is content queued up from his last use of the app. During this exchange, I was imagining Alex's client, a teenager wanting to return to TikTok or Instagram in a moment of boredom or curiosity; being met with the images, messages, and influencers that were significantly involved in his eating disorder. I found this example quite heartbreaking, and I felt overwhelmed imagining how hard it must be for this young person to develop a new way of being outside of his

disorder without being either socially isolated or immediately drawn back in. Finally, in this example, Alex describes a phone with social media apps as a "stalker in your pocket." With this personification, she illustrated a dark and ominous image of a malicious individual tracking every move. This image has lasted in my mind and feels present throughout the interviews where participants continuously considered the safety of young people on social media platforms.

I interpret that these extracts frame social media algorithms as intentionally addictive. In these accounts, therapists describe the adverse impacts of the addictive design, highlighting that they feel these designs may disproportionately impact adolescent users. I gather that these accounts imply that young people may be more vulnerable to the addictive designs of social media platforms due to their developmental stage. Considering both Alex's and Caroline's practice modalities, autonomy is a central tenet in person-centred and existential theories, this leads me to wonder how their practice approaches may impact their views of social media and the importance of personal autonomy. In the above quotes, therapists express a belief that allowing young people to use social media may be negligent to protecting young people from this powerful and controlling entity.

Obsessive TikTok users

Two participants used the term "obsessive" about the ways that some of their clients use social media to learn about diagnostic information. This term stood out as I analysed the data, as obsession indicates a complete preoccupation with something and how participants perceive the impacts of these clients' obsessions with diagnostic information on social media. Ana delved into her experience with a client that she felt was continuing to gain more and more information about their possible diagnosis.

> And the role of social media in that is interesting because I find that every time, we meet again every week, the young person has already read a lot of more new information, so they

> would know new words that maybe they wouldn't use so much before. So, I have addressed with them that there is some obsessive Googling, and I wonder if it's not coming just from them that there is a lot of stuff that gets generated.

From Ana's perspective, the client continuously learns new information and language from social media. She considers how there is a lot "generated", and I wonder if Ana means that there is a possibility of continuously changing and evolving definitions, words, and cultural references to diagnostic content on social media platforms. I interpret that Ana is questioning whether this client is continuing to seek understanding or if this client is so accustomed to learning more about their self-diagnosis that they are habitually returning to these platforms out of impulse.

Across interviews therapists describe young people as believing that learning more diagnostic information may solve or explain something they cannot make sense of. I believe that this "obsession" in the hopes of a solution is a significant foundational idea to consider what motivates young people to view mental health diagnostic content.

4.3 Different types of social media mental health content

Participants shared their concerns about certain types of mental health content available and simultaneously described feeling appreciative of other kinds of mental health content. This distinction was largely across content that participants felt could be harmful versus content that could be helpful. Some therapists noted the difference between content created by trained mental health professionals and content created by young people or adults without diagnostic or therapeutic training.

Jacqui described misinformation on social media, she explained that some videos layer seemingly unrelated symptoms to indicate a diagnosis, like "if you have mood swings and your feet sweat" then you have bipolar disorder. I interpret that in her view, videos like this

are misleading and may impact young people's understanding of a diagnosis leading them to inaccurate conclusions about themselves after watching unreliable content.

Caroline expressed two caveats, one about the accuracy of information and the second about the amount of information.

> I think it's great if it's reputable information, that's being shared and if it's capped at a limit that isn't triggering.

In this excerpt, Firstly, I understand Caroline here to be highlighting that there is reputable and untrustworthy content available, further she notes that not limiting information, even if it is reputable, could be "triggering" or overwhelming for young people to process.

Participants expressed vivid fears, often in connection to specific kinds of content, whilst positive elements of social media were portrayed in more general terms about support or validation of experiences. Therapists interviewed consistently cited specifically content about suicidality, self-harm, eating disorders, and prominent influencers such as Andrew Tate. Notably Andrew Tate was mentioned in five out of six interviews as an example of dangerous content for young people. I argue that the consistency of fears is significant across this data set and that participants share a sense of what lurks in the darkest corners of social media mental health content.

4.3.1 Some social media content is helpful and supportive

Throughout interviews, each therapist offered practice examples where social media content felt facilitative and supportive for their client. However, when participants spoke about the phenomenon of social media mental health content, descriptions of fear and apprehension were more pronounced. The accuracy of information was mentioned by three out of six therapists, all of whom discussed the creator of the content and their education and qualifications to be sharing information about mental health or illness. I have chosen to focus

on two accounts of therapists describing their views of beneficial elements of the presence of mental health content on social media sites.

Dan expressed appreciation for content about mental health and diagnosis on social media. He shared concerns about some content but said that "there is a really positive side as well", citing that many young people are "supporting each other" in online communities, which he believes is valuable for their wellbeing.

From his perspective, "it's a catalyst for someone to be reaching out for support." Dan believes that young people who self-identity with a mental illness from online content would be more likely to seek out in-person support for their struggles, from his vantage point this is a positive and should be encouraged.

> Whether or not the information they learned is necessarily fitting…they end up coming and seeking out in-person support. They might realise that ADHD doesn't match who they are, but they still get to have that contact.

Dan considers how young people may initially seek out support such as therapy because they have self-diagnosed, but that in the therapy they may change their perspective.

I interpret Dan as viewing self-diagnosis from social media as an overall positive as in his view, a young person would be struggling if they identify with a mental illness and whether that self-diagnosis is accurate or not, it leads young people to get support and explore their difficult experiences.

Caroline spoke about the benefits of feeling seen and connected to others who are struggling or accessing support. Caroline related this to her own experience, where she found Facebook groups and YouTube helpful in her own life. She believes that social media content fills an important gap for people with a mental health diagnosis. She explained, "I could find a lot of information, but none of it related to everyday life." She went on to say that when she started looking at ADHD content on Instagram, she found:

> …a lot of information accurate or not accurate, but I remember that I really enjoyed the fact that it was like in the context of people in their everyday lives.

She said that she started watching content and reading blog posts about people living with ADHD and the types of organisational systems they use, "I found it really helpful to see what actually has worked for people." From Caroline's perspective, content focused on how to live with ADHD and examples of other people's experiences was a refreshing contrast for her from the more clinical literature about the criteria and impacts of having a diagnosis.

Although in this excerpt Caroline is speaking about her personal experience, I gather that she is also sharing how social media can be supportive for clients and other people who may be exploring a diagnosis or have been diagnosed professionally. Notably, in this excerpt, Caroline expresses a significant contrast how she feels about some of the risks of social media. I consider how it may feel different to think about social media as a vast construct in contrast to the impacts an individual, including in this example Caroline herself. I posit that there may be some distinctions between how participants perceive the idea of social media mental health content and self-diagnosis exploration and how it feels with an embodied case and an individual young person.

4.3.2 Mental health and illness on social media

Throughout the interviews, some participants described feeling unsettled by the depictions of mental health disorders on some social media posts. Both Jacqui and Caroline spoke about feeling unsettled when they see inaccurate representations of psychiatric diagnoses or hear unreliable information about diagnoses from their clients.

Jacqui spoke about how young people may be influenced by celebrities who are open about their own mental health diagnoses. She feels that some of her clients may be more likely to identify with a diagnosis because a famous person has divulged their disorder publicly.

> You see all the recognition that goes with it because there is this celebrity who is bipolar, and they're special and they had this video on social media.

She believes that social media doesn't show the full picture, and that young people may only be seeing a small aspect of what it is like to have a mental illness. She highlights that young people see the "recognition" and that "they're special" for having a mental disorder, possibly leading to a sense of allure for young people who may desire these feelings.

This concerns Jacqui, as she believes many young people don't fully grasp the impacts of certain psychiatric diagnoses, such as bipolar disorder. She explained, "No one really has a really, really, deep understanding of what it means to be bipolar," she elaborated that "it's not a piece of cake." In these quotes, Jacqui uses repetition of the word really to emphasise that many people only see the surface level of having a mental illness such as bipolar disorder. She illustrates that it is challenging to live with bipolar disorder. I read this as her noting a change in the portrayal of some mental conditions on social media. She alludes to how bipolar disorder has historically been stigmatised, and that now, in some videos and conversations she has with young people, this illness has been destigmatised and has possibly shifted towards a place of acclaim. She seems to attribute this reverse in stigma to oversimplified depictions on social media, which may even highlight the benefits of having a label. Thus, for Jacqui, the attitudes towards having a psychiatric condition have swung away from stigma and towards a kind of kudos which young people are drawn to. Crucially, she regards these imagined benefits as based on a false narrative curated for social media audiences.

Building on this, I interpret that Jacqui is thinking critically about the motivations of celebrities and influencers, framing their experiences to best suit their public personas. As there may be marketing and monetary benefits to sharing some elements of their personal experience and not others, it is, therefore, difficult to decipher what information being shared

by celebrities and influencers is authentic. From this perspective, some participants, like Jacqui hold fears that young people are viewing content that could be a misleading representation of what it is like to live with a mental health condition.

Caroline thought about the portrayal of mental illnesses on social media as a "blurring of what's real and what isn't." In this description, she in part aligned with Jacqui's sentiments above, yet she names what she finds most troubling is how some disorders, such as dissociative identity disorder (DID), are inaccurately shown on social media. She states that she has seen TikToks where "teenagers are dressing up as different alters and things." I interpret that she views these posts as inauthentic performances that make light of the experience of living with DID. She stated that these videos "novelised and romanticised" the illness, seeing DID as entertaining or a playful way of trying on different interests, preferences, and fashions. Caroline goes on to wonder what it might feel like for a person diagnosed with DID to see inaccurate content about their condition.

> It makes my heart break for people who genuinely do have that diagnosis. Yeah, and genuinely have been through the trauma that would create that.

She empathises with people who live with a DID diagnosis and the experiences which lead to this diagnosis. I believe that here she is highlighting that young people creating these videos, may not understand the condition and the suffering which would have led to someone developing DID. I understand her to be expressing that in her view, some young people are playing dress up with the symptoms of having multiple identities which is both inconsiderate and inaccurate, potentially causing damage to those who do suffer with this condition and with the wider understanding of what is already a stigmatised and often misunderstood condition.

These accounts stand out as highlighting fears and concerns regarding the impacts of misleading and sometimes inauthentic depictions of mental illness on social media. I analyse

that participants are both recognising a shift away from the historical stigmatisation of psychiatric diagnosis and how this destigmatisation at times presents having a diagnostic label as a type of benefit or kudos for the individual. Therapists interviewed expressed feeling disconcerted by how some conditions are framed and how that may impact young people's perception of being mentally ill. In my analysis, I argue that this is a significant finding, as participants are considering the possible motivations for young people's self-diagnosis after viewing social media content and reflecting on their perceptions of this phenomenon.

4.4 Who am I? Can TikTok help me figure it out?

4.4.1 Is being mentally unwell a new subculture?

Participants discussed their experience of young people developing their sense of self through social media mental health identities. Therapists explained that they view adolescent identity formation as central to their work as therapists with young people and that they see elements of self-diagnosis overlapping with young people creating and understanding themselves. Ellie mentions that she has observed a growing trend in her experience of working with young people and in her daughter's friend group, that "they all want to have a label." She compares this to historically popular identities such as "being emo." Ellie makes sense of this by thinking about how difficult it is to be a teenager.

> They couldn't just be a teenager who were kind of having a struggle because teenage years are pretty tough.

In Ellie's acknowledgement of how difficult it can be to be a teenager, I interpret her as drawing a connection to young people looking for an explanation to understand their struggle and self-diagnosis with psychiatric conditions. When she compares having a self-diagnosis to other subcultural identities, I interpret her to be sharing a belief that although identifying with mental illnesses may be a new phenomenon in adolescent culture, teenagers seeking an explanation or group to identify with is not. Interestingly, Caroline, too, referenced self-

diagnosis as an identity akin to being “emo.” This sentiment was echoed in the ways that therapists consider how, for some young people, self-diagnosis is a key component of their identity.

Ellie referenced a conversation that she had with a colleague, which “stuck with her.” They had observed adolescent groups of friends where “all of them had self-diagnosed themselves with something” as they spoke about this observation, she wondered if everyone “had to have something to grasp onto.” Here I understand Ellie to be contemplating what function a self-diagnosis may have and how there could be something stabilizing about having a tangible concept to “grasp onto.” From these statements, I perceive that for Ellie, self-diagnosis identities offer categories and language for young people to express how they see themselves, which may serve to validate their difficulties and communicate traits within social groups. Ellie explained that she believes that young people find clarity and excitement in the diagnostic process.

> And for them it's really exciting, it will, it will make them realise why they think differently, why they have these feelings with trying to make friendships or keeping friendships or feeling valued or wanting to feel part of something or some clarity,

In this extract, she explains that she perceives young people to be excited about finding an explanation for their experience. Ellie’s statement alludes to what a diagnostic category may offer a young person, specifically, that a young person may finally understand the parts of themselves which previously made them feel different or inadequate in some way. Thus, I interpret this excitement as something akin to a finding a solution or an answer to a puzzle. I wonder how from the perspective of a young person, a self-diagnosis may appear to be a pathway towards certainty, as a diagnosis may feel like a way to take away struggle, doubt and questioning.

4.4.2 Online identity formation and exploration

Some participants discussed self-diagnosis in terms of adolescent identity formation and exploration. These therapists considered that young people may be trying on different identities through self-identifying with a diagnostic label. I have chosen to highlight both Ana and Caroline's accounts of making sense of self-diagnosis through a lens of identity exploration and formation.

Caroline described the influence of subcultures on adolescent identity development, "they give you a bit of an identity while you're still growing your own." She goes on to say, "I wonder if social media can be a bit like that." Caroline went on to think about the ways that self-diagnosis can be a kind of subculture and identity for some young people.

> C: Like you can almost have this shell of an identity through a diagnosis or like a hashtag that you follow related to that. And it can be protective but also mean you're not in touch with your own personal experience.
>
> M: Like something about trying to fit into that identity or?
>
> C: Yeah. Like a tortoise shell that you're trying to kind of crawl into and inhabit. But it's not in a kind of a fun way, like being a, I dunno being an emo or something was where there was, it kind of covered all aspects of life with music and things. It's a much more one note experience, I guess.

Caroline compares social media diagnoses to premade identities. She uses the image of a shell to describe that in the case of identifying with a diagnosis, as these identities are a rigid set of criteria. This has a possible double meaning, which I first consider the phrase "a shell of" I think of the meaning as an empty and lacking version of something. Caroline extends this this shell metaphor to describe a physical shell which is "protective", I wonder about the protective nature of identifying with a mental health condition and what that might mean.

I interpret that from Caroline's vantage point, young people are drawn to fully formed identities, which may protect them from the disorderly process of identity formation without

a template. Significantly, she believes that self-diagnosing may create a distance from the individual's personal experience, which I read as a simplification of experience where individuals can fit into a mould rather than reflecting on and exploring the elements of themselves which are unique or less able to fit into a predetermined frame. From this view, there could be something comforting about conforming to an identity, which a category explains, whilst this simplification may also hinder a more nuanced understanding of the self. Caroline contrasts subcultures based on preferences such as "being emo" and having a subculture identity based on a diagnosis of a potential disorder. Thus, it follows that in cases where someone may have the desire to fit into an existing identity or category, the frame of psychiatric diagnosis lends itself to this model, as each condition has established criteria, traits, and treatments. Therefore, self-diagnosing a mental health condition could lead to a kind of shorthand where stating, 'I have (insert diagnosis here)', others will know and understand who you are, what may be difficult for you, and what some of your needs might be. Caroline perceives this as a protective and restrictive view of self, painting an image that this way of being is monotonous and lacking in diversity or colour.

Ana described a case with a client who self-identified with DID, from her perspective this client was exploring their identity within the symptoms of the diagnosis. She detailed how this client created various versions or "alters" of themselves with "names and pictures or their part or personalities." She described that these different parts are "designed" and have "different dyed hair or different clothes,"

> …it does feel sometimes quite creative and like, almost like a part of their hobbies, you know, like an identity thing.

From Ana's perspective, this client was in some ways, experimenting by trying on different identities. The client presented these experimentations through the lens of DID, yet their control over the different personalities seems to indicate that the client had decided to

construct and embody these identities. Ana considered this presentation curiously and, throughout our interview, wondered about what possible motivations this client could have for exploring their personality and creativity through the framework of DID. I interpret Ana's view as seeing this client's self-diagnosis in terms of the performance of symptoms which may have underlying communications and aims. I posit that Ana's interpretation of this client aligns with her psychodynamic orientation, which considers conscious and unconscious communication to be an important element throughout therapy.

In my view, both Ana and Caroline perceive that for some young people identity and self-diagnosis may be intertwined. I argue that these accounts emphasise the presence of social media as presenting premade identities through mental health diagnoses, which some young people choose to integrate into their developing sense of self. Crucially, both Caroline and Ana indicate that in their view, a young person taking on a premade identity may cause young people to try to fit into a diagnosis, which could limit their exploration of their unique identities.

4.4.3 What do young people perceive as the benefits of having a self-diagnosis?

Ellie, Caroline, and Ana all shared examples where a young person found "clarity" through a self-diagnosis. There was an overlap in the ways that these participants spoke about the potential for a self-diagnosis to be "empowering." In each client example, there was a sense that the presence of social media content was supportive in offering language and exposure so that the client could better understand themselves and access support.

Ellie described a neurodiverse client who is pursuing a diagnosis; she imagined that a diagnosis would lead to "an awful lot of clarity" and that this client "would realise they're just neurodiverse, there's nothing bad about them…they're just different." Jacqui also shared an example of a neurodiverse client learning, "my brain works in a different way, and what I need may be slightly different." In both examples, participants felt that clients identifying

with a neurodiversity diagnosis led to further self-acceptance and had a positive impact on the young person.

Jacqui shared a hypothetical example of how a person could feel reassured by a diagnosis,

> I thought for all my life I was weird, and now I've discovered that I have ADHD. So that means that there is a reason why. And I think it's very human and certainly I am always looking for reasons why things are happening.

She uses the example of ADHD to share how a young person can feel reassured by learning that traits they previously felt were idiosyncratic or "weird" are in fact symptoms of a diagnosis. At the end of the quote, Jacqui expresses how she relates to her clients' experiences and empathises with their desire to understand themselves through a diagnosis or label. She highlights that for her "it's very human" to desire certainty and to crave an explanation for what may make someone feel "weird" or isolated. Here she universalises and normalises the experience of feeling "weird", considering how normal it is to look for certainty and "reasons why."

I consider how a hallmark of adolescent development and identity formation is feeling strange or different from others. To me, it seems significant that self-diagnosis may offer an alternative lens that reframes being different as both acceptable and may even have a badge of recognition. I consider how my theoretical orientation and my belief in the value of interpretation in therapy may impact my analysis of these accounts. It leads me to wonder if some labels could be viewed as reassurance that being different from others is normal, on the condition that it can be articulated through a diagnostic category.

Client's expectations of self-diagnosis

Both Dan and Alex described their view of what their clients may be seeking from a self-diagnosis. From Dan's perspective, some young people are looking for a diagnosis to understand how they feel and identify why they may be struggling.

> Sometimes the diagnosis can be…that they have a view of the world, and they might get trapped in that because her way of seeking was to want to know more why…she still looked at that. She felt safer with that.

It is clear that for Dan this client was at risk of being "trapped" by looking for an explanation about their experience in the form of a diagnosis. He spoke about how this client's worldview was shaped by a psychopathological lens and identifying with a diagnostic label felt safer than exploring the complexity of her experience. I interpret, that Dan believes this client is endlessly searching for answers through diagnosis categories that may not exist. I gather from Dan's perspective, that young people would be better served by accepting themselves and their struggles internally, as opposed to looking for answers externally through a psychopathological frame. I contend that this framing aligns with Dan's person-centred practice modality, and highlights that he views self-acceptance as an essential element in therapeutic healing.

Dan spoke about young people as "looking for reassurance", he says that young people want more than anything, "to feel reassured and feel respected and heard." Jacqui explains that from her perspective having a "label" can "give lots of reassurance." She experiences some young people as seeking special treatment and acknowledgement through sharing a diagnosis. "I'm special, I'm unique, you need to treat me in a different way because I got this label." She considers this to be a communication of a deeper need for the young person's experience of suffering and trauma to be seen and accepted. Further, from Jacqui's view, young people perceive that they will be treated differently if they have a self-diagnosis or official diagnosis.

> So, I have a label now and I'm really unwell. So, because I have a label, you will then think of me in a different way and you will validate what I've been through.

Jacqui believes that young people are hoping to receive validation and reassurance when they communicate that they have a diagnosis. From her view, young people may expect that having a diagnostic label leads to direct and material changes in their lives.

Jacqui goes on to say that she feels that "it's something about not being dismissed." She feels that young people exploring a self-diagnosis are looking to be heard and valued in their perspective. Jacqui goes on to state that clients "felt quite relieved" that she "hadn't dismissed them by saying 'no you don't have it.'" I gather, that Jacqui is holding in mind that many young people often feel dismissed or overlooked and she argues that a self-diagnosis may serve to make those needs more formal, leading young people to feel that their needs will be prioritised if they have a mental health disorder.

From Alex's view, some clients think about diagnosis as a "magic wand." She elaborates explaining that she perceives that in these cases young people are looking for a solution that explains and solves them.

> They assume that having a diagnosis is gonna make it all better. Giving it a name is gonna make it, you know, fixable. In some cases, having some medication may help, having some coping mechanisms may help, but yeah, it's not the, the diagnosis itself is not the be all and end all. Which I think some young people thing it will be.

During this exchange, she commented, "you know, as they do", making explicit that I too am a practitioner and may have experienced a similar expectation from clients in their desire to "feel better." I interpret that she uses the term "magic wand" to depict a fantasy, a quick sweep of a solution that can take away the pain and suffering from the traumatic experience that this client endured. Crucially, Alex articulates that she perceives that some young people self-diagnose as a way of seeking an explanation that would eliminate their problems. However, in her view, this is an illusion and even if a young person meets the criteria for a diagnosis, that doesn't lead to the eradication of their issues.

Notably, both Ana and Caroline described instances where they felt that clients were seeking regulation through self-diagnosis. Ana spoke of a client that she suspects gains "some regulation benefits" from thinking about themselves through a diagnostic lens. She explained in her view; the client is able to express "different needs" through their diagnosis than they

may feel comfortable expressing otherwise. In this case, Ana explained that this client can track and "signify if their needs have been met" in relation to their self-diagnosis. Caroline also mentioned that in one case, she felt that her client was able to gain "a sense of stability when they get stressed" by taking on a new diagnostic label. In the above examples, I contend that Caroline and Ana interpret these examples of self-diagnosis through a lens of unconscious communication being acted out through self-identifying with a condition. Here, they draw on their psychodynamic orientations to make meaning of their client's experiences. I interpret these examples, that during times of dysregulation, a young person may feel unmoored and overwhelmed and how a diagnosis may provide a feeling of certainty that they find soothing. I'm curious about the factors that lead young people to see diagnosis as a beacon of stability and how this may reflect a larger societal view of organisation and security. I consider that self-diagnosis could be viewed through a lens of personal safety and regulation, particularly for young people who feel out of control of many aspects of their lives. I reflect that my interpretations of these accounts align with my psychodynamic perspective, which contends that from this lens self-diagnosis can be viewed as a defense mechanism to unconsciously soothe an individual from the distress of uncertainty.

I argue that this view is essential to this thesis, as many participants shared that they perceive similar motivations among their adolescent clients. There is a prevalent perception shared across interviews that young people view their experience as a riddle to decode and that the psychiatric diagnostic categories are the solution to breaking through to form a definitive understanding. Further, I argue that therapists' perception that young people may feel that a self-diagnosis offers stability opens important questions about the role of diagnostic categories for young people and in society.

4.4.4 Social pressures and validation of self-diagnosis

Participants spoke about their perceptions of young people's peer relationships around social media self-diagnosis. Therapists spoke about how young people at times label one another, Ellie stated that she has experience of young people speaking about one another's characteristics in diagnostic terms and at times define one another through mental health conditions. Jacqui shared that clients absorb these labels from peers.

> Young people come to me and say, oh yes because so and so said to me, oh you must be bipolar because you're changing your mood very quickly.

I understood this example to illustrate two important elements, first, because many young people are watching mental health content, there is a potential that young people would not only see themselves but also one another through a psychopathological lens. Secondly, Jacqui perceives young people are applying this lens to one another based on inaccurate or oversimplified information.

Each therapist mentioned an example where a young person felt that online content about mental health was supportive for them. However, when speaking about the social impacts of self-diagnosis, Dan stood out by highlighting that his view of mental health content on social media is overwhelmingly positive for young people. He detailed that there are "supportive elements" to online diagnostic communities and cited that these social connections could allow for young people to "feel heard" and "be guided towards support."

From Jacqui's view, some young people see a diagnosis as a "social currency," she stated, "it's not a stigma" but "almost a currency" to have a diagnostic label. This is consistent with her earlier statements that young people may perceive some benefits of having a diagnostic label and that rather than feeling stigmatised, they may feel "special" or "recognised" in their peer groups for self-identifying with a mental health condition.

Caroline also spoke about a kind of social currency. However, she explained that from her vantage point, some young people see mental illness as “competitive” among peers. She cited that this competition is present in many aspects of mental health, she explained that there is a “comparative” element that is “kind of trickling into the peer groups.” Caroline shared that with some of her clients, they feel that social currency is garnered through having poor mental health. Thus, it is seen as socially beneficial to share or even accentuate mental illness amongst peer groups and on social media.

> It's exactly the same as, you know as if you'd post all the best parts of your life on social media and create that image… It's that same process happening but with your mental health creating how bad it is or you know, which bit is hard or it's getting better.

Above, Caroline suggests that the idealised image of social media may be flipped and that there is a social incentive to develop an online persona that prioritises mental health difficulties. She explained that this comparison and competition are noticeably present in clients who self-harm.

> I've had several clients who have kind of like, you know, searched up self-harm or found themselves viewing self-harm and it's made them very insecure about their own self-harm. Like, I'm not cutting deep enough, I'm not cutting enough.

This quote stood out as a clear example of how this possible attitude toward comparison and competition could have detrimental impacts on young people. It seems that for Caroline, young people comparing themselves to others about self-harm could lead to young people feeling shame or insecurity about not being unwell enough. From this perspective, this insecurity could lead to a young person engaging in more extreme acts of self-harm to keep up with others or feel that they fit in.

I argue that it is significant that peer-to-peer dynamics are impacted by self-diagnosis identification. In my view, therapists’ perceptions of young people’s social relationships contribute to understanding the motivations for some adolescent self-diagnoses. Further, I

believe that it is important to note that in these accounts, being mentally unwell may be viewed as a social benefit, which could encourage some young people to portray themselves as mentally ill or contribute to a desire to have more acute mental illness to gain social approval.

Themes related to research question 2:

How are therapists working with adolescent clients exploring a self-diagnosis from social media?

4.5 Therapists' attitudes and biases

4.5.1 Ambivalence and ambiguity of psychopathological diagnoses

Participants considered how they view diagnosis and the ways that they work with psychiatric diagnoses in general. Each expressed some degree of appreciation for the more medicalised model of mental health labels and some hesitation around how labels have the possibility of limiting exploration or crystalising ideas of self that may be less permanent. Participants considered different categories of mental disorders and how they experienced working alongside them. Dan, Ellie, and Alex emphasised their gratitude for the "medical side" and treatment of eating disorders. There was agreement across participants that in some situations, support of the medical and NHS mental health team is essential to safeguarding and supporting a young person.

Both Ellie and Dan talked about clients who were diagnosed with eating disorders and working with CAMHS whilst continuing counselling with him. Dan described working alongside medicalised support noting that they "are different models."

> I was so glad that was being held by this model and that there was a diagnosis.

He acknowledged "there is a medical part of it" and it's "very important."

Alex and Dan both expressed their scepticism about the scientific basis of psychiatric diagnosis categories. Each described viewing diagnosis as situated within a social and

historical context. They both expressed that diagnostic categories have changed over time and how a person may meet the criteria for a diagnosis at one point in time, but could also, as Dan states "grow out of their struggle." He mentioned that people struggled and healed long before the invention of diagnostic labels and categories. This perspective can be viewed in line with Dan's person-centred approach, which emphasises that individuals have an innate "actualising tendency" whereby counselling may support clients to heal within an empathic therapeutic environment (Rogers 1979). Dan spoke about how "the medical world changes" and that there are diagnoses that were used "10 years ago and that's not used anymore."

> I'm aware that what we have right now will not be the end result. It changes over time.

From Dan's perspective witnessing the shifts in categories and diagnostic labels throughout his career, has solidified his view that a diagnosis categories are malleable and a construction of a given time and frame.

Alex likewise mentioned the changeability of diagnosis.

> The medical profession goes through phases…so for a while everyone had borderline personality disorder…

I understand both Dan and Alex to be considering the historical and political factors in diagnosis, particularly that specific diagnoses have times of more prevalence and are then also viewed differently in hindsight.

Crucially, these perspectives on diagnosis may also be linked to a therapists' theoretical orientation. Here, I consider how Dan, a person-centred counsellor and Alex, who practices from an existential approach draw from their theoretical frameworks. Both modalities tend to view difficult experiences through a holistic perspective, which highlight the client's autonomy and the social and historical context of each individual. Thus, I argue that therapists' attitudes towards diagnosis may be relevant to the way they practice with clients who either have a mental illness or have self-diagnosed. As I examine my interpretations and note the framework of participants, I am aware of my own attitudes and approach to

diagnosis are built from my experience and therapeutic training. In my view, both Dan and Alex challenge the diagnostic lens whilst also accepting the value of medicalised support and the place that mental health diagnosis holds in society.

In one example, Ana expressed her frustration that young people's needs are understood and met when they meet the criteria for a psychological diagnosis, but other needs which don't fit as neatly into a psychopathological framework may not be met with the same reception.

> Why does school meet the needs of young people who are neurodiverse, but doesn't meet the needs of the young people who have been through trauma…?

In this excerpt, I interpret that Ana is challenging the power of diagnosis and questioning the disparity between the recognition and resources offered to young people who meet the criteria for a mental disorder and those who are struggling outside of these categories.

In my view, she raises a relevant critique, as throughout this thesis, therapists repeatedly express their perceptions that young people feel that having a diagnosis is the primary way that they will have their needs met socially and institutionally. Therefore, I argue that throughout this section, therapists acknowledge the power that psychological diagnosis holds and continue to question this power in their practice and the lives of their clients.

Finding a way to integrate diagnosis into therapeutic practice

Both Ana and Caroline explained that they aim to thoughtfully incorporate elements of diagnosis into their work. They both expressed reflection on their views about diagnosis and working to find ways to make use of diagnosis when they feel it is therapeutically fitting.

Ana, who has training in psychology, spoke about the ways that she thinks about diagnosis in her practice. She explained that she applies a critical lens to weave psychological language and categories into her framework as a therapist.

> Diagnosis is not something that drives my practice, but there's definitely space in my practice that diagnosis can inhabit.

In this excerpt, Ana articulates that diagnosis isn't central to her way of working, but that it may at times be relevant to her practice. I understand Ana to be communicating that she engages with a psychopathological frame sparingly but is not averse to using this framework when it feels appropriate.

At different times, Caroline described herself as both "cynical" and "very pro-diagnosis." Throughout the interview, she holds both ideas and shares that she sees diagnosis as complex and nuanced. She described her own experience of receiving an ADHD diagnosis as impactful in the ways that she works with clients self-identifying with a mental health condition.

Caroline shared that she feels ambivalent about identifying as "pro-diagnosis" and at times it makes her feel like a "bad counsellor" as much of her therapy training and her colleagues express reservations about the diagnostic process and frame. I interpret that she is grappling with her own experience, values, and ongoing debates between counsellors and psychotherapists about the role of psychopathology in mental health. I interpret Caroline as trying to approach seeking a diagnosis relationally, here she is sharing that she sees space for diagnosis and respects that many of her clients may benefit from a formal diagnosis. However, she sees her role in the process to encourage clients to consider their desire for a diagnosis and to help them understand their choices and the possible outcomes of embarking on the assessment process

Diagnostic Labels May Limit Therapeutic Exploration

Participants explained that at times, they feel a client identifying with a diagnosis leads to a rigid self-view. Both Dan and Caroline articulated that they feel that a diagnosis identity can impact the client's willingness to explore their experience outside of the diagnostic frame. From Dan's point of view, labelling a person's experience with a diagnosis has the potential to be limiting.

> I wonder if sometimes a diagnosis keeps, particularly if medication is involved, it can keep people held back.

Here he thinks about what happens when something is decided upon and how having a clear label may be restrictive in an individual's curiosity and exploration of their experience. I interpret that from Dan's view, young people self-identifying with a diagnostic label could hinder their self-exploration and healing.

Caroline described that she "struggles" when she senses that a young person has identified with a diagnosis without processing or integrating this aspect of themselves into their sense of self. She explained that in her view, some young people see a diagnosis as defining who they are.

> Where does that fit with the rest of you as a person? There's more to you than just the diagnosis.

Caroline shared that she has experiences where young people make little or no distinction between a diagnosis and a self-identity mirroring certain prescriptive content on social media about mental health diagnoses. When she spoke, she accentuated, "there's more to you than just the diagnosis", which I understood as emphasising her frustration and her belief that any person is more than a mental health category.

In my view, Caroline is voicing that for some young people, a diagnosis can become their identity, leading to an inflexible and totalising view of themselves. As I consider this dynamic, I wonder about the impact this may have in the counselling room. As Caroline shared her frustration, I interpret that she feels that young people who have bound their sense of self to a diagnostic category, may be fearful or hesitant to engage in the self-inquiry required in therapeutic work.

4.5.2 Therapists' experiences and attitudes towards social media

In interviews, participants spoke about their attitudes and ideas about social media in both their personal and professional lives. I have chosen to include these in this thesis because, in my view, therapists' experience using social media and viewing mental health content on social media may contribute to their practice approach and perceptions of young people self-diagnosing after viewing social media content.

Personal use of social media

Four of six therapists described that they are not regular users of social media. Jacqui and Ellie both cited that they have some social media accounts but don't use them very much. Alex explained that she doesn't like social media and found when she was using it to be a "drain on my time and energy." Ana and Caroline both stated that they do use social media, saying that they use Instagram and sometimes Facebook. Dan spoke about how he is quite removed from social media and learns about it mostly from clients.

Across participants, there is a spectrum of personal social media use. However, I believe that it is noteworthy that more than half of the participants reported not using social media often or at all. This leads me to wonder how this may shape their views of these platforms and how that may impact their interactions with clients who report using social media frequently. Additionally, none of the therapists interviewed reported using TikTok, which was the platform that was spoken about most frequently throughout participant interviews. This seems to indicate that participants use social media differently than their adolescent clients. I see this as a significant foundation to consider how there may be both cultural, technological, and generational gaps between therapists and their adolescent clients.

Professional use of social media mental health content

Some therapists cited that they use social media professionally, both Jacqui and Ana described their relationship to viewing mental health content on social media.

Jacqui spoke about using social media mental health content made by professionally trained therapists for developing CPD workshops, she noted that she is often looking for something specific, she used the example of looking for a video about anxiety for group training. She explained that if she finds something that she feels is “pertinent”, it can be an addition to a presentation to include something “visual” to a group training or workshop.

Ana spoke about being “quite suspicious of some professionals who are getting quite a lot of fame” and that she feels even when a content creator on social media is trained as a therapist, psychologist, or psychiatrist their content lacks nuance.

> Their ways of defining wellbeing or mental health or mental health issues a little bit superficial or like kind of oversimplified…

Ana referred to “listicles” which often reference topics such as narcissism with titles such as “are you dating a narcissist?” or “do you have bipolar disorder?” She explained, that for her, most of the available content is “quite surface level” and although she views some of these posts, she doesn’t think about them as resources for continuing professional development or that she would encourage clients to learn from.

Both Ana and Jacqui offer different perspectives on using social media as a professional resource. However, both expressed the need to be discerning about the quality and depth of information available about mental health and therapy on these platforms. In my view, these perspectives offer that although therapists may not look to social media as professional resources, it may be beneficial for therapists to have a sense of what kinds of information is available to understand how their clients may experience learning about diagnosis and mental health online.

4.6 Show me the videos: Therapists' way of being with a client exploring self-diagnosis

4.6.1 Listening and being curious

Therapists emphasised their desire to listen and understand the symptoms or traits that a client is experiencing as well as what a diagnosis would mean for a client. I was struck by the consistency among participants in their way of practising alongside self-diagnosis exploration. Each therapist had their own way of describing how they encountered diagnostic categories in their therapeutic relationships, notably, each therapist used the word "curious" about how they approach working with self-diagnosis. Participants shared an overwhelmingly similar process where they listen attentively and openly to a client's experience and endeavour to understand what elements of a self-diagnosis may resonate with them. Therapists expressed that they find it can be a benefit for some therapeutic relationships to be outside of the diagnostic model. Caroline feels that not being invested in the diagnosis process, "really breaks the barrier" and she empathises that clients are holding a lot of "information and worry" on their own. She thinks it's "great if they've got somewhere to take those questions." Alex too stated that she feels having a place that young people can "have a dialogue" about their experience without being "a clinician" can facilitate more exploration. Dan, who practices as a person-centred counsellor draws on his theoretical approach, stated, "I see the client as being the expert in their own lives. I'm not an expert." Dan starts by trying to "gather a picture" of encourages what the client means when the identify with a diagnosis and what they know about a diagnosis. Dan spoke about how his goal is to open a dialogue with clients. He feels that being open about what he knows and what he doesn't know allows him and the client to be curious together. "I'm interested in having more of a dialogue about what does that mean for you?" He highlights that he is "learning with and from the client" and his aim is to better understand their frame of reference collaboratively.

I interpret Dan's approach, as he referenced above, to be rooted within the person-centred framework. By this, I mean, that I understand Dan to offer unconditional acceptance of the client's perspective and to prioritise learning from the client's experience. I note that other therapists too, express that in cases where an adolescent client has self-diagnosed, they reported approaching this in a largely similar way to most other issues and concerns that a client may bring to them.

Alex spoke about seeing her therapeutic role as helping clients to process something they believe. She states that for her, "it's always the unconditional positive regard that you give to your client." Here, Alex uses the person-centred concept of unconditional positive regard to describe the quality of acceptance and attention she feels is critical to offer clients in sessions. She highlights that each client is different and how she approaches a client exploring a self-diagnosis is dependent on the relationship and situation.

> Sometimes it is about challenging it, sometimes it is about supporting it, sometimes it is it about helping direct them to the appropriate services. And sometimes it's just about, yes, they have to make those connections or helping them make those connections and check out whether that diagnosis is going to make a difference for them. Or sometimes I'm not really sure what it is, and they maybe need to hear it from a professional.

Alex reiterates that there is no one single appropriate response to a client sharing a self-diagnosis. Further, she indicates that there may be multiple appropriate and professional responses that she may employ depending on the client, their situation, and the relationship that she has with them. I find this to be a key element of Alex's perspective, I interpret her as sharing her sense of confidence and practice experience, noting that as clients are not uniform, her way of working with them cannot be prescriptive. Critically, Alex also highlights that there are instances where she is unsure of how to best respond to a client and that maybe other professionals, which I understood as medicalised, or NHS mental health services would be better suited to support what the client is exploring.

Ana explained that when a client discloses a self-diagnosis to her, she highlights, “I’m really, really with them in the conversation.” Ana emphasised that she her first response is to listen to the young person and try to understand what they are exploring and why.

> When a young person suggests to me or says something about ‘maybe I have ADHD’, I listen, and I don’t kind of discourage them.

Ana illustrates herself as open and receptive to the client, she endeavours to facilitate an exploratory and non-judgemental space where the client feels able to discuss or explore a self-diagnosis. I interpret that she believes young people may have a fear of feeling dismissed or possibly have a previous experience of sharing their self-diagnosis that led them to feel dismissed or discouraged. Thus, I interpret that Ana is conscious of this and cautious to not be dismissive of clients who are exploring a self-diagnosis.

Jacqui explained that some people have a “bit of disappointment” when they are looking for her to validate their self-diagnosis. She explained that more often there is “also relief that I’m not saying to them, ‘you’re a teenager, what are you talking about?’” In this quote, Jacqui shares that although she may not meet the young person’s expectations of being able to assess if they meet the criteria for a diagnosis, young people often feel “relief” that they are not feeling dismissed by her.

Jacqui feels that her role as a therapist is to understand the importance of a self-identified disorder to the young person and to validate the client’s experience.

> …my role was just to acknowledge the process and how important was for my client to come there and be able to express that…and validate how [they are] feeling about this… also validating if this is so important to you, that it is worth exploring with your GP.

Jacqui highlights that it may be significant for the client to share this information with her. She elaborated stating that many of her clients have “thought about it for a long time” and she wants to acknowledge that process. Jacqui said that for her “it’s about being more curious about the process that led them [to self-diagnose].” She explained that when a client shares a

self-diagnosis, her first response is to say, “thank you for sharing this with me.” In this gesture, I understand Jacqui to be expressing an acknowledgement that her clients’ self-identification could be the result of a long process of consideration.

Notably, Jacqui’s perspective on her clients’ sharing a self-diagnosis differs from how she thought about adolescent self-diagnosis more generally. In her clients, she shares her view that they have had a process of deliberation and considered thought. Whereas, when she spoke about self-diagnosis from a more universal lens, she expressed a view that young people may identify with a diagnosis without much knowledge scrutiny. She shared that one of her concerns is her perception that some young people’s desire to emulate a celebrity or influencer may encourage them to self-diagnose inaccurately. This difference leads me to wonder about how being involved in a therapeutic relationship with a young person may impact therapists’ views, as well as how thinking about adolescent self-diagnosis from a larger societal perspective may feel differently than an individual client exploring a self-diagnosis.

I gather that both Ana and Jacqui’s responses may express an implied caution in how they respond to a young person sharing a self-diagnosis. From their descriptions, I get the sense that they are mindful that there could be hurtful or disruptive consequences for responding in a way that may feel invalidating or unsupportive of the client’s self-identification. I wonder if there is a sense of delicacy to approaching this presentation and how that may differ from other kinds of content that an adolescent client could bring into sessions.

4.6.2 “…What did you see?” Looking at social media content together in sessions

Most participants reported asking clients about the social media content that they have been watching and queried what information they found most relevant. Crucially, therapists interviewed reported that they did not receive training on how to work with mobile phones in

sessions or how to navigate social media content with clients. I argue that this is relevant, as participants are describing that this is a regular occurrence in their practice and feel that it is important to speak directly about social media content and at times, view videos or posts that clients felt spoke to their experience.

Caroline described that she finds it a "really helpful starting point" when a client shares videos that they have seen on TikTok. "I'd probably go, ok then tell me, what did you see?" She asks clients to show the videos that resonated with them so they can view them together, "then we can unpack it." Caroline feels that looking directly at the social media posts helps her understand what the client is speaking about and opens a collaborative dialogue in the session. She then works with them to clarify what aspects of the video and diagnosis match their experience.

> I'd normally get a piece of paper out and write down all the words that they're using so that we've got them. And try to really unpack it like, you know, how long have you been feeling this way? Was it, can you remember ever since you were little? Is it a more recent thing?

In this excerpt, Caroline highlights a system of mapping and documenting a client's experience in relation to a possible diagnostic category. Notably, she mentions the language that the young person uses and records terms for later reference. In other moments, Caroline referenced her background within a more medicalised mental health environment, and as she described this, I was reminded of these experiences. From my view, there are elements of this description that are akin to an assessment process. However, Caroline seems to prioritise staying with the client's experience and is clear that she is not assessing if the client meets the criteria for a diagnosis. In this example, I believe that Caroline makes use of her previous experiences and integrates it with her therapeutic training to support the client to explore their self-diagnosis.

Jacqui tends to ask clients directly about the videos and content they have been viewing and specifically about where they have learned information about a mental health condition.

> And they will say to me, oh, I did this checklist, then I watched this video. And then there were so and so on TikTok, on Instagram, or YouTube saying this and I identify with it.

She cites that clients share learning about mental illness on a variety of platforms and websites. Notably, other therapists also cited clients completing online checklists that claim to determine if an individual meets the criteria for a diagnosis. She asks clients to retrace what sources they have used, and she is clear that she tends to dissuade clients from trusting information that they found on social media sites.

> We'll check where they got their information from and where the checklist is coming from. And sometimes it comes from the NHS. I always say to them, well let's check what the NHS says about it.

Jacqui focuses on giving clients as much accurate information as possible and reinforces the process of NHS diagnosis criteria and process with clients. I gather that in these moments, Jacqui holds in mind that there is a spectrum of information available about mental illness on social media platforms, some of which is inaccurate and misleading. I interpret that for Jacqui, an element of her role is to model critical viewing of social media posts and to guide young people away from ambiguous or misleading information towards more reputable information. From this view, I perceive that from Jacqui's perspective, she feels that she is more equipped to critically sort through mental health content and information available online than many of her clients. I wonder about this dynamic and how it may acknowledge an epistemological underpinning about the therapists' role with CYP based on their experience, theoretical orientation, and setting.

In this subtheme, some therapists report, despite not having training or guidance to work with mobile phones or social media in sessions, that they are viewing and discussing social media content in sessions. I argue that this is pertinent to the findings of this thesis, as these examples could indicate ways that self-diagnosis in therapy could indicate a shift in the skills that therapists use to practice with young people.

4.6.3 "We all feel anxious sometimes": Normalising & making the distinction between illness and difficult feelings

During participant interviews, therapists seemed to ask their clients and themselves, "What is normal?" This question feels relevant to this thesis as it concerns the idea that something that is "disordered" or "pathological" is often defined in contrast to the concept of "normal" experience. As therapists are involved in helping people make sense of their experiences, it is common for therapists to assure clients that it is normal and natural to feel difficult emotions and have difficult experiences in life. Throughout interviews, therapists described offering an alternative perspective that these experiences could indeed be normal (albeit challenging) but may not indicate that a young person is experiencing the signs of a mental illness. Notably, participants spoke most frequently about normalising anxiety as an expected or ordinary experience, making contrasts to the symptoms of having an anxiety disorder, such as generalised anxiety disorder (GAD). I believe that this is significant, as therapists described offering normalising responses to some of the symptoms that led young people to identify with a mental health diagnosis.

When his clients describe considering a mental illness, Dan stated that he frames many experiences by trying to "make it a bit more normal." In Dan's view, some of what young people see through a lens of psychopathology, he views as within a "normal" spectrum of experience. He asks a crucial question, "but what is normal?" I interpret that with this question he is considering that the idea of "normal" may be more complicated than it would initially seem. Dan shared that he challenges many aspects of a "normal frame" and in society he believes that many popular representations are too rigid to encompass the complexity of individual experience and mental health.

Alex also spoke about how it is common for clients to state, "I have anxiety." Here, I understand her to mean that to "have anxiety" indicates disordered anxiety such as GAD.

When this happens, she often responds by reframing that feeling anxious is something that all people experience.

> We all have anxiety…Anxiety is one of many [feelings] that make up that kind of colourful package.

In Alex's view, anxiety is normal, and I gather that she shares this statement both to validate the client's feeling and to normalise it. She invites young people to explore "what's going on in your life right now that is raising your anxiety levels?" When she asks this question of her clients, she seems to be encouraging connections between how they are feeling and their life circumstances.

> And maybe it's just, right now there's a lot going on, there's a lot of uncertainty, there's a lot of pressure, there's a lot of stresses, and you're, you're feeling, you're reacting to that in a normal way, which is to be anxious as opposed to someone who can't leave the house because their anxiety levels are really high and they don't really know what they're anxious about.

In this quote, Alex is offering a degree of psychoeducation to help a young person understand that feeling worried, anxious, or upset could mean they are reacting in a "normal way" in response to a situation which is, in fact, upsetting or stressful. From Alex's vantage point, when thinking about disorder and pathology she views that there is an important difference between anxiety that is caused by external circumstances and anxiety that initiates endogenously. Alex adds, "I think when you go online, it doesn't necessarily unpack that." In this extract, she highlights an important difference between what young people view on social media about anxiety and other mental health issues, and what happens when they are exploring these issues in a session with her. I interpret that from Alex's perspective, young people learning about mental health from social media may lead to a reductive understanding of emotional literacy and the complexity of lived experience.

From these accounts, it would seem participants believe that in some cases, young people perceive content about mental health in a way that reduces or conflates the nuances of

individual experience, leading to confusion about what qualifies as abnormal or disordered. As I interpret these accounts, I consider how therapists practice approach may impact how they view ideas of what is normal. I argue that these examples open an important line of inquiry about the impacts of social media mental health content the possibly oversimplified depictions of psychological experience that young people encounter.

4.6.4 Clarifying mental health roles and procedures

Therapists shared how they communicate with transparency about their role, training, and familiarity with mental health diagnoses. This sentiment was also consistent amongst participants. Each therapist described how they share and educate clients on diagnostic procedures and their role within this process. They stress that they aim to be as clear as possible with clients about their skills, qualifications, and their knowledge of the diagnostic process.

Although this research is focused on self-diagnosis, I believe that it is important to acknowledge that participants described self-diagnosis as often leading to clients questioning and inquiring about the official diagnostic process. Therapists frequently spoke about discussions with clients on whether they would choose to pursue a medical diagnosis. Throughout interviews, it was rare that a participant mentioned a case where the client had not at least considered seeking a discussion with their GP or a CAMHS assessment in connection to their self-diagnosis in session with them. Thus, from my perspective, self-diagnosis and the pursuit of a medicalised diagnosis have overlapping experiences throughout this analysis.

Alex outlines her role and scope with the young person and reiterates that even when a client may consider pursuing an official diagnosis, she is there to continue the therapeutic relationship.

> I am not a clinician, so you need to hear that [assessment of a diagnosis] from someone else. That's something you take somewhere else. And I will continue to work with you to support you in the ways that I am skilled to do.

Alex also adds that she reassures clients that she has "worked with people who have these conditions" and "we can explore them." She reiterates that "for them to get that diagnosis, then they need to contact their GP." I read Alex's explanation as a sense of clarity and competence. She states what is within her role and reassures that "I will continue to support in the ways that I am skilled to do", she clarifies that she feels confident in her skills, and within that confidence, she knows when and how to access support for a client that needs something outside of what she can offer.

Interestingly, Ellie and Jacqui shared that they too offer a similar reassurance to clients, explaining that they both "have lots of experience" to draw from, despite not being diagnostically trained. I interpret this response as twofold; this seems to communicate competence and reassurance to the client, that they are capable of working with the self-diagnosis and discussing diagnosis explorations. However, I also sense that there is something compensatory in these statements, and some participants may feel it necessary to clarify that although they are not trained in the diagnostic side of mental health, they are qualified and capable in their practice. I gather that this is directly connected to how therapists perceive that many young people enter sessions with a limited understanding of the role and scope of therapy and may come into a session with expectations of psychological assessment or confirmation of their self-identified disorder.

Jacqui shared that some young people don't "have a clue about" about the NHS diagnostic process and ask questions like, "why do I need to be assessed?" and "why the GP cannot give me medication immediately?" She spoke about bringing the client back to what they do have, including information like NHS checklists and goes through the steps of pursuing an official diagnosis with them.

> If you choose this pathway, this is what it looks like…this is what you can expect if you go to the GP and they might put you on a waiting list to then see a professional, which can take a certain amount of time…

She explained, "it's about giving them a sense of how the system works." From Jacqui's perspective, because some young people do not understand this process, she chooses to educate herself and then educate clients to manage their expectations about the steps and time required to pursue an official diagnosis.

I chose to highlight these examples because, across participant accounts, therapists reported educating their clients on the NHS procedures. From my perspective, this is significant, as therapists explained that they were not trained in these processes and some therapists described learning these processes in their role with little guidance or continuing professional development. From this, I consider how mental health content on social media and the increase in self-diagnosis presentation may lead to an increase in client interest in diagnosis. This could impact the role of therapists practising with adolescent clients, as in my view, educating clients on NHS procedures may indicate an expansion in the role of therapists. As illustrated above, it could be viewed that therapists are expanding the scope of their roles to educate themselves and their clients in medicalised mental health supports to fill gaps in client knowledge or to clarify misinformation on social media sites.

4.6.5 Supporting young people to navigate the diagnostic process

Each participant spoke about cases where a client they were working with therapeutically was also working with CAMHS. In these circumstances, therapists spoke about clients processing their experiences within a diagnostic environment in therapy sessions. As in the above section, I chose to include these excerpts to highlight how I perceive therapists adapting their practice to meet self-diagnosis presentation. This section focuses on how participants described working with clients who initially came to them with a self-diagnosis. However,

this group of clients have after self-diagnosing, have chosen to pursue an official diagnosis whilst continuing with therapy. I consider how the increase in self-diagnosis presentation may impact the number of clients that therapists work with who are simultaneously accessing mental health services such as CAMHS.

Jacqui and Dan spoke about supporting clients to have conversations with their families, GPs and CAMHS staff. Dan spoke about using the therapeutic space to think about "what would you want to say?" He feels that these conversations "give a lot more opportunities for self-guidance." I understand that Dan is using therapeutic space to support clients to explore their aims and needs from other mental health services. Jacqui supports clients "to plan how they're going to have the conversation." She runs through scenarios with clients considering how they want to approach talking about a self-diagnosis, what questions they might have, and what questions they may be asked to answer. Crucially, as I mentioned in the above section, this kind of preparatory conversation relies on the therapist's knowledge of the diagnostic assessment process.

These accounts frame the therapist as a sort of bridge between the therapeutic relationship and the other adults and professionals in the young person's life. In my view, this is important as therapists share a sense that clients are more trusting of the relationship, they have withing the counselling room than they feel with family and professionals that may be involved in their mental health support.

Ellie detailed a client who had recently started accessing CAMHS for support with an eating disorder, during their ongoing sessions, this client shared information that led Ellie to believe that this client may be experiencing symptoms of OCD. Ellie shared her concern that this client may share information with her that they would likely not share with their CAMHS worker and that without the client's disclosure these developing traits may not be observed in their CAMHS appointments.

> You know, will that be looked at by CAMHS? And it's certainly not something that she had shared with them. And I was kind of encouraging her when she has her next session to maybe just bring that up because it could be something they can work with together.

From this example, I understand that Ellie is sharing her view, that this client disclosed more of her experience in the counselling room because they had an established therapeutic relationship. I interpret that Ellie perceived that this client was not as trusting or comfortable with the CAMHS team and therefore was more cautious about sharing her vulnerable experiences. Therefore, Ellie, who has limits to her role as a therapist, felt some anxiety knowing that she is aware of this information, while the CAMHS team that is trained in working with this presentation is unaware of these symptoms.

From my vantage point, this case could exemplify a view that therapists see a distinction between the relationship that young people have with them, and the relationships that young people have with other mental health professionals. I note that as the role and time that therapists have with clients is different, they may have more time to establish a relationship with clients. Whereas within the medical service, a GP or CAMHS worker may have less frequent or more assessment-based meetings with young people.

I argue that these accounts are significant, as they could indicate that in some client-therapist relationships, clients feel more able to share their experiences openly and might disclose information which could be essential for them to access crucial supports. Therefore, from these examples, I posit that therapists are developing ways of supporting clients to make use of services such as CAMHS by inviting clients to have preparatory conversations and to process their experiences of other mental health services in sessions.

4.5.6.1 When clients are assessed with a different diagnosis than their self-diagnosis

Participants discussed instances where clients decided to have their self-diagnosis assessed by CAMHS where they were told that they did not meet the criteria for the condition they

identified with. I share these examples, like as above, to highlight how self-diagnosis and the processes around self-diagnosis impact what the client navigates in therapy.

Alex commented that she has worked with clients that have identified with a self-diagnosis, yet when they are assessed, it is determined that they meet the criteria for a different diagnosis. She said that she is "noticing it much more" that clients are given "a diagnosis where they feel, 'oh, I didn't really want that.'" She cites an example of a client who believes that have ADHD, "they have their CAMHS appointment and after maybe two or three meetings it's, 'they think I'm autistic and I don't want that.'"

> I don't know if that's because they don't want to have gotten it wrong. Hmmm…They want to be the expert on themselves. Hmmm…Or that it feels okay to have one and not the other, or I don't know. I don't know.

Alex communicates that clients are unsettled by being ascribed a different diagnosis than they self-identified with. She also acknowledges that there may be stigma attached to some diagnoses as compared to others. Alex explains when this occurs, "we would explore that in sessions." She asks, "What is it about that that doesn't feel right?" and attempts to "help them to just unpick it a little." Here she illustrates how the therapy space is a place where clients can process the diagnostic process and that she invites clients to process their experience of the assessment and result.

Ana also referred to a client who felt "very let down" by not being diagnosed with the disorder that they self-identified with. In this case, the client believed that they fit the criteria for a personality diagnosis, Ana explained, that CAMHS was "very, very adamant and reluctant to put a personality disorder label on them." Ana acknowledged that she doesn't feel confident that the client meets the criteria for this disorder but expressed that "for better or worse" the client is left feeling dejected after the experience.

These examples emphasise that in cases of self-diagnosis, a therapist may be working with a young person throughout many stages of self-diagnosis exploration, self-diagnosis, diagnosis

assessment, the results of the assessment, and what happens after. I argue that as these steps begin with self-diagnosis from mental health content on social media, they are possible links in a chain which have impacts on therapeutic relationships.

4.7 A self-diagnosis doesn't capture the whole story

4.7.1 What's trauma got to do with it?

This section focuses on a question which participants returned to across each interview, is the client describing being mentally ill or a response to trauma? The therapists interviewed came back to this idea multiple times, wondering how the characteristics and symptoms of the young people they were working with may be thinking about a mental health diagnosis, but from their perspectives, some of the case presentations they are seeing could also be explained and framed through a lens of trauma. Participants discussed trauma in different ways throughout interviews, at times therapists spoke about family history and generational trauma, as Alex stated, "the parent's mental health's not great" and that with many of her clients "it's very generational a lot of the time."

Jacqui cites "in my experience sometimes it is the need of the trauma to be recognised." In this quote Jacqui personifies "trauma" and its "need" to "be recognised." As though the traumatic history within the young person is speaking through the expression of a possible diagnosis and search for approval of their pain. This framing is consistent with her psychodynamic practice, which works to consider how a person's conscious ideas can be expressions of their unconscious needs and experiences.

Jacqui feels that it is important for her to invite clients to consider that there may be many ways to think about their symptoms and experiences. The diagnoses they have learned about may be an explanation, but there could be other viable and helpful ways of thinking about their experience, such as trauma.

> …I wonder if for these symptoms there is a different explanation and I talked a lot about trauma, some of the stuff that are here are also the symptoms of trauma and you are being through trauma.

Here, I understand Jacqui to be explaining that in her experience, clients may recognise themselves in content created about a mental health diagnosis but that they may not have been exposed to as much information about how those same traits they identified within a video about could also be descriptors of a person who has experienced trauma.

Jacqui reiterated the clarity that can come with a diagnosis, and she contrasts this with the complexity of trauma.

> But I suppose I can see the allure of thinking have this, I'll take medication and then I'm going to be okay. Well, when we talk about trauma, like there is lots of work that needs to be done. Yeah. And there is lots of nurturing, and we need to nurture the younger part of yourself that comes. And it is, it's a really hard work.

Here, she connects with her client's desire to be "okay" and empathises with how a diagnostic label may look like a solution to seek an explanation or clear pathway to becoming "okay." She continues on to contrast the "work" of trauma. She notes that using a lens of trauma on the other hand, is a far less clear pathway and that murkiness may be challenging and painful to navigate. I interpret from Jacqui's perspective, that she feels many young people grasp onto the idea of a diagnosis for clarity, but in her view, considering these symptoms from a lens of trauma may be more complicated, but more valuable.

Ana described a vivid example of a client who is questioning their own experience of early trauma whilst also identifying with traits of ADHD. This client came to therapy and explained that he believes he has ADHD after watching videos on social media, "this guy talks about the signs of ADHD and I have all of them." Ana invited this client to look at his experience through a lens of early childhood trauma.

> But this is for me, like a difficulty of where do you, how do you draw the line and so what if it's that? And he asks me that, he says, 'like, so what do I do? Like what do I do with this fucking trauma? You know, like at least ADHD is something that you can do something with. Whereas this other thing, like how do I explain it? I don't wanna tell everyone about what happened to me as a baby. I don't want to have to explain.'

Crucially, Ana is sharing that from the perspective of this client, trauma requires and explanation whilst, ADHD doesn't. Further, there is an implication that everyone can understand what ADHD is, while if this if this client were to frame his experience through a lens of trauma he felt concerned that he would need to constantly explain these experiences to get the support that he needs.

Ana, who has additional training in developmental trauma explained that she has found this case particularly difficult as she is acutely aware of this client's early trauma, which leads her to feel hesitant to attribute his struggles to ADHD. She expressed that she suspects that his academic struggles are a result of his early childhood trauma.

> …it's so much easier to say ADHD than to look into the reality of what happened to them. And it's just heartbreaking. And I'm kind of like, I don't want him to have to be pathologised. Yeah. Although it's not really like, you know, and he's not pathology, but there's something about what it means and what it means to be good at school. And I don't know…

I interpret that she is frustrated with the paradigm of pathology and that this young person would self-identify with a diagnosis which would reflect that there is something innate or ill about himself in contrast to his struggle and symptoms being a protective way that he has managed to adapt to survive after such a difficult set of experiences. Ana acknowledges that traits of ADHD and responses from trauma can have similar presentations. She illustrates a rich image of this client trying to make meaning of his experience. Ana spoke about this client warmly and she expressed her desire for this client to accept and recognise that his

trauma has had a significant impact on him and to move towards accepting himself from this perspective.

In this section, therapists express viewing client experiences through a lens of trauma. Some therapists describe inviting their clients to shift their view from a self-diagnosis towards considering how their symptoms could be related to their past experiences. In my view, these examples indicate that therapists perceive clients as misattributing their experience to a mental disorder, where in their view the client is responding to adverse experiences in their past. In my view, these examples could indicate that therapists seek to understand the whole client and the entirety of their experience, rather than their symptoms alone. This could also indicate that therapists are practising aligned with their theoretical frameworks which considers hardship and distress outside of a psychopathological lens. This leads me to wonder about how therapists' theoretical orientations and attitudes towards diagnosis may impact the ways that they approach speaking to clients or suggesting alternative frameworks to consider their experiences.

4.7.2 Changing perspective on a self-diagnosis

Participants shared examples where a client began therapy identifying with a self-diagnosis and after exploring this with a therapist, had a shift in their perspective leading them to no longer feel that a self-diagnosis fits their experience. Therapists explained that in their view, having a space to discuss their self-diagnosis offered new ways of thinking about their symptoms and encouraged clients to be curious about what they have been feeling.

Dan considered how young people initially self-diagnose in isolation, but in a counselling relationship, there is an opportunity to contemplate a possible label in the company of another person.

> It's, they're looking at the screen, they're looking at this, I don't know that there isn't that a discourse about someone speaking to them and saying, okay, so you think you've got this now

> I wonder what that is? Or what about something else? They generally just see it and they identify parts of themselves with it. And then 'I think they have it.' So, to have a discussion about it can sometimes change the view.

From Dan's perspective, there is an important difference between learning about a diagnosis on social media and considering a self-diagnosis in isolation, versus talking it over with another person. I gather that Dan believes asking questions and digging deeper into the symptoms and experiences that led a young person to self-diagnose may open space for reflection and a change of perspective. Although Dan doesn't explicitly state this, I understand him to be referring to his experience of self-diagnosis from the perspective of his person-centred approach. He emphasises the impact of exploration within an accepting therapeutic relationship and the potential shifts that can occur within a relational dynamic. Jacqui also cited that after there has been space for discussion, it is "not very often" that a client goes on to pursue a mental health assessment for an official diagnosis. She believes that this is "because we take time to discuss" and that in therapy there is space to consider "that there might be other reasons why they may have mood swings." In sessions with young people, she explains that there can be more than one explanation for many symptoms, such as trauma or relational dynamics. She invites clients to think about these other possibilities and she processes them with clients in the counselling room. These alternative explorations can be viewed through Jacqui's psychodynamic approach, which sees therapist interpretation as an element of therapeutic work. From Jacqui's view, these conversations have the potential to alter the frame that young people use to understand themselves and their experiences. After these conversations, Jacqui stated that, "they may come back and say then I'm not sure anymore if this is what I really have." In this excerpt, I gather that Jacqui views these exploratory conversations she has with clients as contributing to some young people's decision to relinquish a self-diagnosis. She elaborated, explaining that in some cases, a young

person may soften their identification with a self-diagnosis, opting to wait and see if they continue to feel the diagnostic label fits them when they are older.

> Some of my young people will give up on the idea, [and think about] revisiting it when they are old enough to be able to have complete control over it and to be taken seriously.

Above, Jacqui acknowledges that young people have less autonomy in their healthcare and may prefer to wait until they feel more autonomous and respected in their views. I interpret that Jacqui is sharing that for some young people, they feel that their identification with a diagnosis is dismissed or even seen as unreliable due to their age.

Caroline described that after some experience working with clients presenting with self-diagnosis, she adjusted her practice. She began documenting the client's beliefs about their self-diagnosis by recording words, phrases, and ideas collaboratively in sessions. This system allows her and the client to continually revisit their thinking and to reference how the client initially felt about themselves and a potential diagnosis throughout their therapy together. Caroline highlights that she feels this process has been beneficial in many cases and has had impacted how her and the client can explore a self-diagnosis together over time. Caroline also described that she feels this allows for more space and time for exploration and reorganisation of experiences that can come from therapy. She shared an example of client who entered therapy self-diagnosing with ASD after they were encouraged by others that they may be neurodiverse as they were having trouble in social situations and making eye contact with others. However, after some time working together, the client disclosed experiences of childhood abuse. Caroline explains that with more time and further exploration, they both now feel that the client's presentation is more associated with trauma, and their symptoms could be a response to these early experiences.

> …they've gained the perspective that actually, it's trauma, not autism…If I'd made the referral instantly, you know, they would've probably wanted to backtrack and not do it actually by this point.

In the above quote, Caroline shares the impact of her adjustment to the referral process has indeed facilitated further exploration beyond what she believes would have been possible if she had initially completed a referral to CAMHS for this client. In sharing this example, I believe that Caroline is emphasising the value of the time and space for contemplation that therapy facilitated for this client. Significantly, she also notes that if the client had started an ASD assessment process, she believes that they would no longer want to pursue this as they have changed their view.

I posit that in this story, Caroline illustrates that, in some cases, spending more time deliberating on a self-diagnosis, allows space for the whole story to emerge. As in this case, the client and many others around them perceived that she would meet the criteria for ASD, however, spending time with Caroline in the counselling room afforded space for this client's history to be disclosed, presenting a different framework and healing process than a diagnosis would precipitate.

I argue that this subtheme offers significant findings in this thesis, as these accounts may indicate that young people spending time discussing and exploring self-diagnosis could lead to a shift in their perception. Crucially, participants describe engaging with their theoretical approaches to explore self-diagnosis presentations within the therapeutic dyad. Further, across interviews with therapists, there is an assertion that a young person shifting away from identifying with a self-diagnosis is a largely favourable outcome. In my view, these excerpts depict a role that therapy may be fulfilling across adolescent mental health services. These accounts share that there are clients who may have continued to identify with a self-diagnosis or possibly pursued a medical diagnosis after watching social media content, but after engaging with therapy had a different understanding of their needs and challenges.

4.8 Impacts of self-diagnosis on the therapeutic relationship

4.8.1 Social media as "a third" in the relationship

Both Caroline and Ana spoke about social media as being a "third" in the therapeutic relationship. Crucially, both therapists stated that they draw on psychodynamic theories to make meaning of their practice. The third space, or as Ogden (2004) writes from a psychoanalytic perspective, the analytic third, is a term used to describe an intersubjective space beyond the therapist and client where the unconscious can be explored. I interpret Ana and Caroline's references to a "third" space to refer to this psychotherapeutic concept where a third position affords an expansion of the therapeutic dyad and opens an additional space for inquiry.

Caroline spoke about self-diagnosis in terms of a third and thinks about self-diagnosis in terms of play and exploration.

> I really like that because I think it's almost like a new way of playing. It's like you've got that third thing in the space joining you together.

Here, Caroline again references Winnicott (1971) and his idea of play. She posits that clients may be "playing" when self-diagnosing. Using this frame, Caroline sees some instances of self-diagnosis as a creative endeavour, where a young person is engaging with the possibilities of excitement and precarity. Further, Caroline introduced the idea of the third space and shared that for her, self-diagnosis at times, may have the capacity to impact the therapeutic relationship facilitating further space for exploration and unconscious processing. This framing depicts self-diagnosis as a relational catalyst, contributing to the therapeutic process and providing an additional element to engage with.

Ana described a case where she felt that a client's self-diagnosis provided a third space into their therapeutic dyad. In this instance, the client mentioned recognising some of their experience from a TikTok video about someone's experience with autism. Ana said that this

moment stuck with her and led her to reflect that she too had wondered if this client might meet the criteria for ASD, “it had been there in between us and, on my mind...but it hadn’t been voiced.” In this quote, Ana seems to be considering the transference and intersubjective experience of the therapeutic relationship between herself and her client.

Ana detailed how after they spoke further about her client’s possible autism diagnosis, “it was incredible how quickly it all turned around,” sharing her surprise at how quickly this client was seen and supported by CAMHS. She shared that this experience felt “unusual and quite a relief in the work.” Throughout this example, she shared how she felt that TikTok served as a conduit for the therapeutic process.

> So, in a sense, this little moment on TikTok or whatever became an outlet of something that was closed…

In this excerpt, Ana illustrates that she experienced TikTok and this client’s self-diagnosis as a supportive and facilitative element in their work together. In her view, this client learning about ASD from TikTok and choosing to pursue a diagnosis from CAMHS was a very positive outcome.

As Ana conveyed this experience, she smiled widely. I noticed her smile and asked her how it was for her as a therapist to work with this client, and she responded:

> I felt this is what was needed and almost like social media acted as a sort of third of something else that almost suddenly there was more than just a therapeutic encounter and something else kind of penetrated or entered. I’m still trying to make sense of it, but it was really fascinating and it’s something.

Above, Ana describes her excitement and fascination with the impact that social media had in this case. She illustrated that the client’s engagement with social media mental health content “kind of penetrated or entered”, creating a strong image of an additional entity participating in the therapy and the significance of its presence in the room. Her use here of the term “penetrated or entered” evokes the Freudian drives of sexuality.

Notably, both Ana and Caroline describe self-diagnosis and social media as a positive force when speaking about it as a third in the therapeutic relationship. At other times in their interviews, they both also spoke about self-diagnosis as having challenging or even adverse impacts on therapy with certain clients. I argue that it is significant to note that therapists refer to different instances and elements of self-diagnosis as having a spectrum of impacts on their interactions with clients. In my view, this aligns with the complexity of each individual case and how the presentation of self-diagnosis would have different impacts depending on the client, context, and the therapeutic relationship.

4.8.2 A "wall of weeds": Self-diagnosis can feel like a barrier

Throughout interviews, therapists at times described self-diagnosis as an obstacle to therapy with a young person. In the following accounts, therapists consider how it feels for them to be with a client in these instances. I argue that this section adds to the complex picture that participants described in their experience of working with clients self-diagnosing.

Ana detailed an experience where she witnessed a client continuously learning more and more about their self-diagnosis from social media. From her perspective, it felt as though this client was adding each new piece of information into what she called a "wall of weeds."

> It almost feels like this diagnostic language that they learn from social media is like growing weeds and it takes away from something more real in them in the sessions or something more. It, it feels like a one massive kind of wall of weeds that's protection rather than, and I can see how that's needed and I can see how that's kind of, but it's also difficult to witness and it's difficult to like know how to…yeah…I dunno how to stay with them without getting lost in all the weeds.

Ana vividly portrays her experience of how she feels when she is with this client. I consider how a wall of weeds might feel in the counselling room. Further, I feel that Ana's use of the image of weeds implies that these pieces of information and growing things are unwanted.

Interestingly, I wonder about how Ana employs weeds in this image, as weeds are plants that have been characterised as unseemly, depleting, or invasive species that encroach on the wanted, more beautiful, or curated plants that people desire and intend to grow. Additionally, weeds are living plants and in the above extract, it does follow that she feels this client's information about their self-diagnosis continues to grow and wrap around itself. Ana names that this dynamic is uncomfortable for her and that she feels unsure about how to be with the client without getting entangled in these growing weeds. She used the phrase "getting lost in all the weeds." I interpret that feels some fear about what might happen if she too were to get "lost in all the weeds." I interpret that Ana is expressing that she at times finds the way that this client uses social media and self-diagnosis to be overwhelming.

However, Ana describes a kind of dilemma where she feels separated by this wall of weeds and to connect with the client or be alongside their experience, she feels that she needs to reach through this barrier. As she spoke about this image, I kept thinking about her reaching toward the client protected behind the wall of weeds. I wonder how it might feel to be touched by the branches, thorns, and leaves. It makes me think of the emotional experiences of Ana and this client and how touching, growing, and navigating this wall created through social media content impacts their experiences together.

Dan described that in his view self-diagnosis can feel like a "barrier in the relationship." Dan explained that he believes that when young people use a diagnostic lens to understand themselves, it can be restrictive. In his view, using a psychopathological lens encourages a young person to fit themselves into a rigid category and may limit the space for deeper self-inquiry or understanding. He explained that he believes self-diagnosis has the possibility of limiting the client's capacity to be present in the therapeutic relationship.

Caroline too voiced some frustration with the pre-packaging that self-diagnosis from social media can lead to. She said, "I really want to just get to know them" and she feels as though

the diagnostic language and frame that young people bring can impede self-exploration in therapy.

> It frustrates me. Like can you just be here with me? And I hate it kind of. I'm not angry at my client, but with social media. I'm angry at social media because it like they're packaging my client for me…

She spoke about feeling "angry" with social media and how it feels as though the social media is "packaging my client for me." From my perspective, Caroline is sharing how a client arrives at therapy with preconceived notions about their self-diagnosis and those ideas and categories have the potential to limit the possibilities of curiosity and vulnerable connection between the therapist and client. She asked a somewhat indignant question, "Like can you just be here with me?" In this question I think back to how Ana described the wall of weeds as protective, it leads me to wonder about how having a structured identity may feel safer for some clients. However, in Caroline's view, she described her strong reactions, describing her hatred and anger for this dynamic as she feels that sometimes social media impedes the therapeutic process of authentic connection.

This subtheme focuses on accounts where therapists have felt that both self-diagnosis and mental health content have had restrictive impacts on therapy. I argue that these accounts offer an important view, that in some instances young people's self-identified diagnosis may feel like an obstruction to therapists. Further, these examples share that therapists are working to navigate how to reach clients who may relate to a self-diagnosis defensively. I argue that these examples emphasise that therapists are developing skills to navigate these cases using their existing skills and training. However, I believe that it is notable, that therapists express that they find these cases challenging and are continually attempting to develop ways to meet clients with complex self-diagnosis presentations.

4.8.3 Self-diagnosis and its impact on the power dynamics between client and therapist

Ana stood out by sharing a client example which highlighted a significant shift in power dynamics in relation to a client's self-diagnosis. Other participants, including Caroline and Dan mentioned elements of power in connection with diagnostic frameworks, however I have chosen to focus on Ana's depiction in this section as it paints a rich narrative of how the presence of diagnosis impacted her experience of working therapeutically with a client.

Ana detailed a client relationship where she felt that the presence of a possible diagnosis shifted the power dynamics in the therapeutic dyad. Ana described that in this case the presence of the client's self-diagnosis felt overpowering and had impacts on the therapeutic dynamic.

> …with this young person, very often the relationship has slipped into, I am a therapist and you are a patient, almost not even a client, you know, and it's very seductive and sticky.

Ana explained that within this dynamic, she believes there are elements of the client's parental relationship being "acted out." Ana here is referencing the therapeutic idea that relationships can unconsciously mirror other significant relationships.

Ana uses the term "very seductive" to describe the dynamic of therapist and patient, communicating that she is tempted to fall into this dynamic. In relational therapies, the term "client" is often used to signify the client's autonomy in engaging with therapy. This term has become common in contrast to the term "patient", which is associated with the medical model and in relational therapies is often used to reference the history of psychiatry and medicalised mental illness where individuals were often given treatment regardless of their consent.

Ana reflects that the power dynamic in this relationship stands out from how she usually practices. She depicts the example that she will "sit on the same chairs as them" as an embodied example of "equality." As I consider Ana's description, I am aware that she is

communicating that she has made intentional choices in her practice to foster a collaborative relationship rather than a structure where she is seen as an expert.

Therefore, when she described the uneven power dynamic present in this example, she expressed that she found it “tricky”, and she noted that she can see this both relationally in the history of the client in connection to the potential personality disorder diagnosis of this client. For Ana, this has been “really difficult” as she described that it’s a dynamic that “I don’t want, I really want to stay out of that.” She uses the term “slipped into” which illustrates an unintentional and subtle shift. She adds, “I really want to stay out of that”, when Ana said this, she made an “ugh” sound conveying a sense of disgust or distaste, vocalising that she does not want to engage this way with her clients. I believe she is implying by expressing her sense of disgust, that there may be some feelings of guilt, frustration, or even shame about feeling that she is acting out this power dynamic that she felt seduced to engage in.

Additionally, I get the sense that from Ana’s view, playing out this power dynamic could have adverse consequences on the therapy, and she has concerns about these impacts.

In a conversation with her supervisor, Ana felt a sense of relief when she was advised to “stay out of that.” Ana felt renewed and reassured herself, “I was like, okay, just stick to the simple aspects.” I understood this to mean that in that moment she was able to reconnect with her practice ethos and boundaries, leading her to feel less burdened by the other elements of the diagnosis and dynamics that came along with it. When Ana spoke about this sense of relief, her tone of voice shifted and she laughed, I experienced a palpable change in her way of speaking and talking about this. She went on to say, “this is what your limit is”, solidifying her role and reinstating her boundaries as a counsellor working with this client.

I interpret that by describing her feeling of being drawn into holding a more powerful position in the therapy, she is explaining that there was something co-created in this dynamic,

that may have been facilitated by the client's self-diagnosis. I interpret that through this experience Ana has become more aware of the impact that self-diagnosis can have in her practice. Further, thinking about the therapist and patient dynamic, I wonder about how diagnostic language and self-diagnosis in therapy may encourage both clients and therapists to shift into these power dynamics.

4.8.4 Different kinds of self-diagnosis

Throughout the interviews, participants described experiences where they felt unsure about a client's self-diagnosis. Four out of six therapists referenced that, from their view, there are different kinds of self-diagnosis and that each client's situation and relationship to a self-diagnosis is unique. Ana described that some self-diagnoses feel "rich and wonderful and interesting" while others feel precarious and thorny. She cited examples where a client's self-diagnosis felt entangled with their personal identity which led clients to feel committed to their self-diagnosis and rigid in their ways of thinking about their experiences.

Alex shared that in her experience, some clients feel that their self-identification with a mental illness satiates their desire to know about themselves, whereas other clients have a strong desire to complete the medicalised process and assess if they meet the official criteria to be diagnosed.

> There's like those who are really clear that they have a diagnosis, whether or not that's going to be recognized medically. And then there's those who say, well, I don't know if it's actually a diagnosis until I get the rubber stamp.

Throughout interviews, participants frequently mentioned examples where young people are not attached to a diagnosis but are tentatively questioning if they feel a self-diagnosis might help them make sense of their experience. This makes me wonder about the power dynamics of a diagnosis and young people's expectations of what a diagnosis can offer them. I interpret that in part these different orientations towards self-diagnosis may be an indication of the

client's need for either intrinsic or extrinsic validation. I note that there are many diagnoses where being recognised by a medicalised service may lead to support that the individual may need, however, in some cases, there may be minimal difference between have a self-identified diagnosis and an official diagnosis label. I believe that acknowledging the diversity in client self-diagnosis is essential in understanding how therapists practice with this presentation.

I'm not sure you have that: Therapist experiences of feeling sceptical of a client's self-diagnosis

In some instances, therapists spoke about getting a sense that a client was performing symptoms in their sessions to portray themselves within the frame of a certain diagnosis after learning about a mental illness on social media. In three interviews, participants explained how this felt for them and how they chose to engage with clients that they perceived as intentionally presenting themselves through a psychopathological lens.

Jacqui spoke about her experience noticing her response when a young person disclosed that they believed they may have bipolar disorder. Jacqui explained that this client was working concurrently with CAMHS and had a history of abuse and had a pattern of engaging in therapy for a time followed by a period where she would not attend sessions. After a period of disengagement with therapy, this client returned to therapy and told Jacqui that she believed she had bipolar disorder. Jacqui explained that in her view, there was "a very slim chance" that this client would meet the criteria for bipolar disorder. She described that she had a strong reaction to this client's self-diagnosis.

> I had a surge of annoyance, 'yeah, now you're bipolar'. And I had a surge of can we talk about your trauma?

Jacqui shared this example passionately; I could feel her frustration and found myself imagining how it would have felt to work with this client who seemed to find a solution to her complex past which seems to avoid the dynamic playing out in the therapy. When Jacqui

said, “yeah, now you’re bipolar”, she sounded both disappointed and embittered. It was clear from her statement that at the time Jacqui felt that her client’s “solution” to her symptoms was an avoidance for engaging with the trauma that she had lived through. Crucially, Jacqui felt that this self-diagnosis was an avoidance of working through the client’s traumatic past. I got a strong sense that Jacqui was managing her desire to explore what she felt was at the root of her client’s distress. In our interview, I felt that Jacqui’s wish to help and her discomfort with this client’s bipolar self-diagnosis were palpable.

She brought this client to clinical supervision and described what she understands more fully now about what may have been happening during her surge of annoyance.

> I went back to supervision and said, what was that? What was my annoyance? What was played there and, I had a long discussion with my supervisor about this client’s need to be seen, need to be acknowledged.

Jacqui reports that supervision allowed her space to reframe the client’s self-diagnosis and make sense of her adverse reaction. From her view, once she tapped into this client’s need to be seen and acknowledged something fell into place.

> And that has helped us very much to redirect the work but also my curiosity around, okay, you think you are bipolar, talk to me a bit about, what this will mean to you?

In this quote, I gather that Jacqui felt that this change in perspective was pivotal for her to get closer to the client’s frame of reference, which led her to be able to access a deeper sense of empathy for the client and why they may have identified with bipolar disorder. This, in turn, allowed her to reconnect with the client and invite her more about what being bipolar might mean and reconnect with how the client experiences their internal world. I interpret that in this situation; Jacqui encountered the presence of some of her attitudes and biases and how they interacted with how the client was making sense of her experience. Yet, once her experience was processed through a psychodynamic lens of unconscious communication she felt able to shift and meet the client with curiosity.

Caroline described a case where she was working with a client who had self-diagnosed with DID. She went into detail about navigating her relationship with this client and noted that she found this work and work with other DID-presenting clients "the hardest ones that I come across." She explained that this client "seems to cycle through labels from social media" and that "they thought they were trans, now they think they've got dissociative identity disorder."

> And I've seen them really spiral into that and also gain information to kind of, I don't like my wording on this, but kind of create it in themselves.

From Caroline's view, she feels that this client has entered a loop of gaining information about diagnoses and identities and integrating them into their sense of self. I get the sense that she feels this spiral is uncontrollable for the client and continues through the process of viewing more content on social media.

I find this to be a particularly significant interpretation, as I understand from Caroline's view this client is amidst a process of developing their sense of self through these examples of identities and diagnoses that they have learned about on social media. Crucially, this seems to play in a pattern of identity formation. It makes me wonder how social media self- diagnosis may impact the identity-formation process for some adolescents.

She illustrated that in sessions this client uses different voices and presents different identities in the counselling room. She spoke about how she engages with this client, explaining, "I kind of roll with it." I take this to mean that she accepts how the client is and stays with their experience, being curious about what may emerge from these different personas in a session. In her reflections, she imagines the different voices and identities of this client "like a protective shell." She feels that by portraying herself through a lens of DID the client may be able to "hide behind these things and express parts of themself through it." She tried to make use of the relationship and her presence.

> I try to kind of just echo how it makes me think and feel in case they on some level are having those questions themselves.

Above, I gather that Caroline shares how she chose to encounter this client by voicing elements of her own experience in the session. She explained that at times she will wonder aloud about what personality will come to the next session or if the identities will "come together" or "stay separate."

As Caroline spoke about this, she continually conveyed her strong feelings that this aspect of social media self-diagnosis evokes in her, she used the terms "angry", "frustrated", the situation "irks" her, and that she finds it "irritating." She stated, "I really struggle with lying in session when people are being disingenuous or lying to me", she goes on to say that she feels this is "one of my biggest weaknesses" as a counsellor.

> And I think sometimes that really gets me with the diagnosis stuff on social media. It makes me think like, I know there's a reason why you're telling me this and things. But in this instance where it's a cycling through multiple labels, even if it's for good reason, it really grinds my gears.

Here Caroline paints a vivid picture of her internal reaction to when a self-diagnosis feels inauthentic to her. She openly expresses her feelings of anger and frustration, she says "it really grinds my gears" vividly depicting her feeling of being irritated by the ways that she feels disconnected from the client's authentic experience, which she finds irksome in some situations.

Although she said, "I know there's a reason…", there remains a strong adverse reaction to when she perceives that a client is being inauthentic on some level. She looks at this reaction in herself with curiosity, and it seems clear that for her, some self-diagnoses feel more like obstructions than places of connection in the counselling relationship.

Ana also detailed a client example where she perceives that a client's expression of DID felt like a "performance." She described that in the school environment, other adults would sometimes refer to this client as the "child who cried wolf", implying that they had lost trust in this young person and no longer believed them. This is referencing the children's fable

"The Boy Who Cried Wolf", who lies and gets support when there is no real emergency, finally, when an emergency occurs no one comes to help him as he is no longer trusted. She described that in sessions this client would "switch in front of me" and "it would almost be a little bit like a play." Before switching to another personality, the client would announce "now, I'm going to switch", leading her to believe that the client is intentionally switching personalities, rather than experiencing a dissociative state which characterises the disorder.

> …they close their eyes and they do this thing, which is a little bit like, like a performance, right? So it's been quite difficult for me to hold that as to sort of not become another dismissive adult to kind of hold that you know, let's see what happens in that performance and to, but also to not over, to not go on the other end of the split where I'm saying, oh yeah you have a disorder and I'm on.

In this excerpt, Ana reflects on how she simultaneously holds her belief that this client is engaging in some kind of portrayal of a DID diagnosis and she is holding on to the experiences she knows this client has had of being dismissed by adults in her life. In my view, Ana is describing sitting in between two spaces, she is not dismissing or validating the client's presentation of having DID. What she is doing, is staying engaged with the client, saying, "let's see what happens in that performance." Ana described keeping herself open to what the client might be communicating, accessing or acting out through the performance of this disorder.

Ana spoke about an experience discussing some of these dynamics with a therapist at CAMHS who was also involved in this client's support. She explained that in her view, their perspectives highlighted a difference "where they didn't quite meet" in their approaches to working with what they both perceived as a performance of this diagnosis. Ana described that the CAMHS therapist was focused on determining if the client's symptoms were "true" or "not true." She explained, "whereas I was more curious about it." Here she positions herself and the CAMHS therapist as diverging in their value of truth and fiction. From Ana's

perspective, she seems to believe that these lenses may have impacted their relationships to the client.

I interpret that she and the CAMHS therapist are asking different questions. I wonder if this in part due to both their roles and training, as therapists outside of a medicalised setting are generally less likely to be involved in the assessment process and tend to be more focused on what the client may be communicating through their behaviour. I perceive that Ana chose to prioritise bracketing her sense of scepticism to remain open to the client's experience, leading her to sit with uncertainty to remain open and curious in a way that having a decisive sense of "true" or "not true" can limit. This led her to reflect on what the client may be seeking by identifying with this personality disorder, sharing, "my experience is that they want to be held." She went on to wonder about the client's history and how in their frame of reference, having a medical diagnosis could lead to be supported and taken care of in a way that asking for support differently may not.

Across these examples, I interpret that therapists are challenged by self-diagnosis presentations where they have doubts about the client's authenticity. In my view, these instances point out crucial differences across cases where a self-diagnosis may be complicated by the presence of unspoken motivations, possibly encouraged by social media content. These examples seem to highlight a process of the integration of a diagnosis and an identity formation, leading to complicated dynamics within therapeutic relationships to work with the client whilst also holding uncertainty about the veracity of what is being said and portrayed in sessions. In these examples therapists describe making meaning of these presentations through their practice modalities, noting that processing their experiences through theoretical frameworks supported them to engage with client and process their experiences. Overall, I interpret therapists in the examples above as drawing from their training and skills to stay with the client's experience and reflect on how these presentations

may evoke judgements and discomfort for practitioners. In my view, these cases seem to indicate that therapists need to engage in continued reflections to expand awareness of their attitudes and biases to best meet clients with empathy and curiosity despite the authenticity and motivations of their self-diagnosis identities.

4.9 Therapist Competencies

4.9.1 How much should therapists know about psychiatric diagnosis?

Therapists reflected on their training and experience with mental health diagnoses. Participants explained that they did not receive training on psychological diagnosis or the NHS mental health processes throughout their qualifications. In addition, therapists described that they were unaware of continuing professional development opportunities created for counsellors and psychotherapists to develop their knowledge of diagnosis and diagnostic processes. Interestingly, the participants of this study fall into two groups, one where therapists explained learning mostly about diagnosis from experience on the job and from their personal lives, and another where the therapist had some background in psychology or working in a medicalised mental health setting. I argue that this is a crucial difference, particularly with therapists working with CYP because therapists tend to take a more integrated role in the young person's life, communicating and collaborating with families, school staff, and other mental health professionals.

Dan explained that he at first felt "really, really out of my depth, completely" when he was working with a client who was labelled with an eating disorder while they were working together. He illustrated that he was unfamiliar with the CAMHS process, and it felt "way beyond" his experience. He described that in this first instance; he found it very overwhelming. Dan shared that over time, he found himself able to reframe some diagnostic presentations through person-centred theoretical ideas and this led him to feel more assured in his work with clients who were presenting with self-diagnosis or had received a mental

health diagnosis. He emphasised the importance of supervision, describing it as "really important" as an important factor that has led him to "feel far more able" and to notice "a shift in me."

From Dan's description, I interpret that when he first encountered working with a client that needed CAMHS support, his lack of training and exposure to these services left him feeling unsure of his abilities and uncertain if he was qualified to work with clients who may also meet the criteria for a mental health diagnosis. However, from his perspective, gaining more experience, having support from supervision, and reframing some diagnostic symptoms through the lens of his modality, assured him of his competence to practice with clients who have these presentations. I interpret that from this experience, what began as anxiety-provoking for Dan, led to an expansion of his practice confidence and proficiency.

Ellie explained that in her training, she was discouraged from working with clients who were accessing other services, such as CAMHS. She described that when she first qualified, she was firm about this boundary and would end therapy with a client if they started accessing CAMHS or other psychological supports. She believed that it "would just get too messy and kind of blurry" to continue therapy with someone who was getting support from another intervention. However, she described that over time, she has softened this boundary and now considers the individual case when deciding whether she would continue with a client if they were getting support from other services. Ellie attributes this shift to gaining more experience and to discussions she has had with her supervisor. She explained that more recently, she sees herself as playing a different role from CAMHS, noting that when clients are going through a diagnosis assessment or other interventions that may follow a diagnosis, she can offer something different.

> …it's okay to continue with the young person but just stay away from the eating disorder side of it. So maybe just work with the emotional side of how their feeling and how it impacts them.

I interpret that from Ellie's view, that her experience has led her to see the boundaries of mental health support from a different angle. What initially felt to her like a hard and distinct line now feels more nuanced and specific to the client's needs and her perceived capacity to work with them. I interpret that in this excerpt; Ellie is sharing a sense of reflection and depth in her practice that she has gained from experience. In my understanding, she is expressing an internal shift away from a universal rule, towards a case-by-case more client-centred approach. I argue that Ellie's experience is significant to this thesis, as in her training, she reported that she did not have instruction on how to work with clients receiving care from NHS mental health services and was discouraged from working with clients in these circumstances.

Although this thesis is focused on self-diagnosis, I have chosen to include this section to highlight that therapists report self-diagnosis as a catalyst for some young people to inquire about the diagnostic process and/or access medicalised health services. Therefore, I argue that it is significant that it is not common for therapists to have focused training in these areas. In Ellie's instance, I posit that because of this gap in training, when she qualified and started having clients in these circumstances, she felt unable to offer them therapy, even in cases where the client may be receiving different kinds of support from another service, such as assessment or medicalised interventions.

However, I wonder if the increase in self-diagnosis exploration may impact the frequency of adolescent clients who access CAMHS for assessment or other support. Further, considering this possibility, how does that impact the role of therapists and the competencies they need to navigate therapeutic work with young people?

In both Ellie and Dan's experiences, I found myself interested in how they both reported feelings of self-doubt and apprehension when they initially had clients who needed medicalised mental health support. This led me to consider the perceived power of diagnosis and the feeling that without specialised knowledge they would not be qualified to discuss or support a young person therapeutically.

Significantly, the therapists interviewed all reiterated that they are "not qualified" or "not a specialist" when it comes to mental health diagnosis and expressed some assurance that they are still competent in their role as therapists. I interpret the idea of diagnosis as an authoritative categorisation that may feel overwhelming for therapists, particularly if they have not had education or training to support their practice alongside clients with diverse needs from different mental health services. Simultaneously, therapists express to themselves and to clients that they are competent but highlight the scope of their practice and what support they can offer.

In contrast to Dan and Ellie, Caroline and Ana described feeling equipped to navigate diagnosis with their clients. Caroline felt that her role within the NHS left her feeling literate in the diagnostic process.

> I had a really good idea of what the diagnostic criteria were…the different conditions and what the assessment process for them were all like.

She emphasised, "I don't feel wobbly and confused about it," she continued saying that if she hadn't had these prior experiences, she would imagine herself feeling overwhelmed, "I'd feel like I was really drowning because there's so much information out there." Notably, as Caroline referenced that she imagines that she might feel like she was "really drowning", Dan expressed that he felt "out of his depth." I interpret that there is something about the vastness of social media mental health and diagnostic information that may evoke water, possibly even an immense or treacherous ocean, that therapists may feel overpowered by.

Caroline expressed gratitude for her experience working in an NHS setting and that she feels it has prepared her for the number of diagnostic discussions that she has had with clients. I gather that from Caroline's view, she feels that her confidence in working with clients exploring self-diagnosis is directly linked to her experience within the NHS.

In my view, Caroline paints a contrasting story to the other excerpts in this section. I argue that this divergence among participants is significant. In my view, these different experiences may indicate that the anxiety and overwhelm shared by some participants may be unnecessary and could point to a gap in training. I argue that as self-diagnosis exploration has become more common in sessions, the prevalence of young people engaged in therapy and considering or accessing medicalised mental health support may also increase. In this case, the frequency of therapists discussing diagnosis, diagnostic procedures, and working with clients alongside CAMHS services may be impacted. If this is the case, I wonder how these shifts could impact the skills that therapists working with CYP need to be competent and feel assured that they are qualified in their role.

4.9.2 Social media competencies

When therapists spoke about competence, they often mentioned their fluency in using social media platforms and knowing what is relevant in the lives of the young people they work with. Throughout this section, I draw from participants to consider the relevance of therapist's social media competencies and how age and generational differences could impact the ways that therapists work with young people who are social media users and learn about mental health on these platforms.

Multiple therapists referred to their age concerning their social media use. Ellie used the phrase, "I'm not a dinosaur", which I understood as her sharing that she is in touch with what young people are interested in and describes understanding the ways that her clients engage with social media. Ellie noted that having discussions and being around her teenage daughters

has helped her to stay informed of the ways that social media is integrated into the lives of young people. Jacqui described that she is not a "huge consumer of social media", and she attributes this "because of my age." She went on to describe that from her view, "maybe it's a bit of a generational thing." She reiterated that when she speaks to clients about social media, her first step is to ensure that they are being safe online. She explained that sometimes clients "are laughing" because when she speaks about online safety, they say she "sounds like a granny." Throughout our interview, Jacqui reiterated that she feels that it is important for her to check in with how young people are using social media and to check that they are aware of the risks on these platforms.

When Dan spoke about social media, he spoke about websites, but not about social media platforms specifically, he shared that has seen some videos from social media in safeguarding training and other CPD. Dan explained, "I don't know about these things", but he is "always curious about it" with clients. I interpret Dan's stance as prioritising being open to the client's experience, and that he is comfortable learning about social media from the young people he works with.

I interpret that in the extracts above; therapists feel a sense of otherness when they speak to clients about their social media use. Both the therapists and their clients openly acknowledge that they have different understandings and ways of using social media. Adults not understanding new technologies that are important in the lives of young people is far from new, yet in my view, in this case, it is significant. Because social media is the access point of mental health information for many young people, I recognise how there could be impacts to therapy when therapists describe feeling out of touch with the way that this technology is integrated into the lives of their clients. I argue that this complicates what is in many ways, a historically predictable dynamic. In my view, this opens considerations about generational gaps and what allows therapists to be able to bridge these gaps and understand the frame of

reference for adolescent clients. Further, I wonder how understanding social media might impact the therapeutic relationship, including effects on power dynamics, and anxiety levels of therapists learning about young people's social media use. I contend that understanding social media and the mental health content found on popular platforms may be a crucial point of knowledge for therapists to hold to work with young people.

Caroline shared a different view about social media, noting that she sees the generation gap between clients and therapists as being important to be aware of and to continually work to keep up with what is relevant in the lives of CYP clients.

> I feel frustrated by older generations of counsellors. It's not any fault of their own. But I feel like things can be a bit out of date sometimes.

She qualifies that many therapists she knows make efforts to engage with social media and understand what is relevant to adolescents.

> [I do know] older counsellors who try really hard to catch up and stay on top of, you know what Snapchat and things are. And I love them for that.

However, she feels frustrated when the experiences that young people have on social media are dismissed by older counsellors and supervisors.

> ...it's so integral to young people's lives and your supervisees that work [with young people], I think you have to try to be as aware as you can and willing to engage with it. Not just to have formed an opinion. Think, oh well that's just a dangerous thing. Write it off.

Caroline holds the belief that because social media is significant in the lives of clients and supervisees, therapists and supervisors need to have considered responses to working with these topics. I gather that Caroline has experienced some therapists as dismissive of social media, looking at the impact of social media use from a simplistic perspective, focusing on what is "dangerous." Whereas, from Caroline's view, she feels it is important that therapists have a more nuanced approach that comes from reflection on personal biases and attempts to grasp what she describes as "a whole other world" of social media.

Caroline, who described herself as a social media user, expressed that for her it is challenging to "keep on top of it" in terms of how her adolescent clients use social media. She explains that "it's constantly evolving" and "hard to read."

> *M:* You need a lot of knowledge to be able to access what that particular video is actually saying.
>
> *C:* Yeah that's it. And I don't always get it. Hmm…But oh god bless me I try.

In this exchange, Caroline and I are referring to the memetic nature of social media, where many posts and trends are referential to other posts and trends on social media. We both laughed after she said this. For me, I took this laughter as an acknowledgement of a shared experience. Knowing that both of us have felt clumsy trying to understand an interaction, post, or new platform that a teenage client has brought up in a session. In this excerpt, Caroline seems to be expressing her attempts, even if they are imperfect, to learn and her desire to understand. I interpret her attempts as a desire to communicate to clients that she values what they find important and, therefore, wants to learn and understand as much as she can.

Caroline said that she has been interested in understanding how social media use and mental health content through a therapeutic lens, she has looked for resources and read books but, in her experience, books even published in the last couple of years, are "already very out of date." Thus, she finds it is difficult to find professional resources that are still relevant by the time they are published. She explained that many of the professional books and resources she has encountered start from a basic level of comprehension as to what social media platforms are and how they function, she gave the example, "this is Snapchat and it lets you do this."

> It left me feeling frustrated because I was looking for like a real explanation of, I dunno, like the purpose it serves and like a theoretical look at things…it didn't give me that.

Caroline suggested that the kinds of training and CPD available are out of date and simplistic. She described that she would like to see therapists engage with social media, rather than just

read about what was relevant in social media at the time a book or article was written. Caroline described that for her an ideal way of learning about social media and mental health content would be to create a social media forum with other therapists where ideas and resources are shared. She described that this could be a space where practitioners can discuss the impacts and best practices for working with young people who use social media. She detailed that this idea is built on the relational aspect of therapy.

> I think you could have a talk about it, but then also have like a lived experience in social media in a way through doing it. So, I really like the idea of a forum…which would force you to engage with social media as an experience whilst learning.

From Caroline's perspective, there is a gap in effective training about social media.

I interpret that she is homing in on the idea of praxis and how learning about something as complex and ever-changing as social media mental health content is a far different experience than engaging with it. She explained that this is something that therapists can "get their hands on" in contrast to reading books, "which can't really evolve with the issue." In her vision of this forum, I gather that she has the desire to be immersed in these worlds with other practitioners to participate collaboratively in the medium and for Caroline, this is an attempt to bridge both the generation gap and training gap in these areas.

In my view, Caroline's perspective on social media offers key points in this thesis. I interpret that she has a growing awareness of potentially crucial gaps in knowledge and training about social media mental health content for therapists working with CYP.

In my view, these accounts demonstrate that therapists have chosen different approaches to social media mental health and there may be divergences in the field impacted by age, attitudes, and personal social media use. I posit that this is relevant to this research, as the recent shift towards mental health information on social media platforms seems to integrate young people's understanding and engagement with mental health and social media use in an unprecedented way. Therefore, although social media may have previously been an element

of young people's social lives that therapists could engage with passively, I argue that with the integration of mental health content on these platforms, young people's experiences on social media have taken new form and prominence in therapeutic relationships and may impact the skills and competencies that therapists need to navigate therapy with adolescent clients.

4.10 Engaging in reflective process

4.10.1 Integrating experience working with self-diagnosis from a therapeutic framework

A key element throughout interviews with participants centred on the reflexive process that each practitioner engages in and their ongoing reflections on how to navigate and respond to clients presenting with self-diagnosis exploration.

Alex said that for her, working with diagnosis presentation it is an evolving and iterative process.

> As a reflective practitioner, you're constantly evolving and learning from responses I would've made previously, [reflecting on] how to do it slightly differently and kind of just finessing it I suppose.

Here she uses the term "constantly evolving," clearly noting that in her practice, she sees herself in an ongoing process of learning and adjusting her technique according to her experience. Alex stated the above quote matter-of-factly as if to express that this is a self-evident element of her work as a therapist and the work of other therapy practitioners. At this moment, I considered how my role as researcher-practitioner may have influenced the simplicity of her answer. The training and qualification requirements in UK counselling and psychotherapy prioritise reflective practice and ongoing curiosity as main tenets of ethical and effective practice. I felt that Alex was speaking to me as a colleague and considered that we would have a shared understanding of the role of ongoing reflexivity in therapy practice.

Caroline went into depth about the ways that her reflection has led her to make internal and practical adjustments in her practice exploring diagnosis with adolescent clients. Caroline cited her experience working as a counsellor within a medical setting as both an asset and a challenge to integrate her past experiences into her therapy practice.

> It took me a little while to think, actually, I can do this differently, and it works better.

Caroline explained that after some reflection, she became more curious about how she could incorporate her previous experience and develop a way of exploring self-diagnosis in a way that aligns more seamlessly with her practice.

> I think in the past I used to act on making a referral at the start. But now I've found that can kind of derail the counselling relationship a bit. It's like, okay, that's done. Why are we still here? Otherwise, I find that if I leave it integrated into the whole counselling thing, you just get a richer sense of what life's like for the young person.

Caroline explains that there were therapeutic impacts from following the diagnostic procedure and immediately referring a client exploring a self-diagnosis for an assessment. In her view, this interfered with the therapy and left the client unsure about the purpose of continuing to discuss and explore how they were feeling. In her view, spending more time getting to know the client and context of their experience, may lead to a better sense of whether the symptoms that the young person has understood within the frame of a psychiatric diagnosis could also be attributed to trauma, adolescence, or other external factors.

She was consistent in saying that she prefers to have these conversations at the end of the therapy.

> I like to kind of take is slow, not be jumping down any alleys or anything, just to kind of sit with it for a while, then also if I write a referral then I've got lots of information to, to back it up.

She considers how being in the counselling role she has a different set of circumstances than most other professionals who would be alongside a young person in this process.

I think in counselling you do have the luxury of time. So, I want to try and take it.

Caroline is noticing a difference in her role as a counsellor and the role of medical and mental health professionals in other settings. At this moment, I understood Caroline to be referring to a sense of scarcity of time and resources within the NHS and particularly within the CAMHS service. I also believe that she is contrasting the service model, noting that within the NHS, clients are frequently offered psychological assessments to determine whether an individual meets the criteria for a particular psychiatric diagnosis or treatment within their service. I interpret that as CAMHS is limited in what they can offer, one of the strengths of counselling and therapy may be more autonomy in the therapist's role to continue sessions as they feel is appropriate.

In my view, Caroline presents a model that could benefit therapists working with self-diagnosis. I argue that the process she outlined above prioritises the therapeutic relationship and invites clients to reflect on their experience while continually revisiting if a self-diagnosis identification matches their self-understanding.

4.10.2 Making use of clinical supervision

Participants each referenced making use of supervision to reflect and process their experiences working with this presentation. Some participants went into detail about their experience of speaking about young people self-diagnosing and using social media to learn about mental illness.

Participants overwhelmingly described supervision as helpful and supportive in developing their way of practising with young people while self-diagnosing. The therapists interviewed spoke about a variety of elements within their supervision including exploring their role and boundaries, and their initial reactions to clients' self-diagnosing.

Jacqui spoke about having "lots of conversations" with her supervisor in "terms of how I validate the need of having that label of that diagnosis and how important it is for my young

people." She explained that this processing space has encouraged her to speak with clients about "how is this going to change things for you?" Dan too, shared how supervision had supported him, stating, "supervision is really important." He explained that supervision has supported him in framing diagnosis within a person-centred model, leading him to appreciate and value what he is offering to clients.

> I'm not rushing away to think, 'Oh there must be something else we could do.' This person's sharing it with me and that's really useful.

I gather that prior to speaking about this in supervision, Dan may have felt uncertain about what he was able to offer as a therapist, but with this support, he was able to feel more at ease in his role and what he was able to offer clients. I see this as a significant statement, as these discussions led him to build confidence in his competency to work within his scope and alongside the self-diagnosis.

Ana, who has two clinical supervisors, explained that she has explored cases within two different supervisory relationships. She described that, particularly in more complex cases, "supervision has been helpful" and she feels that her supervisor has "really, really, great insight." Ana described an example where she felt overwhelmed and "oppressed within my work in various different ways" when working with a self-diagnosis case she found particularly complex. She explained that in this instance, her supervisor advised her to stay within her scope.

> As a counsellor you have a limit to what you can do, so just stick to that. Don't try to treat something that's you know, not within your capacity.

Ana described feeling "quite a relief at the time" when she had this discussion with her supervisor. For Ana, it seems that this input from her supervisor gave her permission to let go of some of the elements of this case that were out of her control. I interpret that when Ana speaks about "sticking to what she can do" she is referring to holding the therapeutic frame, being a consistent, empathic, and confidential presence for the client. In my view, Ana

received a supportive reminder of her locus of control and scope within the client's life. She expressed that this feedback was reassuring and reminded her of what she could offer.

Caroline, who also has two clinical supervisors associated with her different roles, noted differences in the ways that her supervisors gave input on social media-derived self-diagnosis in her practice. She expressed that she felt "frustrated" when one of her supervisors offered "quite practical" advice, particularly when her supervisor suggested finding ways to limit access to social media for the client they were discussing. From her perspective, this supervisor "had a lack of insights into the reality" of how young people use and engage with social media. From her description, it seems that Caroline felt that this input was out of touch with the lives of young people that she works with and seemed out of step with the type of reflection she endeavoured to engage with in supervision.

On the other hand, Caroline found the discussions around this with her other supervisor thoughtful and "much more helpful." She explained that in their discussion, her supervisor wondered if social media was playing a role in young people "looking for their packaging" or "sense of self" and that social media may be offering an environment to explore and confirm a sense of self.

She went on to frame social media platforms and the way that algorithms curate content according to presumed identity and preferences is in a way.

> It's like a holding or containment thing - social media is echoing back their sense of self to them…the algorithm is a bit like the mother in that way, like echoing it back…

Here Caroline is referencing the psychodynamic theories central to object relations theory, holding and containment. These theories posit the conditions that a child ned to feel safe and held both physically and emotionally. She is referencing how they understand themselves through the eyes of their caregiver, described in object relations as "mother" (Klein 1949).

Caroline and her supervisor are taking this phenomenon and using a lens of relational psychodynamic theory to make meaning of what social media identities might be providing for young people. In the moment that Caroline shared this dialogue, I was struck by this framing. I continued by sharing how much this concept had landed for me, and I found myself sharing my curiosity with Caroline as we spoke about this idea together.

> C: It really struck me. Yeah, I dunno what kind of mother it is that would take you, I mean if it was something, if you were researching Guinea pigs or something on TikTok, that'd be a lovely Yeah. Lovely thing to have echoed back to you. But if you're going down a dark path that's a slightly different quality of a mother. Yeah.
>
> M: Hmm. Yeah. And I guess there's something about how there is, there is that constant It is feedback. It is attunement to a certain degree. Yeah. It's, yeah. because basically you are putting something out there and it's responding by giving you more of, of what, what it's assuming you want.
>
> C: That's it. Yeah. That kind of scares me.

In this exchange Caroline and I are sharing a dialogue on the concept that there is an individual relationship between the social media platform algorithm and the user's sense of self, akin to the echoing of experience from the mother and child. I add the concept of attunement, which I meant in reference to psychoanalyst Kohut's concept mother being connected to the child's needs and desires, particularly when the child is pre-verbal (Finlay 2015).

In this moment, our dialogue felt collegiate and connected. Reflecting on this moment, I notice that my psychodynamic orientation led me to feel connected to these interpretations, as these formulations connected with my practice approach and ways of processing my work with clients. Although we were amidst the interview and I was holding the dual role of researcher-practitioner, in this moment, it felt as though we were two practitioners being

curious about our experience and looking to make meaning of this phenomenon that we were witnessing and working with.

In my view, the discussion Caroline shared with her supervisor offers an interesting interpretation of how young people may experience social media. This framing posits that platforms algorithmically attune to the interests of the users and offer both understanding and regulation through additional content. I argue that this is pertinent to making meaning of social media self-diagnosis through a lens of therapeutic theory. These interpretations could allow for therapists to better understand this phenomenon within a therapeutic frame and offer guides for how to work with clients with this presentation.

These accounts highlight that participants felt encouraged to work within their scope and found that discussing their experiences in supervision allowed them to make sense of the dynamics and reframe some of their experiences through a lens of therapeutic theory. I argue that these examples indicate that therapists felt that supervision was most supportive when they were able to consider self-diagnosis presentations through a lens of their practice modality. In my view, these accounts depict therapists' experience in supervision as supporting them to feel capable of navigating self-diagnosis from mental health presentations using their existing skills.

4.11 Conclusion

In this chapter, I have presented a detailed analysis of therapists' experiences and perspectives on adolescent self-diagnosis influenced by social media mental health content. The ten themes identified illuminate the complex interplay between social media algorithms, adolescent identity formation, and therapeutic practice. Therapists described navigating challenging power dynamics, offering alternative perspectives, and developing creative approaches to support clients with these presentations. The data reveals that despite varying theoretical orientations and years of experience, participants employed remarkably similar

therapeutic methods while expressing concern about the impacts of social media mental health content on young people. These findings contribute to our understanding of how therapists make meaning of and work with this growing phenomenon in their practice with adolescent clients.

Chapter 5: Discussion

5.0 Introduction

In this chapter, I will examine the research questions; *How are therapists working with adolescent clients exploring a self-diagnosis from social media?* And *What are therapists' perceptions of what a self-diagnosis means for adolescent clients?* I will examine these questions in connection to participant data and analysis to identify key findings to situate this study within existing research.

In this section, I will consider the connections between my analysis of the data in connection with the literature review. I will summarise key findings in the data and consider best practices for therapists working with young people exploring self-diagnosis.

For this discussion, I have chosen to organise my analysis and dialogue with research by themes. Mirroring the analysis section above, I have grouped themes according to the two research questions of this thesis. I will draw on my analysis and research the literature review to contextualise and make further conclusions about how this thesis is situated in a larger discourse about counselling and psychotherapy with adolescent clients self-diagnosing from social media mental health content.

5.1 Discussion of themes related to research question 1: *What are therapists' perceptions of what a self-diagnosis means for adolescent clients?*

5.1.1 Young people are vulnerable on social media

A pervasive theme constructed from the data was that therapists perceive young people to have various vulnerabilities unique to adolescence when using social media. In therapists' accounts, fears and concerns often overshadowed the benefits of social media mental health information. These fears included that social media has dangerous information and influences, such as content encouraging eating disorders, suicide, or self-harm. Participants

also expressed fears that social media platforms are rife with misinformation about mental health and illnesses that could mislead young people and have adverse effects.

Parallel to literature, therapists' accounts overwhelmingly focused on the adverse impacts of mental health content (Conte et al. 2024). These views are closely aligned with research on social media mental health content which confirm the presence of content that glorifies and instructs young people to engage in eating disorders (Custers 2015), suicidality (Bojanić 2024), and self-harm (Dyson et al. 2016). Concerns voiced by participants about misinformation are supported by research which has determined there is a significant amount of misinformation about mental illnesses and conditions on social media platforms (Suarez-Lledo and Alvarez-Galvez 2021; Yeung et al. 2022; Zenone et al. 2022).

Simultaneously, therapists shared examples of clients who benefited from learning about a mental condition on social media, leading to deeper self-understanding and improvements in their life. Participants noticed that content creators shared about their experiences living with a mental condition, adding new perspectives and sharing ways to manage everyday life. This too corresponds with literature, as Lupton and Southerton (2024) assert that TikTok videos about neurodiverse individuals described lived experiences, as opposed to clinical information.

Participants illustrated examples where clients felt that information, they learned online was beneficial to them, describing that some clients felt that a self-diagnosis was "clarifying", "empowering", or led to a sense of "self-acceptance." This too correlates with existing research, as Eagle and Ringland (2023) found that individuals experienced online health communities to be encouraging and supportive of self-diagnoses. Moreover, Lupton and Southerton (2024) found that neurodiverse individuals had positive experiences of re-defining themselves through either a self-diagnosis or formal diagnosis. Their findings determined that identifying with a label led people to engage in self-acceptance and community connected to

their diagnostic label. Lupton and Southerton, add a critical perspective, arguing mental health content displays a cultural encouragement towards self-optimisation, which contends that a self-diagnosis may offer an avenue towards self-acceptance and authenticity. I argue that Lupton and Southerton's perspective adds an additional layer to consider the motivations of young people who self-identify with a mental condition.

Looking through this framework, I posit that from the perspectives of the above accounts, therapists perceive that young people feel the benefits of a self-diagnosis is akin to how Lupton and Southerton describe self-optimisation. Thus, some young people may perceive that identifying with a psychiatric condition may lead them to living a more authentic and self-accepting life.

5.1.2 Young people are trapped on social media

Therapists expressed concerns that social media platforms are profit-driven and are designed to maximise user-engagement, which could be particularly impactful to adolescents who may lack self-control. Participants illustrated their fears through examples of clients who were "addicted", "frozen", or "obsessed" with TikTok and explained that they believed at times, young people may lack agency or control to disengage from using social media, even when they feel it could be harmful.

My analysis posits that therapists expressed seeing some young people as unable to extricate themselves from using social media and at times portrayed social media as intentionally trapping adolescent users to keep them on the platform.

This analysis agrees with research which signifies that in the adolescent stage, self-control is a key component of development and young people may be more susceptible to becoming influenced by and addicted to social media (Caner et al. 2022; Adiele and Olatokin 2014). As Chao et al. (2023) found, adolescents with poor mental health may be more likely to become addicted to social media, which can pose additional threats to ongoing mental health of young

people. Crucially, as this thesis focuses on therapists' perspectives, adolescents discussed are within a clinical sample of young people who are accessing therapy and therefore may have more pronounced mental health issues.

5.1.3 Who benefits from social media mental health content?

The analysis highlighted therapists' perception that some social media posts inaccurately depict mental illnesses, which could have harmful impacts for both users learning about these conditions and the individuals living with them. Participants observed that young people seem to connect with popular influencers and celebrities that have publicly disclosed their own diagnoses, which they perceived as sharing positive elements of having a mental illness, i.e. to be recognised and seen, while neglecting to share the more difficult aspects of living with a disorder. I assert that therapists offered a critical viewing of celebrities and influencers and their intentions to cultivate a public persona to gain popularity to meet their professional and monetary aims. Therapists perceived that young people were viewing the positive aspects of mental illness, they may be more likely to self-diagnose.

From my perspective, these perceptions of celebrity culture agree with existing literature that argues that young people widely trust social media influencers (Engel et al. 2024). Therapists' critical considerations about the incentives of influencers and celebrities supports Chevalier's (2024) description that the motivations for influencers and social media platforms can make it difficult to determine the authenticity of individual accounts.

Further, I assert that therapist's views on the motivations of social media platforms and their perceived entrapment of adolescents' attention aligns with critical research of mental health technologies. These ideas align with Stein and Prost's (2024) argument that mental health content on social media maintains neoliberal motivations, meaning that platforms such as TikTok have a vested interest in holding users' attention to collect data and market products. This view is also confirmed by Cosgrove et al.'s (2020) perspective that presence of mental

health content on social media platforms may be seen as a form of mental health surveillance which collect personal data as an exchange within a capitalist marketplace.

Thus, in my view, the perspectives of both the existing research and of participants in this study, place the emergence of mental health information on social media platforms as a continuation of capitalist aims, as Chevalier (2024) contends there are an entanglement of motivations, some of which are to commodify user data for the purpose of efficient advertising and increased profits.

5.1.4 Young people are vulnerable

Throughout my analysis, therapists expressed an urge to insulate young people from potential harm on social media. This impulse to protect young people online correlates with literature on adult views of children and young people, I see this theme in relation to research by Livingstone and Third (2017) which indicates that adults may underestimate young people's skills to navigate their online lives. These views align with broader discourse on adult perceptions of young people, which often portrays them as having less capacity to make autonomous decisions (Bakhtiar 2022; Wood 2022).

Engel et al.'s (2024) research confirms these concerns by demonstrating that many young people perceive social media influencers as trusted sources for mental health information. Crucially, Pfender and Bleakley (2024) found a difference in young people's views compared with their adult family members, who were hesitant to trust these sources.

However, Harris et al.'s (2021) research adds nuance to these generational debates, as they determine that many young people critically appraise the accuracy of mental health information on social media by discerning the authenticity and motivations of the content creator. Crucially, they note in their findings younger adolescents appeared to be more trusting and less critical of health content. Notably, the assessments offered by young people focused on perceived genuineness as a sign of validity. This idea aligns with Lupton and

Southerton's (2024) assertion that on TikTok users determined the credibility of influencers by their ability to articulate their experiences, rather than by their credentials. Which I posit may indicate a shift in framework for assessment of online health information.

As Bakhtiar et al. (2022) note, this research necessarily frames adolescent experiences through adult perspectives, since it analyses therapists' perceptions of their clients' experiences rather than adolescent accounts. Further, as this research analyses data from the perspective of adult therapists' perceptions of adolescent clients' experiences, these examples are adult perspectives of young people's subjectivity and agency. I argue this discourse may highlight a generational divide, where young people and adults have distinct relationships with social media and therefore have differing views on the value of health information available.

As Walsh (2020) contends, these fears and desires to protect young people online may be attributed to a "moral panic" which inflates the risks of social media use. However, I argue that the analysis of this thesis complicates this view, as the accounts above do present instances where young people experienced detrimental effects from viewing content that could be defined as dangerous or harmful. Notably, the available research does not distinguish adolescent perspectives that have mental health issues or engage in therapeutic intervention, therefore the adolescents in these examples may have distinct characteristics or experiences that are particular to young people accessing mental health supports. Thus, this thesis contributes an additional perspective of therapists' views of adolescent clients.

These accounts point towards a perception that young people are vulnerable and unable to safeguard their own well-being when using social media. Thus, I posit that these views may underscore therapists' beliefs about adolescents and their capabilities, which may have implications for therapeutic relationships with adolescent clients. I argue that this research expands on existing literature by examining the role of therapists' attitudes about adolescent

social media use and the potential impacts of these beliefs when working with this population.

5.1.5 Self-diagnosis as adolescent identity

In my analysis of this theme, therapists perceived that many young people, including those accessing therapy, "want to have a label." Participants explained that they consider these labels as a contemporary way for young people to identify with a group, serving the same function as subculture identities centred on preference of music, fashion, or interests.

Firstly, participants' interviews are consistent with research conducted by Hermann et al. (2022) that conveys young people's belief that being "mentally unwell" is the "new normal." Additionally, research that posits that young people may be more likely to self-diagnose is echoed across literature (Foulkes & Andrews 2023; Nelson 2023; Martin 2023).

Notably, participants perceived that young people are more likely to self-identify with a mental health condition after repeatedly viewing content about a diagnosis on social media. I contend that these accounts closely align with Foulkes and Andrews' (2023) theory of the 'prevalence inflation hypothesis', which argues that increased mental health education may lead individuals to view their distress through a lens of mental health problems. Additionally, these accounts contribute practice examples of what Foulkes and Andrews define as a 'self-fulfilling prophecy', where some individuals may experience an increase in symptoms after viewing themselves through the lens of a mental health label. I argue that these accounts align with Foulkes and Andrews' theory of a 'self-fulfilling prophecy' whilst adding therapists' perceptions that these impacts are present in some cases of self-diagnosis.

In my analysis, I consider that these accounts offer an assertion that young people may be developing identities through pathology rather than through preferences that are associated with other subcultures, marking a cultural shift in adolescent identity-formation which could be linked to the increased prevalence of mental health content on social media. My analysis

of participant perspectives contributes to a growing body of research asserting that young people's mental health symptoms may be impacted by their identification with a mental health condition. Although broadly converging with existing literature, this thesis offers a distinct insight that from the perspective of youth therapists, young people may employ self-diagnosis identities in lieu of identities associated with individual preferences or interests.

5.1.6 Self-diagnosis as an expression of needs

Concurrently, participants expressed beliefs that some young people are seeking reassurance or validation through a self-diagnosis. In my analysis, I interpreted that young people may see self-diagnosis as way to communicate their needs to others. I argue that as a medicalised diagnoses hold cultural authority, it is widely accepted that there are specific challenges and needs that a person with a mental condition may have. Therefore, some young people may, consciously or unconsciously, self-diagnose as an articulation of their needs, in the hope that they will be met more favourably when endorsed by a diagnostic category.

Furthermore, these assertions collaborate with the perception that young people may feel that a diagnostic identity may fulfil a profound desire to feel "seen" by others, which Giedinghagen (2023) asserts may be a motivator for some adolescents. Additionally, this aligns with how Lawlor and Kirakowski (2017) propose that cases of "factitious" self-diagnosis may be linked to early childhood trauma, which may lead individuals to seek positive attention and identity affirmations through a diagnostic identity.

This research expands on existing considerations of self-diagnosis identities and offers that from therapists' perspectives, young people may perceive that having a diagnosis justifies their needs and may impact the likelihood that their needs would be met or respected.

5.1.7 Algorithmic identity formation

Furthermore, some participants described that they believe diagnostic identities are developed as a response to algorithmic design which attunes to user preferences through engagement

such as liking, following, or spending more time viewing a particular post. Hence, therapists perceive that young people are continuously looking at content that endorses diagnostic identities, which influences their understanding and possibly leads them to look at themselves through a psychopathologised lens.

In the research, Perez-Torres (2024) proposes, social media can be viewed as a digital mirror, where adolescents are mutually producing and produced by the content they view. Therefore, as adolescents view, create, and interact with social media posts, they are simultaneously engaging with and creating an identity in relation to themselves and others both on and offline.

Concurrently, Yeung et al. (2022) concluded that repeatedly viewing content about a diagnosis may increase users' perception that they have a diagnosis, regardless of if their symptoms match the criteria. I view this in line with Andres and Foulkes (2023) assertion that knowledge of and repeated exposure to information about mental conditions may lead to increased self-diagnosis. Additionally, these ideas align with Bimo and Bhandari's (2024) concept of the "algorithmized self", Schellewald's (2023) "reading for personalisation" and Avella's (2024) "platformed diagnosis". Each of which make meaning of algorithmic engagement and curation that is co-created by the user and the platform algorithm which may lead to identity formulations. Bimo and Bhandari describe this as a reflexive process where users engage with versions of themselves mediated through their participation with the algorithm. This finding broadly relates to existing research and contributes added perspectives of practitioners' voices into the existing body of literature.

5.1.8 The perceived certainty of psychopathological labels

Participants voiced their interpretation that a self-diagnosis may offer adolescents a sense of certainty about themselves. Therapists perceived that young people may seek this certainty to alleviate feelings of discomfort associated with being a teenager and the ambiguous process

of developing a coherent identity. From this view, therapists perceive that the emergence of mental health content on social media has impacted the common experiences of adolescence by offering diagnostic labels as identity options to adhere to.

Participant's views are partially supported by literature in adolescent identity development, which claim that one of the main tasks of the adolescent stage is a critical starting point for developing personal identity (Erikson 1968). In my view, Crocetti's (2008) model offers a valuable lens, as he frames identity development to be a cyclical and iterative process, which continually revises and adjusts identity through exploration and experience. I argue that this non-linear process could evoke feelings of uncertainty, leading to discomfort for young people who have the desire to feel assured in their sense of self. This theory supports participants' perceptions that some adolescents seek diagnoses as a "magic wand" to escape the discomfort of the ambiguous process of identity formation, opting to choose pre-defined templates through self-diagnosis.

These interpretations are also aligned with research positing that biomedical diagnosis offers a sense of certainty and apps designed for medical self-diagnosis are often seen as offering certainty to patients (Jutel 2021; Lupton and Jutel 2015). Further as Sukmawati et al. (2023) argue people may be more likely to self-diagnose with a psychiatric disorder when they are uncertain about the cause of their symptoms. However, my research expands existing knowledge articulating that from therapists' perspectives, young people may be particularly drawn toward self-diagnosis due a belief that a diagnostic label may offer certainty and quell discomfort during a notably uncertain period of identity development.

5.1.9 But are diagnoses so certain?

Participants expressed their ambivalence about psychiatric diagnosis, citing their doubts about the value, limitations, and history of mental illness and diagnosis categories. Therapists viewed some depictions of mental conditions on social media as inaccurate and sometimes

glorifying illness. Notably, the conditions that participants were most concerned about being misrepresented were personality disorders such as DID. Misrepresentation of DID was described as “blurring reality” and “romanticising” the illness.

The concept that some social media content may emphasise the benefits of living with a psychopathology is acknowledged in literature, as Adeane and Stasiak (2024) observed, some young people believed that social media content may “unintentionally glorify mental illness.” I contend that view on the phenomenon of alternative depictions of mental illnesses can be viewed through Hacking’s (1999) theory of looping, where he argues that pathologies are context-specific and changeable. This is also in line with how Haltigan et al. (2023) describe social media platforms as an “incubator” for revised definitions of mental conditions. I contend this is also in conjunction with Haslam et al.’s (2016) theory of “concept creep” where psychological terms are evolving in dialogue with culture, taking on semantic revisions that have meaningful impacts to the ways that people conceptualise and apply these terms.

Thus, as participants observed, the depictions of mental conditions on social media may not coincide with the formal criteria of a disorder. However, as the literature asserts, these depictions, despite their misalignment with the DSM criteria for a condition, have impacts on the concepts and self-identifications of the viewers of this content. Therefore, I posit, that a social media user may identify with the symptoms or traits being attributed to a disorder, leading them to self-diagnose. However, if the information presented is out of sync with formal diagnostic criteria, a user may be seen as misdiagnosing themselves from a biomedical perspective, while still being seen as accurately diagnosing themselves within their online and peer communities. This leads to both a cultural and professional tension as definitions of mental illness may be context-dependent rather than uniformly coinciding with the formal

DSM criteria. My research aligns with existing literature while extending it through richly illustrated practice examples from therapists' perspectives.

5.1.10 The stigma remains

Additionally, my analysis acknowledges that some participants perceived that celebrity and influencer endorsement of pathology may contribute to a cultural shift away from the historical stigma of mental illness and towards a type of kudos for individuals with a psychiatric label. Research by Giles and Newbold (2017) supports this perception, as they argue that in recent years there has been a cultural shift which has inverted "mental-illness-as-stigma." From this perspective, a diagnosis may be viewed as a favourable attribute rather than a challenge to overcome.

Therapist accounts described that there may be social benefits and challenges for adolescents with a self-diagnosis. In the analysis, I traced through examples where clients felt supported by peers and online communities. However, participants also described their beliefs that self-diagnosis may be viewed among peers as a "social currency" where having more severe mental health difficulties is seen as socially beneficial. Moreover, views were expressed that young people can be both comparative and competitive about the severity of their symptoms, particularly in cases of self-harm. I analysed this example to be particularly worrying for participants and their clients, as the risks associated with self-harm combined with the social pressure to fit in could incentivise young people to either adjust their self-harming to be more severe or depict themselves as more unwell than they are.

There is research that supports the notion that more severe mental illnesses may be favoured on social media platforms. Giedinghagen (2023) states that social media algorithms prioritise circulating content that depicts more extreme symptoms of mental illness. The concept that young people might leverage diagnostic identities as social currency aligns with Ahn's (2011) assertion that online activities can generate social capital within peer groups.

Notably, there is a body of research that stands in contrast to participant perceptions that self-diagnosis is seen as socially beneficial. Underhill and Foulkes (2024) identify, self-diagnosis is still a "highly contested issue" and adolescents who self-diagnose are often the subject of scepticism and scrutiny by peers and adults. They also identify a distinction between research findings about self-diagnosis that focusing on adolescent perspectives versus the more widely available catalogue of adult considerations on this subject. Studies that interviewed adolescents about their views, found that young people feel that self-diagnosing has significant risks, as there is significant stigma associated with "faking" a mental illness and disclosing self-diagnosis opens them to social scrutiny from peers (Dixon-Ward and Chan 2022; Hermann et al. 2022; Teng et al 2017).

Thus, participant perspectives align more closely to adult perspectives in the literature than with research analysing adolescent perspectives. This indicates a further alignment with existing literature on adolescent self-diagnosis from social media content.

5.2 Discussion related to research question 2

How are therapists working with adolescent clients exploring a self-diagnosis from social media?

5.2.1 Prioritising the therapeutic alliance

In the analysis of this theme, therapists described approaching adolescent clients exploring self-diagnosis in session in a largely similar way. Participants' descriptions reiterated the importance of building rapport with clients, listening, validating, asking what led a client to believe that they have a mental health condition, and remaining open and curious.

To varying degrees, participants made meaning of self-diagnosis exploration through the lens of their practice modalities. Therapists cited their theoretical orientations and referenced theories that influenced their approaches to working with clients identifying with a self-diagnosis. This was further evidenced in participants reflections of supervision, where

therapists described finding supervision most supportive when their supervisor framed cases through modality-specific theories.

I posit it is significant, that despite different modalities, years of experience, and views about self-diagnosis from social media, participants used a very similar therapeutic methods in sessions with clients exploring a self-diagnosis. Additionally, therapists highlighted that there is no one single approach to working with this presentation, and that it is best to use professional judgement and employ a variety of elements depending on the client and their circumstances as well as the relationship between client and therapist.

These points correspond with existing literature in counselling and psychotherapy which emphasises that CYP therapists focus on building a strong therapeutic alliance (Cirasola & Midgley 2023) and tend to approach clients from a holistic, humanistic perspective (Herlihy & Remley 2020). Additionally, these accounts align with Nelson's (2023) findings which maintain that therapists' practice remains aligned with a humanistic perspective when working with self-diagnosis presentations.

Therefore, therapists' accounts emphasise that when a client presents a self-diagnosis their practice remains relational and grounded on their existing therapeutic training and skills. This largely aligns with existing research and offers additional insights into therapists' practice when working with self-diagnosis presentations with adolescent clients.

5.2.2 Remaining relational and grounded when sceptical

Therapists expressed that in some cases, they felt sceptical of a client's self-diagnosis and perceived that a client was "performing" their symptoms. Participants explained they found these presentations challenging and struggled to establish a strong therapeutic alliance with these clients. Additionally, therapists considered inauthentic presentations of self-diagnosis as a communication of the client's distress and internal world.

These sentiments are in part, aligned with research in psychiatry and psychology that describe individuals with inauthentic presentations of a diagnosis as developing an illness identity due to the perceived benefits of having a labelled disorder (Giedinghagen 2023; Lawlor and Kirakowski 2017). Crucially, Giedinghagen highlights that these presentations may be "conscious or not" indicating that young people presenting with a feigned disorder may be doing so outside of their own awareness.

On occasion, therapists perceived clients as dynamically shifting their self-diagnoses, as if trying on different diagnostic identities, participants interpreted this as an expression of identity-formation through diagnostic presentation. I suggest that these cases can be viewed through Crocetti et al.'s (2008) research which views adolescent identity formation as dynamic process where young people may consider and try on various identities in a fluid process. I suggest that therapists view self-diagnosis exploration as a part of the identity formation cycle, where young people continuously evaluate various identities as they develop their sense of self.

Participants expressed that working with these clients was specifically challenging for them as they felt tension difficult position where clients were frequently dismissed by others, including mental health professionals, but they too felt sceptical of these presentations.

As noted in other sections, the literature supports participants' perception that individuals who self-diagnose may be subject to feeling rejected by both professionals (Corzine & Roy 2024; Giles & Newbold 2011; Milton et al. 2023) and others in society (Underhill & Foulkes 2024; Dixon-Ward & Chan 2022; Hermann et al. 2022). The difficulty of clinical work with inauthentic presentations is also echoed in the literature, as Giedinghagen (2023) argues that feigned self-diagnosis presentations are complex and require careful attention from professionals. In her view, it is essential for professionals to build rapport with these individuals and to develop understanding of factors contributing to this presentation. Based

on participants' descriptions of their challenging experiences, their practice methods largely align with the approaches recommended in current research.

Therapists described grappling with how to maintain therapeutic relationships with clients who had rigid or seemingly inauthentic self-diagnoses. Additionally, participants illustrated their efforts to remain curious about what the client may be communicating through their symptoms and performativity. Further, therapists explained that they held nuanced views about these cases, considering how they can work therapeutically whilst declining a binary of a "real" or "fake" diagnosis presentation.

Although there is no specific research on this topic, I posit that therapists' curiosity about a client's self-identification may be communicating their internal experience can be linked with how Johnstone (2013) describes a social constructionist perspective of formulation. Thus, therapists curiously consider what may be "useful" about a self-diagnosis for this client and shy away from a binary view of what is "accurate" or "inaccurate." These therapeutic approaches are also mirrored across humanistic approaches, as in Roger's (1939) view that therapy seeks to understand the child and not the symptoms or the diagnosis.

Thus, this research offers significant contribution in elaborating on practice insights of therapists' approaches to practice with adolescent clients perceived as presenting with inauthentic self-diagnosis after viewing social media content.

5.2.3 TikTok self-diagnosis expands therapists' role

An additional theme in therapists' practice included the presence of social media and mobile phones in sessions. Participants explained that is common in their work for adolescent clients to share social media mental health posts with them in the counselling room. These accounts described that therapists are open to and sometimes encourage clients to "show them" what they've been watching on TikTok.

The presence of social media in session is supported literature (Martin 2023; Nelson 2023; Phillips 2022). At present there is little research on the impacts of social media or mobile phone use in adolescent therapy sessions. My research offers a significant contribution by illustrating rich practice examples where therapists view and discuss social media mental health posts with adolescent clients in sessions.

Additionally, participants in this study cited varying degrees of familiarity and use of social media platforms. Therapists referred to their age, as a factor in their familiarity with social media, identifying being older or of a different generation to than their adolescent clients. Some therapists emphasised that they are "not a dinosaur" or that clients see them as a "granny" when talking about social media. I analysed that this may create a dichotomy between therapists and their CYP clients. Alternatively, some participants illustrated making efforts to understand the memetic culture of social media platforms. One participant expressed their view that some therapists may dismiss the importance of social media in young people's lives and don't make efforts to stay informed about social media. Although this therapist acknowledged the difficulty of staying informed, this led them to feel frustrated with "some older therapists." Finally, participants expressed a desire for more relevant and effective training on social media, suggesting that therapists could engage in an online forum focused on a relational and experiential learning about mental health content and social media.

A number of these ideas are supported in U.S. research by Derges et al. (2023) which determined that young people want to speak about their online lives in therapy and feel more able to discuss these topics with a therapist who knows about social media. Despite youth preferences, some therapists feel that not knowing about social media is a way to build rapport. Moreover, Phillips (2022), who also writes from the U.S., suggests that therapists should engage with mental health content on social media, intentionally liking and engaging

with posts that clients may be viewing. I posit that this research directly aligns with the views shared by some therapists in this thesis.

The literature cited above is based on U.S. practice, where requirements for therapists regarding social media literacy differ significantly from those in the UK. As Nelson (2023) cites, there is a professional obligation for therapists working with CYP populations to be familiar with social media platforms. Notably, Nelson concluded that these requirements were "not enough" and in her view there needs to be more in-depth training for therapists to understand the impacts of social media in the therapy room. I assert that this body of research based in the U.S. highlights a contrast to therapists' requirements in the UK, as at present, there is no existing stipulation or obligatory training for therapists to have knowledge about social media platforms to be qualified CYP practitioners.

In UK-based research, White and Chen-Wilson (2024) determined that UK therapists did not have specific training for working with social media and therapists mainly drew from their own social media experiences. They too urge that therapy-specific training is crucial for practitioners to meet the needs of CYP clients.

I contend that my research contributes to this growing area of literature and indicates an expansion of therapists' roles resulting from mental health content on social media. Concurrently, these accounts signify a desire for therapy-specific social media training and indicate an absence of effective opportunities for therapists to develop their skills. Therefore, I assert this research offers a significant contribution by elaborating on practitioners' voices which point to a gap in available training and professional development to meet this phenomenon.

5.2.4 Self-diagnosis leads to increased psychoeducation

Participants cited numerous cases where a client learned inaccurate information about mental conditions from social media. Therapists explained that when they view social media in

sessions, they correct misinformation and sometimes recommend that clients look at the NHS website for diagnostic information. I conclude that the phenomenon of mental health information on social media may lead to additional psychoeducation from therapists as young people are exposed to significantly more unmoderated information on these topics.

The presence of inaccurate information about mental health is widely researched (Zenone et al. 2021; Suarez-Lledo & Alvarez-Galvez 2021; Yeung et al. 2023). However, there is an absence of empirical research on impacts of assessing social media content with adolescent clients in sessions. There is limited research establishing the presence of misinformation from social media in therapy sessions. Martin (2023) advocates that therapists should "counterbalance misinformation" with adolescent clients by offering accurate information about mental disorders.

In my view, Nelson's research (2023) offers an interesting contrast, as her work focuses on therapists based in the U.S., where therapists receive training in psychological diagnosis and some mental health counsellors and therapists hold diagnostic qualifications. This marks a crucial difference from therapists practicing in the UK, particularly as the qualification process does not require therapists to have training in diagnostic frameworks (BACP 2022). As Cooper (2008) describes counselling in the UK emerges from a 'pastoral tradition', which has significant epistemological implications. He contrasts this with the United States, where psychotherapy is grounded in psychology and often includes diagnostic training as part of professional preparation.

My research adds to previous literature which establishes that social media and mobile phones may be an ongoing element in CYP therapy. In my view, the presence of social media in therapy sessions may indicate a shift in the therapist's role, introducing a potentially new dynamic into the therapeutic relationship, where the therapist is positioned as an expert on the credibility of social media mental health information. Further, as therapists in the UK do not

have required training on psychiatric diagnoses, therapists may have varying degrees of knowledge about the accuracy of diagnostic information, which could potentially lead to additional misinformation. Further, therapists appraising mental health information in sessions could have relational impacts in adolescent therapy. I contend that there could be various instances where therapists taking this role could have adverse impacts on the therapeutic process.

This thesis expands on the available research by contributing practice examples and indicates a gap in knowledge about the impacts of misinformation from social media in CYP therapy.

5.2.5 Self-diagnosis leads to discussions about the formal diagnosis process

Therapists illustrated that clients with a self-diagnosis often consider or sometimes pursue a formal diagnosis while they are in therapy. Participants explained to clients that therapists have a non-diagnostic role. In addition, therapists outlined the NHS diagnostic process and explored diagnostic options with clients. In some cases, therapists depicted working with clients alongside CAHMS and supported to process this experience. Participants reported that they did not have training in these procedures, which led some to feel unclear and at times unqualified to work with clients considering a formal diagnosis. Notably, participants with previous experience in medical mental health settings felt confident in these processes and noted that they would have felt overwhelmed with self-diagnosis presentations without this background. Further, in my analysis, therapists perceived that clients may be more open in therapy sessions than with CAMHS staff which may indicate the strength of the therapeutic alliance and highlight the importance of rapport building with adolescent clients exploring self-diagnosis.

There is no research exploring how self-diagnosis within therapy could impact young people's likelihood to pursue a formal diagnosis, however, this research points towards a

connection where exploring self-diagnosis may lead to exploring formal diagnostic pathways in therapy (Jutel et al. 2017; Monteith 2024; Milton 2023).

Therapists also explained that when they outline their role as non-diagnostic, they tend to reassure clients of their experience and capacity to work with them. There is no extant literature on these themes in counselling and psychotherapy, however, there is literature that highlights the tensions and segregation within mental health professions (Gabbard 2009). I suggest that when therapists reassure clients of their competence despite not having diagnostic authority, this reflects an underlying power hierarchy that exists within UK mental health professions. Within this hierarchy, being qualified to diagnose may be seen as a higher level of competency and authority from a medicalised lens. Therefore, when participants share these reassurances, I contend that they may be expressing internalised concerns that clients would view them as holding less credibility or qualification to work psychopathological symptoms or labels.

As I analysed from therapists' perspectives in this thesis, the prevalence of self-diagnosis seems to open conversations about the process to undergo a formal diagnosis through CAMHS and could lead to an increased frequency of collaboration between therapists and mental health services. In my view this may indicate a shift in skills needed for therapists working with adolescent clients. I suggest that these accounts may point towards a gap in therapists' knowledge and may suggest that therapists are more frequently informing clients about these diagnostic processes. Thus, based on this thesis, some therapists may lack the professional expertise to guide clients through these steps, potentially leading to imprecise or inaccurate advice for adolescents exploring these options. Therefore, I posit that with the current prevalence of self-diagnosis presentations in adolescent populations, therapists working with young people may need to acquire additional skills and training in diagnosis and diagnostic processes to ethically work with this client group.

5.2.6 Social media self-diagnosis is a "third" in the room

Participants have noticed changes in their practice in response to exploring self-diagnosis in sessions and described adjusting elements of therapy to best support clients with this presentation. Therapists discussed cases where they felt that the presence of social media and self-diagnosis was like a "third in the room." In some instances, participants described this third as a supportive presence in the therapy, sometimes leading to self-reflection and insights. While in other cases participants described the presence of self-diagnosis and social media as a barrier which posed complex challenges in their working relationship.

I argue that participants' perspectives align in part with Zeavin's (2021) concept of "mediated therapy" as social media mental health content and self-diagnosis could be viewed as a "third" in the therapeutic dyad. As Avella (2024) posits, social media algorithms and mental health content can be viewed through Zeavin's framework, particularly for young people self-identifying with mental health disorders. However, the existing research is mainly focused on the relationship between the individual and the social media platform (Avella 2024). Thus, I propose that therapists' framing social media self-diagnosis as a "third" in the therapeutic relationship is a novel contribution of this research. The analysis of this theme also focused on therapists' experience noticing a shift in power that they attributed to a self-diagnosis presentation. One participant detailed that they felt that there was a shift away from a "therapist" and "client" relationship towards an "expert" and "patient" dynamic.

Although there is no existing research examining power in relation to self-diagnosis in counselling and psychotherapy, I consider how this dynamic could echo Rogers' (1951) fears about psychiatric diagnosis in counselling, which he argues could lead to clients relinquishing their personal power by seeking expert guidance from the counsellor and potentially disrupting the impacts of therapy. I also link these accounts to theories of medical authority and dominance throughout society (Jutel & Nettleton 2011; Lupton & Southerton 2024). This

observed power shift in the therapeutic relationship suggests that therapists may need additional skills to effectively work with self-diagnosed clients while maintaining appropriate therapeutic boundaries.

Further, as in the UK therapeutic work is often separate from diagnostic assessment and treatment, the prevalence of self-diagnosis in sessions may form a bridge between these delineations leading to different dynamics, which may signify the need for additional skills for therapists to work with this presentation. This research offers practice insights into this phenomenon and highlights that self-diagnosis exploration in therapy sessions has significant impacts from the perspectives of youth therapists.

5.2.7 Shifting the frame: offering alternatives to a pathological lens

Therapists shared that each case is different and that there are many variations to self-diagnosis presentations. In my analysis, I determined that therapists perceive some clients' self-diagnosis as exploratory and flexible, and other clients as certain and rigid. Participants' felt it was more difficult to engage therapeutically with client's they perceived as having a more rigid self-identification.

Therapists described educating clients about the difference between "normal" experience and experience that may indicate that a young person may meet the criteria for a mental illness. In these descriptions participants perceived that some young people may conflate difficult feelings with having a mental disorder. Throughout interviews participants offered examples of working with clients where they tried to normalise experiences and symptoms that clients viewed through pathologised language.

The concept that young people view their experiences through an overly pathological lens is mirrored in the literature. Suhr and Johnson (2022) determined that self-diagnosis in university students may result in over-pathologising normal behaviour. Haslam et al. (2016) describe "horizontal concept creep," where psychological terminology expands to include

less severe behaviours. This phenomenon helps explain why young people might interpret normal experiences through a diagnostic framework, as the meaning of psychiatric terms has undergone changes in popular usage. Additionally, Connor (2022) confers that in her psychotherapy practice, she often "normalises" the experiences of adolescent clients and explains that having difficult periods in life and struggling with negative feelings is a part of being human. She argues that it takes time to develop a relationship and understand a young person's experience to distinguish if a client is presenting symptoms of "ordinary struggles" or signs of pathology.

Participants explained that in some instances they offered alternative perspectives for clients to consider their symptoms and experiences outside of the pathological label that a client identified with. These perspectives looked at the client and their circumstances holistically, considering their life and experiences. Across participant accounts, using a lens of trauma was mentioned most frequently as an alternative explanation. I analyse that these alternative perspectives are more aligned with therapist humanistic views on lived experience and may be influenced by therapists' attitudes towards mental illnesses and their perceptions of self-diagnosis from social media content.

Novac et al. (2019) position psychotherapy as a space where identity narratives can be reshaped and reconsidered. Further, I argue that therapists' accounts can be viewed in line with the concept of psychological formulation, which Johnstone (2013) posits a socially constructionist view where the same experience can be considered through different models and narratives. She argues that therapy is a space where clients have the ability engage in a process of collaboratively formulating and re-formulating experiences in an iterative relational process. Additionally, from a relational and social perspective, formulations can be viewed as "useful" rather than through a lens of "correct" or "incorrect", offering a distinct deviation from the framework of psychiatric diagnoses. I suggest that these participant

accounts are describing a process of re-formulation where clients initially viewed their struggles through a psychopathological lens, but through a collaborative process where therapists offered alternative formulations clients found themselves considering other frameworks to understand their experiences.

Therapists also explained that after they spent time exploring a client's experience and self-diagnosis some clients shifted their perspective and no longer identified with their self-diagnosis. Some participants cited that it was in fact "not very often" that clients continued to identify with a self-diagnosis or chose to pursue a formal diagnosis. They perceived that offering space to explore their feelings and experiences allowed for young people to think about themselves and their experiences differently, often in a way that made clients feel that their self-diagnosis no longer fit.

I argue that this is a significant contribution of this research, as these accounts could point to a pivotal role that therapy can contribute to adolescents self-diagnosing with an unclear or inaccurate mental condition. Further, as evidenced in the research, the phenomenon of social media mental health influenced self-diagnosis has raised concerns about the impacts of misdiagnosis and the increased demand on mental health services (Suhr & Johnson 2022). My research expounds on existing literature and adds distinct insights into the impacts of therapists offering additional perspectives may shift a young person's view, leading them to reframe their experiences outside of diagnostic frameworks.

5.2.8 Therapists' attitudes and biases about self-diagnosis from social media

Throughout the analysis chapter, I noted therapists' attitudes and biases towards social media, self-diagnosis, and adolescence. I contend that therapists practice can be influenced by existing beliefs and values when working with adolescent client exploring self-diagnosis via social media content.

This assertion is supported by research, as it is widely accepted in counselling and psychotherapy literature that therapist reflexivity is an essential component to ethical therapy practice (Willig 2009). This analysis also aligns with research conducted by Yager et al. (2021), which concludes that therapists' biases can play an important role in therapy, sometimes having detrimental impacts to the client and therapeutic relationship. They argue that therapists must continually expand their self-awareness to mitigate the role that personal biases may play in therapeutic practice.

I note that participant accounts in this thesis are fluid, and individual therapists expressed overlapping and at times contradictory views about self-diagnosis, social media mental health content, and adolescence. Notably, across interviews, there was a tendency for participants to offer more nuanced perspectives when speaking about a specific client or when a topic was more closely related to therapy practice, compared to when a participant spoke these topics in wider picture of this phenomenon.

This difference is illustrated in the analysis chapter, for example, when therapists spoke about young people, they emphasised a perception that adolescents view self-diagnosis is a social benefit. However, when therapists spoke about their practice experiences, they illustrated responding to self-diagnosis with caution and held concern that a client may feel dismissed or rejected if their self-diagnosis was not validated by the therapist. Although this can be viewed as an element of respecting the therapeutic alliance, I argue that this highlights variance in therapists' views. Thus, I argue that this points to a possible distinction in therapists' attitudes depending on context, implying that some of their views may shift within therapeutic relationships or when considering a specific client, as compared to their views when speaking about adolescent self-diagnosis as a phenomenon.

I argue that although therapists hold largely pessimistic views about social media mental health content and self-diagnosis. In their practice accounts of working with adolescent

clients exploring self-diagnosis, participants expressed more nuanced and person-centred attitudes. In illustrations of practice, therapists appear to maintain a professional therapeutic approach prioritising the client's perspective and empathising with clients as they explore these self-identified disorders. Crucially, participant accounts are necessarily from their viewpoint and would not acknowledge unconscious biases or impacts that therapists are unaware of. However, I contend that a significant contribution of this thesis elaborates that, from these accounts, therapists remain relational and grounded in their existing training and theoretical orientations when working with adolescent clients exploring self-diagnosis.

5.2.9 Reflexivity in supervision

Therapists described that working with self-diagnosis and social media mental health content led them to adjust their approach to practice. Therapists detailed their experiences discussing cases with self-diagnosis from social media presentations in supervision. Participants found supervision most helpful when supervisors could discuss self-diagnosis issues within the framework of specific therapeutic modalities relevant to the therapists' practice. I argue that these accounts may indicate how therapists practice modality impacts their interpretations of self-diagnosis exploration. Some therapists reported feeling disappointed with supervisors who offered limited perspectives on self-diagnosis and social media issues. These therapists perceived that their supervisors offered inadequate support due to either knowledge gaps or personal biases.

Research contends with elements of the above themes, as reflexivity and the use of supervision is widely seen as a crucial element of ethical and effective therapy practice (Harries 2017; Willig 2019). Although there is no available research in counselling and psychotherapy on the impacts of re-framing I again draw from Johnstone's (2013) literature on formulation and consider that these descriptions also pertain when reframing self-diagnosis into therapeutic terms in supervision. I propose this point could be viewed as re-

formulation from a diagnostic lens to an alternative therapeutically oriented narrative. Thus, I argue that therapists' accounts in part mirror existing research and add depth to practice literature by elaborating on the lived experience of working with adolescent self-diagnosis. Further, as Rankine's (2017) study in social work posits, it is essential for practitioners to have open and trusting relationships within supervision. Notably three of six participants in this research are therapists and supervisors. At present there is an absence of research on the impacts that supervisor's knowledge about self-diagnosis or social media may have on both the supervisee or the therapeutic relationship with clients. This research contributes new insights into both the challenges and supportive aspects of clinical supervision when addressing social media-influenced self-diagnosis in adolescent clients. However, I contend that these accounts highlight the importance of supervision for practitioners working with this presentation. Additionally, these accounts highlight that this phenomenon may also impact the knowledge and skills that clinical supervisors require to support supervisees working with adolescent clients, potentially indicating an additional gap in training and knowledge in counselling and psychotherapy.

5.3 Conclusion

This research offers significant insights into how therapists perceive and work with adolescent clients exploring self-diagnosis from social media. The findings reveal that therapists generally maintain their core therapeutic approaches when working with these presentations, prioritising the therapeutic alliance and remaining grounded in their theoretical orientations. While participants express concerns about the accuracy and impacts of social media mental health content, they simultaneously recognize its potential benefits for some clients.

The analysis identifies several practice implications. First, the prevalence of social media in therapy sessions positions therapists as evaluators of online mental health information, potentially shifting therapeutic dynamics. Second, therapists frequently navigate conversations about formal diagnostic processes despite many lacking specific trainings in these areas. Third, therapists offer alternative formulations that help clients reframe their experiences outside pathological frameworks, often resulting in clients no longer identifying with their initial self-diagnosis.

This research also highlights significant gaps in professional development, as UK therapists receive limited training regarding social media literacy or diagnostic frameworks. Supervision emerges as crucial for processing these cases, though the supervisors' contributions to support therapists varies based on their knowledge of social media and self-diagnosis phenomena.

The findings contribute to emerging literature in this field while offering unique insights from UK therapists' perspectives. The study illuminates the dynamic interplay between adolescent identity formation, social media algorithms, and therapeutic relationships. As self-diagnosis from social media becomes increasingly prevalent, this research suggests the need for enhanced training and guidelines to support therapists working with these complex presentations while maintaining ethical, client-centred practice.

Chapter 6: Conclusion

6.0 Summary of key findings

This thesis focused on exploring therapists' practice experiences and perceptions of adolescent clients exploring self-diagnosis after viewing social media mental health content. The findings reveal a multifaceted picture of how therapists understand and work with this phenomenon. Participants described self-diagnosis as occurring at the intersection of adolescent identity formation, social media engagement, and therapeutic practice. Therapists perceived adolescent self-diagnosis from social media as a complex interplay between young people's developmental stages, their search for certainty during identity formation, and the influence of algorithmic curation on social media platforms.

A key finding emerged that despite varied theoretical backgrounds, participants employed remarkably similar approaches when working with self-diagnosed clients, prioritizing the therapeutic alliance, normalizing experiences, and offering alternative perspectives outside pathological frameworks. Therapists consistently reported viewing social media content with clients in sessions, providing psychoeducation, and clarifying their non-diagnostic role while supporting clients who chose to pursue formal assessment.

6.1 Practice implications

The analysis identifies several important practice implications. First, therapists are increasingly positioned as evaluators of online mental health information, potentially shifting therapeutic dynamics toward a more directive approach. This suggests the need for practitioners to develop critical literacy regarding mental health content on social media platforms. Second, therapists frequently navigate conversations about formal diagnostic processes despite many lacking specific training in these areas, highlighting a gap between practice demands and professional preparation. Third, therapists offer alternative

formulations that help clients reframe their experiences outside pathological frameworks, often resulting in clients no longer identifying with their initial self-diagnosis.

Additionally, the research suggests that therapists' own attitudes toward social media, adolescence, and diagnosis influence their approach to self-diagnosed clients, underscoring the importance of reflective practice and supervision. The accounts illustrate that therapists find themselves adapting their practice methods to accommodate the presence of social media content and self-diagnosis exploration, expanding their traditional role to include elements of psychoeducation about both mental health conditions and NHS diagnostic processes.

6.2 Study limitations

My research is limited in several ways. I had a relatively small sample of participants that largely work within school settings. Additionally, interviews were conducted in central Scotland and did not represent therapists across other areas of the UK. The demographic characteristics of participants showed limited diversity in terms of gender and cultural background, which may have influenced the perspectives captured in this study.

Furthermore, this research analyses therapists' perspectives on adolescent client experiences and suggests that future studies should include adolescent voices to provide a more comprehensive understanding of this phenomenon. Since therapists were discussing their perceptions of clients' experiences rather than clients directly sharing their experiences, this creates an additional interpretive layer that should be acknowledged.

Additionally, as the research was conducted during a specific time period following the COVID-19 pandemic, the findings may reflect the particular social and cultural context of this period rather than representing more enduring patterns in adolescent self-diagnosis from social media.

6.3 Contribution to the field of CYP counselling and psychotherapy

This thesis makes several significant contributions to the existing body of knowledge in counselling and psychotherapy research, particularly in the emerging field of social media-influenced self-diagnosis among adolescent populations. This study uniquely positions UK therapists' voices at the centre of analysis to address a critical gap identified by Nelson (2023) and White and Chen-Wilson (2024) regarding the absence of therapy-specific perspectives on how practitioners navigate social media-influenced presentations in clinical practice.

This research highlights how therapists adapt their practice to accommodate the influence of social media while maintaining their therapeutic integrity. It illustrates the challenges they face in navigating between validating clients' self-understanding and offering alternative perspectives that may be more therapeutically beneficial. The study's most substantial contribution lies in its detailed exploration of how therapeutic relationships are reconfigured when social media mental health content becomes a "third" in the therapeutic dyad. Building on Zeavin's (2021) concept of "mediated therapy," this research extends theoretical understanding by demonstrating how algorithmic curation and self-diagnosis exploration has the capacity impact power dynamics within therapeutic relationships. This research highlights that in some cases therapists experience shifts from traditional "therapist-client" dynamics toward more "expert-patient" configurations, echoing Rogers' (1951) historical concerns about psychiatric diagnosis disrupting therapeutic empowerment. This contribution is particularly significant given the absence of empirical research examining how social media content impacts therapeutic processes in clinical practice.

Furthermore, this thesis challenges prevailing assumptions about the rigidity of self-diagnosis presentations by demonstrating that therapeutic intervention can facilitate identity re-formulation. The finding that many adolescent clients eventually moved away from their

initial self-diagnoses after exploring alternative frameworks in therapy represents a novel contribution to understanding the malleable nature of social media-influenced identity formation. This aligns with and extends Johnstone's (2013) work on psychological formulation by illustrating how collaborative re-formulation processes can help young people reframe pathologised self-narratives within supportive therapeutic relationships. These insights add further nuance and practice-based perspectives to existing literature that explores the emergence and complexity of self-diagnosis from social media (Foulkes & Andrews 2023; Suhr & Johnson 2022).

The research also makes a crucial contribution to understanding professional development needs within UK therapeutic practice. This thesis offers insights which can be considered in the development of professional practice guidelines, which as Underhill & Foulkes (2024) identify have yet to be established, in part due to a lack of research on clinicians' perspectives and experience of self-diagnosis in adolescent therapy. This thesis offers clear implications for training and supervision, highlighting the need for practitioners to be equipped with tools to engage thoughtfully with diagnostic language and self-diagnosis exploration introduced by clients.

This thesis points to a crucial distinction between UK and US-based studies where therapists receive diagnostic training (Martin 2023; Nelson 2023), and illuminates the unique challenges faced by UK practitioners. This research considers that therapists may be inadequately prepared to address misinformation, guide formal diagnostic processes, or critically evaluate social media content highlights significant training gaps within UK counselling and psychotherapy education.

Finally, this thesis contributes methodologically by demonstrating the value of centring practitioner perspectives in understanding complex social phenomena affecting therapeutic

practice. The research reveals important generational and epistemological divides between adult therapeutic perspectives and adolescent experiences of social media, building on work by Livingstone and Third (2017) and Harris et al. (2021). By analysing therapists' nuanced and sometimes contradictory attitudes toward self-diagnosis, the study advances understanding of how professional biases and cultural anxieties about adolescent autonomy in the digital age may impact therapeutic practice. This contribution extends existing literature on therapeutic reflexivity (Willig 2019; Yager et al. 2021) by examining how contemporary digital phenomena challenge practitioners to examine their assumptions about adolescent capacity, diagnostic authority, and the boundaries of therapeutic expertise.

6.4 Recommendations for further research

Future research on self-diagnosis exploration in therapy from adolescent perspectives would significantly enhance our understanding of this phenomenon. Studies examining how young people experience discussing their self-diagnosis in therapy would provide valuable insights into the therapeutic process from the client's viewpoint.

Additional research could explore the long-term trajectories of adolescents who self-diagnose from social media, examining whether these identifications persist into adulthood or shift over time. Comparative studies between different therapeutic approaches to self-diagnosis could help identify best practices for working with these presentations.

Furthermore, research examining the effectiveness of specific training and professional development opportunities related to social media literacy for therapists would be beneficial. Investigations into the role of supervision in supporting therapists working with social media self-diagnosis could provide valuable guidance for clinical supervisors.

6.5 Final reflections

Alongside developing deeper awareness of the complexities surrounding adolescent self-diagnosis, I engaged with a process of expanding my self-awareness and assumptions and reconnected with the core of therapeutic work, which is making sense and meaning of experience. As a researcher-practitioner, I found myself reflecting on my own relationship with diagnosis and the role of social media in my personal and professional life, deepening my understanding of how these factors might influence my therapeutic practice.

Trying to make sense of our experience is deeply human and ever-changing, and I have been honoured to share this experience with my clients and the practitioners who so generously offered their reflections, challenges, and insights to make this thesis possible. As therapists working with young people exploring self-diagnosis, we are invited to hold space for this complexity, offering both understanding and the possibility of alternative narratives that may better serve their journey toward self-discovery and well-being. I have chosen to end this research with the words of Irvin Yalom:

> "Our theories are 'self-created, wafer-thin barriers against the pain of uncertainty'" (Yalom in Dumont 1993, 203).

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Appendices

Appendix 1

Mental Health TikTok and Young People's Counselling, Version 1, 15 Nov 2023

Appendix 2
Mental Health TikTok and Young People's Counselling, Version 2, 03 Nov 2023

RECRUITMENT EMAIL

Study Title: Mental Health TikTok and Young People: The Impact of Social Media Self-Diagnosis in the Counselling Room

Hello_____,

My name is Melissa D'Angelo and I'm doctoral student in psychotherapy at the University of Edinburgh and practicing therapist working with children and young people in Scotland. I am conducting research that will investigate the experiences of therapists working with young people aged 10-18, who are exploring a mental health self-diagnosis after watching social media content on platforms such as TikTok or Instagram. For this research, I will enquire how therapists work with this emerging phenomenon.

I will conduct interviews with counsellors and psychotherapists working with young people aged 10-18 in Scotland. The interview will last between 45-90 minutes and will be conducted by myself. These interviews will be semi-structured and will seek to understand how counsellors and therapists practice when a young person presents exploration of self-diagnosis after consuming mental health social media content. This study is being conducted to contribute to the resources and literature available in the field of counselling and psychotherapy for children and young people in the context of increasing presence of mental health content on social media platforms. This research has received ethical approval from the University of Edinburgh and data will be used to develop a doctoral thesis.

For this project I am seeking counsellors and psychotherapists who meet the following criteria:

- A qualified counsellor or psychotherapist recognized by a professional body such as COSCA or BACP or UKCP
- Currently providing talk therapy to young people in a non-NHS counselling service or private practice
- Experienced for a minimum of 6 months in this work
- Currently working with young people aged 10-18 in Scotland

Please feel free to circulate this email and the attached recruitment flyer to any members of staff who may be eligible to participate in this study.

Best,

Melissa D'Angelo

DPsychotherapy Candidate

University of Edinburgh

Participant Information Sheet

Study Title: Mental Health TikTok and Young People: The Impact of Social Media Self-Diagnosis in the Counselling Room

You are being invited to take part in research to investigate the experiences of therapists working with young people aged 10-18, who are exploring a mental health self-diagnosis after watching social media content on platforms such as TikTok or Instagram.

My name is Melissa D'Angelo, and I am a Doctoral Candidate at the University of Edinburgh and practicing therapist working with children and young people and I am leading this research. Before you decide whether to take part it is important that you understand why the research is being conducted and what it will involve. Please take time to read the following information carefully.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to ask you in your words how you have worked with young people's experience of self-diagnosis within your therapeutic practice. The aim of this study is to explore in-depth accounts of therapists working with young people who are exploring self-diagnosis from social media platforms. I am seeking to research how you have met this emerging phenomenon in your therapeutic practice. This study is being conducted to contribute to the resources and literature available in the field of counselling and psychotherapy for children and young people in the context of increasing presence of mental health content on social media platforms.

WHY HAVE I BEEN INVITED TO TAKE PART?

You are invited to participate in this study because you have indicated that you are a qualified counsellor or psychotherapist working with young people aged 10-18 and that you have experience working with clients, who are exploring self-diagnosis after watching content on a social media platform such as TikTok or Instagram. In order to take part in this project you must meet the criteria listed below.

Participants will be:

- A qualified counsellor or psychotherapist recognized by a professional body such as COSCA or BACP or UKCP
- Currently providing talk therapy to young people in a non-NHS counselling service or private practice
- Experienced for a minimum of 6 months in this work
- Currently working with young people aged 10-18 in Scotland

DO I HAVE TO TAKE PART?

No – it is entirely up to you. If you decide to take part, you are still free to withdraw from the study at any time, without giving a reason. Deciding not to take part or withdrawing from the study will not affect your employment.

WHAT WILL HAPPEN IF I DECIDE TO TAKE PART?

If you do decide to take part, please keep this Information Sheet. You will be asked to read a Consent Form to show that you understand your rights in relation to the research, and that you are happy to participate. If the interview is scheduled in person, you will be asked to sign a paper version of the

Consent Form. If the interview is scheduled online, you will be asked to complete an online version of the Consent Form.
You will be asked a few questions about your professional background, therapeutic practice, and your experience working with young people as they explore self-diagnosis. I would like to audio record your responses (and will require your consent for this), and the interview should take between 45-90 minutes to complete. The interview will take place face-to-face in your place of work, a suitable room at the university, or another confidential space of your choosing. If neither of these is suitable, we could explore another confidential space, however, I would not be able to conduct the interview in your home. If it is not possible to meet in-person, we will organise to meet virtually on Microsoft Teams from a suitable location.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

There are no direct benefits, but by sharing your experiences with us, you will be helping the researcher, Melissa D'Angelo, and the University to better understand a significant contemporary phenomenon where practice guidelines are yet to be developed. This study is being conducted to contribute to the resources and awareness of this emerging phenomenon and the literature available on the impact of the increasing presence of social media mental health content in field of counselling and psychotherapy for children and young people.

ARE THERE ANY RISKS OR DISADVANTAGES ASSOCIATED WITH TAKING PART?

There are no significant risks associated with participation.

WILL MY TAKING PART BE KEPT CONFIDENTIAL?

All the information collected during the research will be kept confidential and there are strict laws which safeguard your privacy at every stage. Names of individuals, places of work, clients, and any identifying details would be altered to anonymise and protect your privacy and the privacy of your clients.

HOW WILL WE USE INFORMATION ABOUT YOU?

We will need to use information from you for this research project. This information will include your name and contact details. People will use this information to do the research. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure.
Your data will be referred to by a unique participant number rather than by name. If you consent to being audio recorded, all recordings will be destroyed once they have been transcribed. Your data will only be viewed by the researcher/research team. Electronic data will be stored on a password-protected account in the university system and all paper records will be stored in a locked filing cabinet. Your consent information will be kept separately from your responses to minimise risk of compromising your privacy. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

WHAT ARE YOUR CHOICES ABOUT HOW YOUR INFORMATION IS USED?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

WHERE CAN YOU FIND OUT MORE ABOUT HOW YOUR INFORMATION IS USED?

You can find out more about how we use your information at https://www.ed.ac.uk/records-management/privacy-notice-research, by sending an email to or by emailing the University Data Protection Officer at dpo@ed.ac.uk.

The University of Edinburgh is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this

study. This means that we are responsible for looking after your information and using it properly. The University of Edinburgh will keep identifiable information about you until the thesis has been submitted and marked and your anonymised data for up to 2 years after the completion of the thesis.

WHAT WILL HAPPEN WITH THE RESULTS OF THIS STUDY?

The results of this study will be used to develop a doctoral thesis. In addition, data may be summarised in published articles, reports, and presentations. You will not be identifiable from any published results. Quotes or key findings will always be made anonymous in any formal outputs. With your consent, your anonymised information may also be kept for future research. You will have the opportunity to request a copy of the thesis, it will be sent by email after the thesis is submitted and marked.

WHO IS ORGANISING THE RESEARCH?

This study has been organised by Melissa D'Angelo (Professional Doctorate in Psychotherapy Candidate) and sponsored by the University of Edinburgh.

WHO HAS REVIEWED THE STUDY?

The study proposal has been reviewed by the School of Health in Social Science Ethics Committee.

WHO CAN I CONTACT?

If you have any further questions about the study, please contact the researcher, Melissa D'Angelo ( ).

If you would like to discuss this study with someone independent of the study please contact Mandy Laing, ( ).

If you wish to make a complaint about the study, please contact Matthias Schwannauer ( ) or Research Governance Team (cahss.res.ethics@ed.ac.uk).

8.4 Appendix 4
Mental Health TikTok and Young People's Counselling, Version 3, 15 Nov 2023

Participant Consent form

Study Title: Mental Health TikTok and Young People: The Impact of Social Media Self-Diagnosis in the Counselling Room

Researcher's name and contact details:
Melissa D'Angelo; Email:

Participant ID: _____

Please initial box or tick box if completing online.

1. I confirm that I have read and understood the Participant Information Sheet Version 3 dated 15 Nov 2023 for the above study. ☐

2. I have been given the opportunity to consider the information provided, ask questions, and have had these questions answered to my satisfaction. ☐

3. I understand that my participation is voluntary and that I can ask to withdraw at any time without giving a reason and without my employment being affected. ☐

4. I understand that my anonymised data will be stored for up to 2 years after the completion of the thesis and may be used in future ethically approved research. ☐

5. I understand that relevant sections of my data collected during the study may be looked at by individuals from the Sponsor (University of Edinburgh), where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data. ☐

6. I agree to my interview being audio recorded. ☐

7. I agree to take part in the above study. ☐

The below signature spaces will be replaced by the above tick box, if Consent is online.

Name of person giving consent **Date**

Signature _____

Name of person taking consent **Date**

Signature _____

If Consent is online the following instructions will be removed.

1x original to be kept by research team
1x original to be kept by participant

CAHSS Interview Schedule Guidance

Study Title: Mental Health TikTok and Young People: The Impact of Social Media Self-Diagnosis in the Counselling Room

Introduction

Thank you for agreeing to take part in this research. I am interested in your practice experience of working with young people exploring self-diagnosis after consuming social media content. I expect the interview to last between 45 and 90 minutes, but we can stop to take a break at any point, and you can finish the interview at any time without giving an explanation.

[If participant has consented to be recorded, switch on the recorder]

May I confirm that you consent for this interview to be recorded?

[Continue recording, if participant has confirmed their consent.]

Outline questions:

First, for context, can you tell me a bit about your practice background?

- How long have you been practicing as a counsellor/ psychotherapist?
- How do you identify your theoretical orientation?
- How long have you been working with children and young people?
- Can you tell me a bit about the setting where you work?
- Have you watched social media mental health content?
    - Do you notice any personal or professional responses to the presence of social media content about mental health?
    - Do you have any personal or professional responses to mental diagnosis and mental health categories?

Next, I would like to start speaking about your experience working with young people exploring self-diagnosis.

- Can you tell me about when you first started encountering young people exploring self-diagnosis in your practice?
- How do you respond when a young person speaks about a self-diagnosis in a session?
    - Have you noticed any shifts or developments in your responses to this over time?
- Can you give me some examples of when a young person has explored self-diagnosis with you?
- What have you found helpful in your practice to work with self-diagnosis exploration with your clients?
    - How has supervision helped you navigate working with self-diagnosis exploration?
    - Have you found any training, research, or resources helpful to developing your practice with this phenomenon?
- What, if any, are the dilemmas that arise in your practice when a young person is exploring self-diagnosis?
    - How has your experience navigating these dilemmas influenced your practice?

Closing question: Is there anything else you would like to discuss that has not already been covered? Thank you very much for taking part in this interview.

8.6 Appendix 6

Mental Health TikTok and Young People's Counselling, Version 2, 03 Nov 2023

Debrief Form

Study Title: Mental Health TikTok and Young People: The Impact of Social Media Self-Diagnosis in the Counselling Room

Thank you for taking time take part in this research. The aim of this study is to investigate the experiences of therapists working with young people aged 10-18, who are exploring a mental health self-diagnosis after watching social media content on platforms such as TikTok or Instagram. This study is being conducted to contribute to the resources and literature available in the field of counselling and psychotherapy for children and young people alongside the increasing presence of mental health content on social media platforms.

Your data will be used to produce an account of themes that you and others experience in their therapeutic practice whilst working with young people aged 10-18 in Scotland. All the information collected during the research will be kept confidential. Names of individuals, places of work, clients, and any identifying details would be altered to anonymise and protect your privacy and the privacy of your clients.

If you wish to have a copy of the final doctoral thesis or have any questions or concerns regarding the research, please contact the researcher, Melissa D'Angelo ( ). If you would like to discuss this study with someone independent of the study please contact Mandy Laing, ( ). If you wish to make a complaint about the study, please contact Matthias Schwannauer ( ) or the Research Governance Team (cahss.res.ethics@ed.ac.uk).

8.7 Appendix 7

University of Edinburgh
College of Arts, Humanities and Social Sciences
Research Governance Office
55 George Square
Edinburgh
EH8 9JU

16th November 2023

Melissa D'Angelo
c/o School of Health in Social Science

Dear Melissa,

Study Title: Mental Health TikTok and Young People: The Impact of Social Media Self-Diagnosis in the Counselling Room

Sponsor number: CAHSS 2309/15

Under the requirements of the UK policy framework for health and social care research, the University of Edinburgh agrees in principle to act as Sponsor for this project. Sponsorship is subject to you obtaining institutional ethics for the project.

As Chief Investigator, you must ensure that the study does not commence until all applicable approvals have been obtained. Following receipt of all relevant approvals, you should ensure that any amendments to the project are notified to the Sponsor (including an extension to the study end date). Please note that there is a requirement to notify the sponsor once the study has ended.

Yours sincerely

Matt Erikson

Research Governance Coordinator

8.8 Appendix 8

School of Health in Social Science Research Ethics Application
The supervisor or primary investigator must complete and sign this form after checking that all relevant sections are completed, and relevant documents are attached. For all undergraduate (UG) and MSc student projects, it is the supervisor's responsibility to submit this form and all attachments. Please note that failure to do this will result in the application being returned (and not processed) causing your research to be delayed.

Supervisor (name and UUN: Seamus Prior	
Primary Investigator (name and UUN): Melissa D'Angelo s2122537	
List of all collaborators (with affiliated institutions in brackets):	
Student's programme of study (if applicable): Doctorate of Psychotherapy	
Project Title: Mental Health TikTok and Young People: The Impact of Social Media Self-Diagnosis in the Counselling Room	
Case Number (if known – assigned by Administrator at time of 1st submission): CAHSS2309/15	
Proposed Project Start Date: 01/12/2023	Proposed Project End Date: 31/8/2024

Please indicate whether the primary investigator on this project is staff or student and select your subject area:
☐ Staff ☐ UG or MSc Student ☐ DClin Student ☒ PhD Student
☐ CPASS ☐ Clinical Psychology ☐ Nursing Studies

This is a:
☒ New application for ethical review – first submission
☐ Resubmission following reviewer comments
☐ Resubmission with requested amendments

Has been reviewed by an external ethical board, such as NHS IRAS or a UK HEI (multi-site studies only) with a favourable opinion? Level 1 *
☐ IRAS (NHS research ethics) ☐ Other: _____

Please tick one option that best describes your application:
☒ Collecting or generating new data involving other people: Level 2
☐ Extracting, re-coding and analysing existing data that contains sensitive information (i.e. identifiable information): Level 2
☐ Analysing secondary (archival) data that is routinely collected or is an existing anonymised dataset: Level 1
☐ Collecting new data BUT an external ethical review board (such as NHS IRAS; UK HEI – for multi-site studies; etc) has fully reviewed this project and generated a favourable opinion: Level 1

This application is complete with the following attachments (tick all that apply):

Advert/flyer ☒	Caldicott application stating what data was requested ☐	Caldicott signed approval ☐		Consent form/s
Data collection tools (e.g. interview guides) ☒	Debrief with signposting ☒	IRAS application ☐	IRAS opinion letter ☐	NGO or local authority letters
Participant Information Sheet/s ☒	Participant Information Sheet (young person version) ☐	R&D application ☐	R&D approval ☐	Researcher Checklist (C-19)
Risk assessment ☐	Standardised recruitment email ☒	Sponsorship Letter OR Email to confirm no sponsorship needed / statement explaining why sponsorship is not needed. ☒		

Other attachments (please specify):

To be completed by primary investigator or project supervisor
By signing this front sheet, I confirm that I have prepared and/or reviewed this ethics application and related documents in accordance with ethical guidelines. I also confirm I have checked that all relevant sections of the application form are completed and relevant documents are attached. Supervisor or/PI Signature: 27.09.23 Student signature: Date:

On completion, this Word document along with the relevant attachments should be submitted to ethics.hiss@ed.ac.uk.

Note: Please note all undergraduate and MSc applications MUST been signed and submitted by the project supervisor.

This section is to be completed after review only
ISSUES ARISING FROM THE PROPOSAL – to be completed by Ethics Reviewer
Dear applicant, Thank you for your application. We have completed the review process and can provide a favourable opinion. This is a very interesting, comprehensive and well-organised application. All good luck with this research project. Signature: M.Levitanus and A Ross Position: CPASS REC Reviewers Date: 05.1.24
APPLICANT'S SIGNATURE FOLLOWING REVISIONS – to be completed by applicant
I confirm that I have addressed all of the queries generated during the ethical review process of my application. I have outlined in the box above underneath each comment how each request was addressed and/or provided further clarification. Supervisor/PI Signature: Student signature: Date:
CONCLUSION TO ETHICAL REVIEW – to be completed by Ethics Lead

The applicant's response to our request for further clarification or changes has now satisfied the requirements for ethical practice and the application has therefore been given a favourable opinion.

OR

Thank you for providing responses to our comments. Some outstanding questions remain:

Signature:

Position:

Date:
that a favourable opinion has been provided for this project (for example as an attachment to MSc dissertations).

NOTE: Once reviewed please include the page on which this box appears as a formal document demonstrating that favourable opinion has been provided for this project (for example as an attachment to MSc dissertations).

If you are applying for amendments to a previously reviewed and processed project, please use the below form to detail the amendments you wish to make:

This section is to be completed for amendments only
AMENDMENT/S: REQUEST FOR APPROVAL – to be completed by applicant
I would like to apply for the following amendments to this previously processed project which had generated a favourable opinion: Supervisor/PI Signature: Student signature: Date:
CONCLUSION TO ETHICAL REVIEW OF AMENDMENT – to be completed by Ethics Lead
The requested amendment satisfies the requirements for ethical practice and it has therefore received a favourable opinion. OR Additional information is required related to: Signature: Position: Date:

NOTE: Once reviewed please include the page on which this box appears as a formal document demonstrating that favourable opinion has been provided for this project (for example as an attachment to MSc dissertations).

University of Edinburgh, School of Health in Social Science Research Ethics Application

LEVEL 1 and 2 – Confidentiality and Handling of Data
Section 1: Introduction

External Research Ethics Approval:

Does your research project require the approval of any other institution and/or ethics committee, nationally or internationally?

Note: It is each researcher's responsibility to check whether their project requires Sponsorship, Caldicott Approval, R&D approval, and/or IRAS (see https://www.ed.ac.uk/health/research/ethics/sponsorship-and-governance). The principal investigator is responsible for ensuring compliance with any additional ethical requirements that might apply, and/or for compliance with any additional requirements for review by external bodies.

☒ This research project does not require external ethics approval.
OR

If you require external approval, please state the name of the review body:
☐ IRAS (NHS research ethics) ☐ Local Authority ☐ Other:
_____

NB: If you require external approval from IRAS/NHS/Caldicott, you must have external approval before submitting your application for School of Health in Social Science Research Ethics approval. You can only submit your application to us once external approval has been obtained, and you must include all documentation including your application to and approval of external approval as an attachment.

If you require approval from a local authority, you must first receive ethics approval from the School of Health in Social Science Research Ethics Committee, before submitting your application to the local authority.

Q1. Project summary

Please provide a brief summary of your proposed study. Do not exceed 1500 words. Our interest is in areas of your methodology where ethical issues may arise so please focus your detail on areas such as recruitment, consent, describing your participants and the nature of their involvement, and data handling.

I am a qualified therapist working as a school counsellor in a City of Edinburgh High School with young people aged 10 to 18. I am researching the phenomenon of young people presenting for counselling with an account of mental health self-diagnosis following social media use and how therapists work with this. This is an increasingly frequent occurrence for which, as yet, we have no research, policy or practice guidance.

In recent years the prevalence of mental health content on social media has increased. This increase has led to many people consuming information about mental health conditions from content creators on platforms such as TikTok and Instagram. As a result, young people who use these social media platforms have been exposed to content about mental health issues and diagnoses. This increased exposure of mental health information has led young people to explore self-diagnosis of mental health issues in their own lives. Consequently, in recent years exploration of mental health self-diagnosis has become a significant phenomenon within therapy sessions. Although this phenomenon has emerged amongst clients of all ages, in this project I am looking to investigate the experiences of therapists working with young people aged 10-18 in Scotland, who are exploring a mental health self-diagnosis after watching social media content on platforms such as TikTok or Instagram.

As is often the case with new technologies, advances in technology use have outpaced academic research as well as professional policy and practice development. There are as yet no policies or good practice guidelines, whether from professional bodies, government or employer organisations, for therapists working with young people who present with an account of self-diagnosis following social media use. Equally, there is no published research on this increasingly common phenomenon. My research aims to meet this gap and contribute to the development of good practice guidance.

I will use semi-structured interviews to explore therapists how they work with this emerging phenomenon in the absence of training and practice guidelines. For brevity, throughout this application I will use the term ‘therapist’ to refer to qualified counsellors and psychotherapists and ‘therapy’ to refer to counselling and psychotherapy. This study is being conducted to contribute to our understanding of this emerging phenomenon and the development of good practice guidance in relation to it.

My research will take the form of semi-structured interviews, lasting between 45 and 90 minutes (please see Appendix 4 for the Interview Schedule). I will be conducting a qualitative research project using thematic analysis and I require 6-10 research participants.

Participants will be:
A qualified counsellor or psychotherapist recognized by a professional body such as COSCA or BACP or UKCP
Currently providing talk therapy to young people in a non-NHS counselling service or private practice
Experienced for a minimum of 6 months in this work
Currently working with young people aged 10-18 in Scotland

I will recruit participants by contacting counselling services working with children and young people in Scotland and request that they share this recruitment email with therapists involved in the organization (please see Appendix 2 for the Recruitment Email and Appendix 6 for the Flyer). Interested therapists will be given my email. If they are interested, I will send them the Participant Information Sheet (please see Appendix 1). I will then liaise with the potential participant about the project providing the opportunity to field any queries or concerns before discussing if the therapist would like to arrange a meeting for the interview. If the individual is happy to take part, we would then organize a time and place to meet confidentially, either at the therapist’s place of work, a suitable room at the university, or another confidential space chosen by the participant. I will not, however, agree to meet participants in

their homes. If it is not possible to meet in-person, we will organize to meet virtually on Microsoft Teams from a suitable location.

At the beginning of the interview, participants will be given the opportunity to further discuss the Participant Information Sheet and any possible risks involved in partaking in the research. If they feel that they have had ample opportunity to ask questions about my research, I will then ask participants to sign the Consent Form to confirm that they have been consulted on the research and agree to partake and be audio-recorded (please see Appendix 3 for the Consent Form).

We will then begin the interview (please see Appendix 4 for the Interview Schedule). After the interview is finished, participants would be thanked for their participation and handed a Participant Debrief Form outlining the aim of the research and what would happen next to their data (please see Appendix 5).

The interviews would be recorded using a password-protected recording device. After the interview, the recordings would be transferred to OneDrive. The interviews would then be transcribed by the researcher, and the transcripts also saved on OneDrive. Once the study has concluded, the audio files of the interviews and word-based transcripts will be deleted. Information relating to what data will be kept and how long for will also be found on the Participant Information Sheet (please see Appendix 1).

Participation in this research would be confidential. Names of individuals, places of work, clients, and any identifying details would be altered to anonymize and protect the privacy of the participants and their clients.

As discussed below, I do not foresee significant ethical issues in this project. The participants will all be qualified and experienced therapists under clinical supervision and the practice issues we discuss will be on a par with the kind of issues that they would normally discuss in supervision, such as challenges in practice, ethical dilemmas, clients' responses to their interventions, and thoughts and feelings about, and evaluations of, their practice.

The City of Edinburgh Council has confirmed that with a favourable opinion on this application from the University, I will be able to approach school counsellors in all their schools. In other local authority areas, school counselling services are sometimes provided by out-sourced independent counselling agencies (usually third sector/charities). I expect that the majority of those services would also accept University ethics approval as sufficient to recruit from their counsellor staff. I will not be approaching NHS counselling and therapy services.

Q2. Will you collect or use NHS data?

☐ Yes ☒ No

If "yes" – what NHS data will you collect or use?

Q3. What information about participants/data subjects will you collect and/or use?

I will ask therapists how they have worked with this emerging phenomenon in the absence of practice guidelines. In my research I will inquire about the practice of therapists working with young people ages 10-18 has been impacted by their client's exploring self-diagnosis within sessions. My research will take

the form of semi-structured interviews, lasting between 45 and 90 minutes (please see Appendix 4 for the Interview Schedule).

I will need their name and email address for the purposes of communication.

I will ask about their work setting in general (such as school, children's charity etc) but will not need the name of their employer or their precise work location, and their professional background, including their training, theoretical orientation and length of time working in the CYP therapy field.

I will also ask them if they have a preferred pseudonym and their preferred pronouns.

Q4. What training will staff who have access to the data receive on their responsibilities for its safe handling? Have all staff and students who have access completed the mandatory data protection training on the self-enrolment page of Learn?

Data will be handed solely by myself, and I will complete the mandatory data protection training prior to collecting data.

Q5. Will the information include special categories of personal data (health data, data relating to race or ethnicity, to political opinions or religious beliefs, trade union membership, criminal convictions, sexual orientations, genetic data and biometric data)?

☐ Yes ☒ No

If "yes" – Explain what safeguards e.g. technical or organisational you have in place; including any detailed protocols if this requires special and/or external processing, storage, and analysis.

Q6. Please indicate how your research is in the public interest:

☒ Your research is proportionate
☐ Your research is subject to a governance framework
☐ Research Ethics Committee (REC) review (does not have to be a European REC)
☐ Peer review from a funder
☐ Confidentiality Advisory Group (CAG) recommendation for support in England and Wales or support by the Public Benefit and Privacy Panel (PBPP) for Health and Social Care in Scotland
☐ Other

Q7. It is essential that you identify, and list all risks to the privacy of research participants. You will then need to consider the likelihood of the risks actually manifesting and the severity of harm if the risks actually manifest.

Risk	Likelihood of risk manifesting			Severity of harm		
	Remote	Possible	Probable	Minimal	Significant	Severe
Identifiable due to data linkage	☒	☐	☐	☒	☐	☐
Identifiable due to low participant numbers	☒	☐	☐	☒	☐	☐
Identifiable due to geographical location	☒	☐	☐	☒	☐	☐
Identifiable due to transfer of data	☒	☐	☐	☒	☐	☐
Identifiable due to access of data	☒	☐	☐	☒	☐	☐
Insert more rows as appropriate	☐	☐	☐	☐	☐	☐

Please use this text box to record any other risks and the likelihood of them occurring, along with the severity of harm. Please also use this when dealing with secondary data.

Please identify measures you could take to reduce or eliminate risks identified as possible/significant or probable/severe.

Q8. Will information containing personal, identifiable data be transferred to, shared with, supported by, or otherwise available to third parties outside the University?

☐ Yes ☒ No

If "yes" - Please explain why this necessary and how the transfer of the information will be made secure. If the third party is based outside the European Economic Area please obtain guidance from the Data Protection Officer.

Q9. Other than the use by third parties, will the data be used, accessed or stored away from University premises?

☐ Yes ☒ No

If "yes" - Describe the arrangements you have put in place to safeguard the data from accidental or deliberate access, amendment or deletion when it is not on University premises, including when it is in transit, and (where applicable) it is transferred outside the EEA.

Q10. Will feedback of findings be given to your research project participants or data subjects?

☒ Yes ☐ No

If "yes" - How and when will this feedback be provided?

Participants will be offered the opportunity to request a final copy of the thesis, which will be sent after the thesis has been successfully submitted.

If "no" - Please provide rationale for this.

Q11. How do you intend to use/disseminate the results of your research project?

I am intending to use the interview data created by transcribing it, and then by analysing it for my Doctoral Thesis. Data from this Doctoral Thesis may be used for further research papers or conferences, as stated on the Participant Information Sheet.

Section 2: Security-sensitive material

The Terrorism Act (2006) outlaws the dissemination of records, statements and other documents that can be interpreted as promoting or endorsing terrorist acts.

Q12. Does your research involve the storage on a computer of any such records, statements or other documents?

☐ Yes ☒ No (if you answered no to this question please jump to section 3)

If "yes" - Please type 'Yes' to indicate that you agree to store all documents on that file store

Q13. Might your research involve the electronic transmission (for example, as an email attachment) of such records or statements?

☐ Yes ☐ No

If "yes" - Please type 'Yes' to indicate that you agree not to transmit electronically to any third party documents stored in the file store

Q14. Will your research involve visits to websites that might be associated with extremist, or terrorist, organisations?

☐ Yes ☐ No

If "no", please proceed to Question 15.

If "yes" - You are advised that such sites may be subject to surveillance by the police. Accessing those sites from University IP addresses might lead to police enquiries. Please type 'Yes' to acknowledge that you understand this risk

By submitting to the ethics process, you accept that your School Research Ethics Officer and the convener of the University's Compliance Group will have access to a list of titles of documents (but not the contents of documents) in your document store. Please type 'Yes' to acknowledge that you accept this.

Please confirm that you have contacted your School Research Ethics Officer to discuss security-sensitive material by ticking 'Yes'

☐ Yes, I have contacted my School's Research Ethics Officer

☐ No, I have not contacted my School's Research Ethics Officer

Section 3: Copyright

Q15. Does your project require use of copyrighted material?

☐ Yes ☒ No

If “yes” please give further details

Section 4: Good conduct in collaborative research

Q16. Does your project involve working collaboratively with other academic partners?

☐ Yes ☒ No (if you answered no to this question please jump to section 5)

If "yes" - Is there a formal agreement in place regarding a collaborative relationship with the academic partner(s)?

If "no" - Please explain why there is no formal agreement in place

Q17. Does your project involve working collaboratively with other non-academic partners?

☐ Yes ☐ No

If "yes" - Is there a formal agreement in place regarding a collaborative relationship with the non-academic partner(s)?

If "no" - Please explain why there is no formal agreement in place.

Q18. Does your project involve employing local field assistants (including guides/translators)?

☐ Yes ☐ No

If "yes" - Is there a formal agreement in place regarding the employment of local field assistants (including guides and translators)?

If "no" - Please explain why there is no formal agreement in place

Q19. Will care be taken to ensure that all individuals involved in implementing the research adhere to the ethical and research integrity standards set by the University of Edinburgh?

☐ Yes ☐ No

If "no" - Please explain why care will not be taken

Q20. Have you reached agreement relating to intellectual property?

☐ Yes ☐ No

If “no” - Please explain why you have not reached agreement

Section 5: Good conduct in publication practice

In publication and authorship, as in all other aspects of research, researchers are expected to follow the University's guidance on integrity. https://www.ed.ac.uk/governance-strategic-planning/content-to-be-removed/research-integrity. By ticking yes, you confirm that full consideration of the items described in this Section will be addressed as applicable

☒ Yes ☐ No

If you intend to collect new data, please continue completing the Level 2 application in the next page.

If you are NOT collecting any new data, you have now completed the Level 1 application. Please submit this document alongside all attachments to ethics.hiss@ed.ac.uk .

LEVEL 2 ONLY – Participant Risk and Information

The following Sections are to be completed if you are collecting new data. Please do not complete it if you are using existing data.

Section 6: Potential risks to participants and researchers

Q21. Is your research project likely or possible to induce any psychological stress or discomfort in the participants or others, indirectly associated with the research?

☐ Yes ☒ No

If "yes" state the types of risk and what measures will be taken to deal with such problems

It is not likely that this project will induce psychological distress, however, if discussing sensitive matters of therapeutic practice or client experiences causes distress, I would enquire about the participant's access to clinical supervision and encourage them to seek support from their clinical supervisor.

Q22. Does your research project require any physically-invasive or potentially physically harmful procedures?

☐ Yes ☒ No

If "yes" give details and outline procedures to be put in place to deal with potential problems.

Q23. Does your research project require the use of privacy-invasive technology, such as CCTV, biometrics, facial recognition, vehicle tracking software?

☐ Yes ☒ No

If "yes" - Give details and outline procedures to be put in place to deal with potential problems.

Q24. Does your research project involve the investigation of any illegal behaviour or activities?

☐ Yes ☒ No

If "yes" - Give details of any illegal behavior or activities you may investigate

Q25. Is it possible that your research project will lead to awareness or the disclosure of information about child abuse or neglect?

☐ Yes ☒ No

If "yes" - Indicate the likelihood of disclosure and the procedures to be followed if you become aware that a child has been or may be at risk of harm

A significant portion of young people attending therapy will have experience with abuse, neglect, or other issues of safety. As I will be speaking to therapists working with young people, it is likely that are likely that examples of abuse and neglect may be discussed. However, as all participants will have regular meetings with their clinical supervisor, it is unlikely that any new disclosures would be made to me in the course of this interview. If I hear of any significant harm or initial disclosures, I will ask the participant if they have spoken to their clinical supervisor. If they have yet to speak about this disclosure in clinical supervision, I would ask them to do so.

Q26. Is it likely that dissemination of research findings or data could adversely affect participants or others indirectly associated with the research?

☐ Yes ☒ No

If "yes" - Describe the potential risk for participants/data subjects of this use of the data. Outline any steps that will be taken to protect participants.

As we will be discussing therapeutic practice, including challenges and dilemmas, particular clients may be mentioned. I will ensure that any client detail including names and any other identifying details are entirely anonymized, additionally, all participant information will also be entirely anonymized.

In this interview therapists will be invited to speak about their practice and process as they would in clinical supervision. I would not expect any information discussed in this interview to go beyond the material that therapists often speak of with supervisors and peers. If in the course of the interview a participant becomes distressed, I would encourage them to explore their distress with their clinical supervisor.

Q27. Could participation in this research adversely affect participants and others associated with the research in any other way?

☐ Yes ☒ No

If "yes" - Describe the possible adverse effects and the procedures to be put in place to protect against them.

See above

Q28. Is this research expected to benefit the participants, directly or indirectly?

☒ Yes ☐ No

If "yes" - Give details of how this research is expected to benefit the participants.

Participants may benefit directly by speaking about their practice experiences. The interview process could lead to deeper understanding and reflection of the participant's practice competencies and continuing professional development. This study is being conducted to contribute to the resources and awareness of this emerging phenomenon and the good practice guidelines that may emerge. Therefore, participants may benefit indirectly through an expanded set of research on this topic.

Q29. Will the true purpose of the research be concealed from the participants/data subjects?

☐ Yes ☒ No

If "yes" - Explain what information will be concealed and why.

Q30. Will participants/data subjects be debriefed at the conclusion of the study?

☒ Yes ☐ No

If "no" – Why will participants / data subjects not be debriefed?

Participants will be thanked for their participation and informed about how they can learn more about the outcomes of this research project.

Q31. At any stage in this research could researchers' safety be compromised, or could the research induce emotional distress in the researchers?

☐ Yes ☒ No

If "yes" - Give details and outline procedures to be put in place to deal with potential problems.

In this research I will be exploring themes and topics which I also experience in my own therapeutic practice. These are alive issues which I explore in clinical supervision as a part of my therapeutic practice. I do not expect exploring or discussing these themes to cause emotional distress. However, in the event that I feel distressed, I will call upon my research supervisor for support.

Further, as I will be meeting with participants, I am aware of the potential safety concerns. To deal with this potential problem, I will be mindful to meet participants in safe and appropriate settings and have my mobile phone and email available to communicate in case of an emergency or unsafe situation. I will not agree to meet participants in their homes.

Please tick to confirm you agree with the following:

I will adhere to School guidance on risk assessment and health and safety and will seek advice on project and travel insurance prior to project commencement.

☒ I agree

☐ I do not agree

☐ Not applicable

Section 7: Participants and data subjects.

Q32. How many participants or data subjects are expected to be included in your research project?

I will interview between 6-10 participants.

Q33. What criteria will be used in deciding on the inclusion and exclusion of participants/data subjects in your research project?

Participants will be:
A qualified counsellor or psychotherapist recognized by a professional body such as COSCA or BACP or UKCP
Currently providing talk therapy to young people in a non-NHS counselling service or private practice
Experienced for a minimum of 6 months in this work
Currently working with young people aged 10-18 in Scotland

Q34. Are any of the participants or data subjects likely to be under 16 years of age?

☐ Yes ☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q35. Are any of the participants or data subjects likely to be children in the care of a Local Authority?

☐ Yes ☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q36. Are any of the participants or data subjects likely to be known to have additional support needs?

☐ Yes ☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q37. In the case of participants with additional support needs, will arrangements be made to ensure informed consent?

☐ Yes ☐ No ☒ N/A

If "yes" – What arrangements will be made?

If "no" – Please explain why not

Q38. Are any of the participants or data subjects likely to be physically or mentally ill?

☐ Yes ☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q39. Are any of the participants or data subjects likely to be vulnerable or likely exposed to harm in other ways?

☐ Yes ☒ No

If "yes" - Explain and describe the nature of the vulnerability and the measures that will be used to protect and/or inform participants/data subjects.

Q40. Are any of the participants or data subjects likely to be unable to communicate in the language in which the research is conducted?

☐ Yes ☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q41. Are any of the participants or data subjects likely to be in a relationship (i.e., professional, student-teacher, other dependent relationship) with the researchers?

☐ Yes ☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

As I am a practicing therapist with children and young people in Scotland, it is possible that I will have some knowledge or acquaintance with interview participants. However, I will not be interviewing any close colleagues, friends, line managers, or supervisors for this project.

If there is a prior acquaintance, I will begin the interview acknowledging the prior knowledge and establishing that all the data collected within the interview will be kept within the confidentiality of the project. Additionally, I will state that all prior knowledge will remain outside of the interview and research project unless the participant elects to speak about these topics within the interview.

Q42. Are any of the participants or data subjects likely to have difficulty in reading and/or comprehending any printed material distributed as part of the study?

☐ Yes ☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q43. Describe how the sample will be recruited.

I will recruit participants by contacting counselling services working with children and young people in Scotland and request that they share this recruitment email with therapists involved in the organization (please see Appendix 2 for the Recruitment Email and Appendix 6 for the Flyer). Interested therapists will be given my email. If they are interested, I will send them the Participant Information Sheet (please see Appendix 1). I will then liaise with the potential participant about the project providing the opportunity to field any queries or concerns before discussing if the therapist would like to arrange a meeting for the interview.

Q44. Will participants receive any financial or other material benefits as a result of participation?

☐ Yes ☒ No

If "yes" - What benefits will be offered to participants and why?

Section 8: Participant or data subject information and consent

Q45. Will written or oral consent be obtained from all participants or data subjects?

☒ Yes ☐ No

If "yes" – attach participant information sheet and consent form and detail the process you will follow.

If "no" – explain why not and what process you will follow regarding consent, or if consent cannot or should not be sought for some reason, please provide a clear case and rationale for this (e.g. in international contexts where speaking to foreign researchers is prohibited).

Yes, all participants will be asked to review and sign a consent form, attached as appendix 3.

Q46. Have you made arrangements to tell participants what information you will hold about them and for how long?

☒ Yes ☐ No

If "yes" - what arrangements have been made?

Participants will be given details about the data arrangements and information on the participant information sheet (see Appendix 1).

If "no" – why not?

Q47. Have you made arrangements to tell participants whether you will disclose the information to other organisations?

☐ Yes ☐ No ☒ N/A

If "yes" - What arrangements have been made?

If "no" – why not?

Q48. Have you made arrangements to tell participants whether you will combine that information with other data?

☐ Yes ☐ No ☒ N/A

If "yes" - What arrangements have been made?

Q49. In the case of children participating in the research, will the consent or assent of parents be obtained?

☐ Yes ☐ No ☒ N/A

If "yes" - Explain how this consent or assent will be obtained

If "no" – Please explain why you won't be obtaining consent

Q50. Will the consent or assent of children participating in the research be obtained?

☐ Yes ☐ No ☒ N/A

If "yes" - Explain how this consent or assent will be obtained

If "no" – Please explain why not

Q51. In the case of participants who are not proficient in the language in which the research is conducted, will arrangements be made to ensure informed consent?

☐ Yes ☐ No ☒ N/A

If “yes” – What arrangements will be made?

If “no” – Please explain why not

Q52. Does the activity involve using cookies or tracking individual’s activity on a website or the Internet in general?

☐ Yes ☒ No

If “yes” – Describe the arrangements you have put in place to obtain informed consent for the use of these tools

You have now completed the Level 2 application. Please submit this document alongside all attachments to ethics.hiss@ed.ac.uk .

Appendix 9

Theme charts with codes example- September 2024

	1				2						3					
Themes	**Young people are vulnerable**				**You don't know what you are talking about (that's not real information?)**						**Where does therapy fit into a puzzle of support?**					
Sub-themes	*Adults should intervene to protect young people*		*THE ALGORITHM is dangerous*		*Adult responses to adolescent self-diagnosis*		*Not all social media mental health content is created equally*		*The 'reality' of mental health disorders*		*Roles and Procedures- educating young people and families on the diagnostic process*		*Scarcity of mental health resources*		*Working with oth professionals (adu*	
Codes & Number of references	Safeguarding and risk	30	The algorithm is dangerous	24	YP Being dismissed by adults	36	sm content as a resource	11	depictions of mental health in media	1	explaining the diagnostic process?	18	CAHMS doesn't have time	6	Working with CAHMS	
	CYP as vulnerable	24	sm can be traumatising	12	Adults Sceptical of YP presentation	12	accurate and inaccurate information	7	takes away validity of diagnosis	2	refers to GP for diagnosis	12	Scarcity of mental health resources	1	stuck between counselling and diagnosis	
	Desire to protect CYP	10	The alogorithm is controlling	10	(therapist) sceptical of client presentation	16	sceptical of professional content on mental health (social media)	2	hypochondria	2	Counselling role is not diagnostic	21	lack of support	1	Involving parents and other adults	
	safeguarding yp when posting on SM	10	dangerous influences	14	Adults Responding unhelpfully or dangerously to symptoms	6	encouraging reputable sources	1	limited understanding of diagnosis (YP)	4	Gp is helpful support	14	frustration over access to NHS support	3	Working on a team of MH professionals	
	adults are concerned	1	social media is addicting	7	yp being dismissed leads to more extreme symptoms and behaviour	4	reputable sources on social media	6	relational vs. parasocial	2	some cases need further support	11			advocating for yp with cahms, gp, parents	
	concern for client	1	The algorithm remembers	7	(adults feeling) Frustration with feeling lied to	4	symptoms listed in videos are inconclusive	1			need for diagnosis for particular conditions	3				

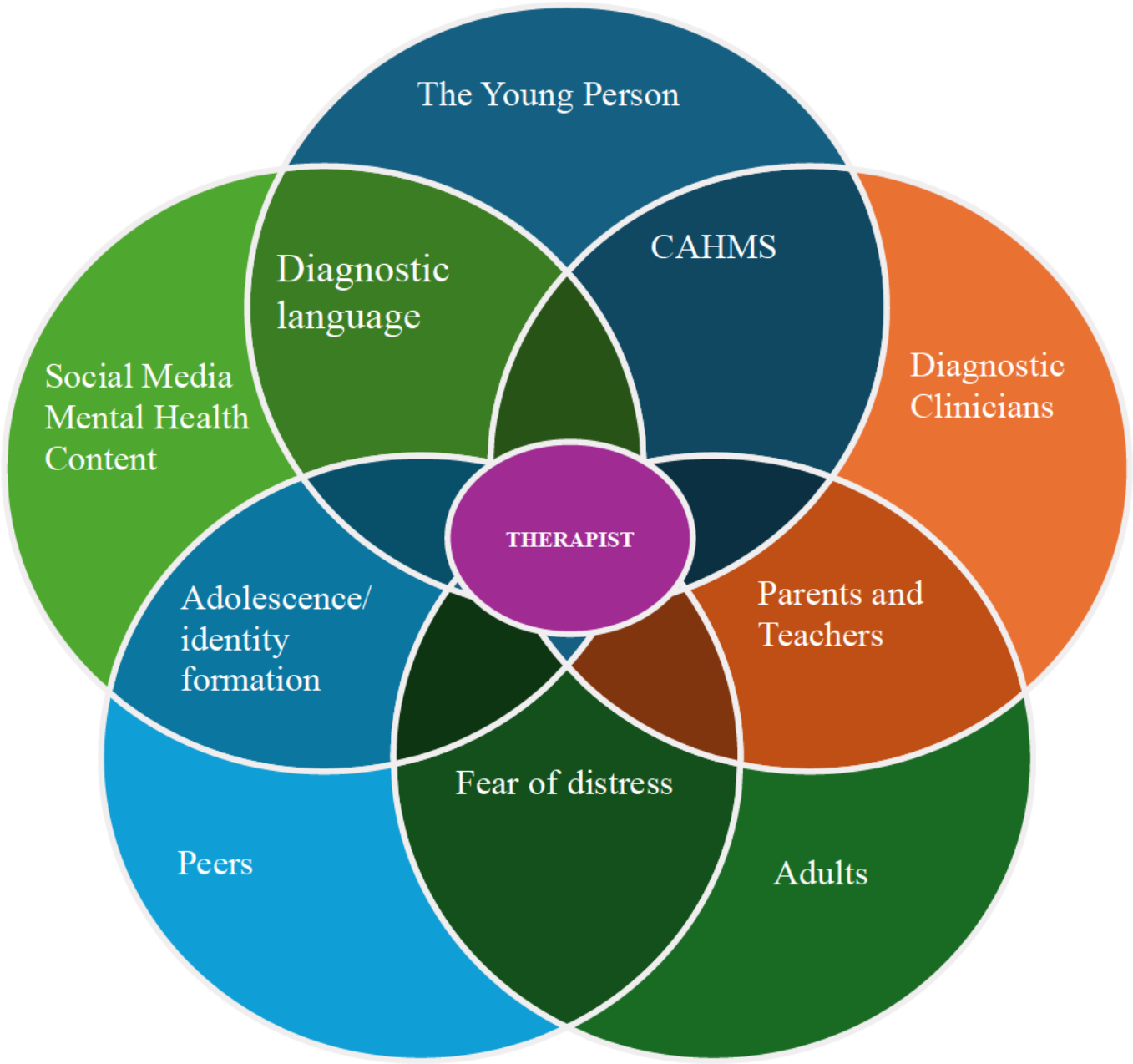
Theme chart and subthemes- September 2024

THEMES	Sub Themes
Young people are vulnerable	*Adults should intervene to protect young people*
	THE ALGORITHM is dangerous
You don't know what you are talking about (that's not real information?)	*Adult responses to adolescent self-diagnosis*
	Not all social media mental health content is created equally
	The 'reality' of mental health disorders
Where does therapy fit into a puzzle of support?	*Roles and Procedures- educating young people and families on the diagnostic process*
	Scarcity of mental health resources
	Working with other professionals (adults?)
Practicing from a relational framework	*Therapist way of being with the client exploring self-diagnosis*
	What's trauma got to do with it?
Stuck between relational and diagnostic frameworks	*How much should I know about diagnosis?*
	Processing the diagnostic process in a non-diagnostic relationship
	The impact of self-diagnosis on the therapeutic relationship (self-diagnosis is a third in the room?)
Seeking an explanation for suffering	*Understanding identity through a diagnostic lens*
	The language of identity
	Can Tiktok tell me who I am?
The impact of self-diagnosis for the young person	*Different kinds of self-diagnosis exploration*
	What can diagnosis provide?
Mental Health language is everywhere (and most definitely on social media)	*Social pressures and validation of diagnosis*
	Self-diagnosis trends and prevalence
Covid-19 Pandemic	

Appendix 10

RELATIONSHIP W/ THERAPIST
INSIDE SOCIAL MEDIA
PERSONAL CONTEXT
PROFESSIONAL CONTEXT
CULTURAL CONTEXT

Appendix 11


The Young Person
Diagnostic language
CAHMS
Social Media Mental Health Content
Diagnostic Clinicians
THERAPIST
Adolescence/ identity formation
Parents and Teachers
Fear of distress
Peers
Adults