Beyond the screen: Exploring the association between problematic social media use, neuroticism, and self-diagnosis in relation to ADHD

Bachelor-of-Science-Arbeit

Abteilung für Klinische Psychologie, Institut für Experimentelle Psychologie

Heinrich-Heine-Universität Düsseldorf

Düsseldorf, der 05.06.2025

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1 Abstract

Self-diagnosing psychological disorders using social media platforms like TikTok and Instagram is a growing trend. This study investigated the relationship between self-diagnosing behavior, neuroticism, and social media usage in the context of Attention Deficit Hyperactive Disorder (ADHD). Data were collected from a total of 406 participants, primarily consisting of psychology students and ADHD patients from the Alexianer Krefeld diagnostic center. They all completed an ADHD screening (ASRS), a Big Five questionnaire (BFI-S) and self-diagnosis questions. The sample comprised 322 participants without a verified ADHD diagnosis or self-diagnosis, 30 participants with a verified ADHD diagnosis, and 54 participants who self-identified as having ADHD. The results showed that individuals who self-diagnosed ADHD scored significantly lower in the ADHD screening (ASRS) than those with verified ADHD diagnoses. Additionally, participants with higher neuroticism scores and greater social media usage were significantly more likely to self-diagnose and to hold a more favorable attitude toward self-diagnosis content. Furthermore, significant correlations were found between social media usage and favorable perceptions of self-diagnosis videos, between neuroticism and self-diagnosing behavior, and between viewing mental health-related content and self-diagnosing behavior. These findings suggest that individuals with higher neuroticism scores are more likely to engage in self-diagnosing behavior and that increased time spent on social media platforms is associated with more favorable views of self-diagnosing content. Also self-diagnosed individuals exhibit lower clinically relevant symptoms compared to those with verified ADHD diagnoses. The study emphasizes the urgent need for media literacy and critical evaluation of mental health content online.

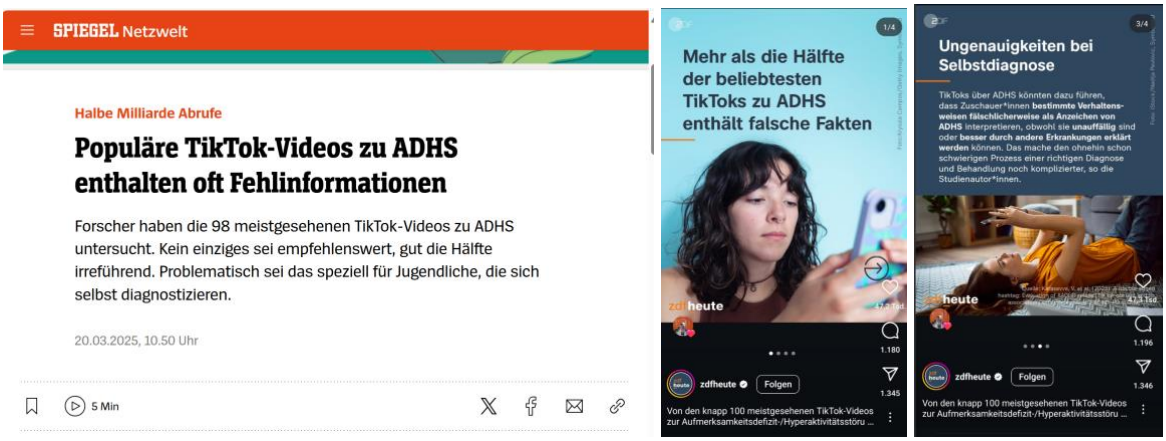
Keywords: Self-diagnosis, ADHD, Neuroticism, Big 5, Big Five, social media, misinformation, BFI-S, ASRS, self-handicapping

2 Introduction

Recently, a friend of mine claimed to have executive dysfunction. When I asked her why she thought so and whether she had consulted a psychologist or medical professional, she explained that she occasionally struggles with motivation and had therefore concluded it must be executive dysfunction. Drawing on my knowledge, I clarified the clinical definition and diagnostic criteria of the term. Her response was, “Oh, my bad, I guess TikTok gave me the wrong information.” (personal reference). This anecdote illustrates the increasingly common phenomenon of self-diagnosis. *Self-diagnosing* describes the process of diagnosing oneself with a medical condition without professional consultation (Aaiz A., & Stephen S., 2017). This practice has become increasingly prevalent, particularly in the field of mental health, largely due to the accessibility of health-related information on social media platforms such as TikTok and Instagram (Poon, C. V., 2024; Pretorius, C., et al., 2019; Foster, A., & Ellis, N., 2024). Many psychologists report encountering similar situations during therapy sessions or diagnostic evaluations (Richmond, L. M., 2023). The prevalence of self-diagnosing through social media has grown to such an extent that major German media outlets, including *Der Spiegel*, *ZDF*, and *Stern*, have published reports addressing the trend (Corzine, A., & Roy, A., 2024; Richmond, L. M., 2023).

Figure 1 Screenshots of Recently Published Articles

Screenshots of articles about self-diagnosis from Der Spiegel and the Instagram page of the ZDF



Populäre TikTok-Videos zu ADHS enthalten oft Fehlinformationen - DER SPIEGEL, https://www.instagram.com/p/DHbH1fmKIUf/?igsh=MXZjZWRuaDM2cDZiNQ==

Further studies showed that, in addition to social media, personality traits such as neuroticism and self-handicapping also play a significant role in the emergence of self-diagnosing behavior. In the following sections, these variables will be examined in the context of ADHD.

2.1 What is ADHD, and What are its Burdens?

Attention Deficit Hyperactive Disorder, short ADHD, describes "high levels of hyperactive, impulsive, and inattentive behaviors that begin during early childhood, are persistent over time, pervasive across situations, and lead to clinically significant impairments" (UKAAN, 2013). These impairments are found in many different areas in life, like social, emotional, and professional (Agarwal, R., et al., 2012; Katzman, M. A., et al., 2017). The prevalence of ADHD is estimated at 4% to 7% in children and 2.5% in adults (Katzman, M. A., et al., 2017). ADHD exhibits overlapping symptomology with other psychological disorders, such as depression or autism, which underscores the importance of differential diagnostics (Abdelnour, E., et al., 2022; Agarwal, R., et al., 2012; Katzman, M. A., et al., 2017). Individuals with ADHD often face neuropsychological challenges, including difficulties with inhibition, memory (Ossmann, J. M., & Mulligan, N. W., 2003), executive functioning (Boonstra, A. M. et. al.,2005), decision-making (Mowinckel, A. M., et. al., 2015), and emotional regulation (Retz, W., et. al., 2012). In adulthood, ADHD can have a negative impact on self-esteem (Kirino, E., et al., 2015), academic success (Biederman, J., et al., 2004; Wilens, T. E., & Dodson, W., 2004), lead to an increased risk of serious traffic accidents (Chang, Z., et al., 2014), contribute to financial problems (Das, D., et al., 2012) and strain interpersonal relationships, both professional and personal (Das, D., et al., 2012; Kirino, E., et al., 2015). These do not represent the full extent of the negative consequences (Katzman, M. A., et al., 2017). Often severe comorbid psychiatric disorders, like addiction (Biederman, J., et al., 2004; Katzman, M. A., et al., 2017; Sullivan, M. A., & Rudnik-Levin, F.,

2001; Wilens, T. E., et al., 1998), bipolar disorder, depression, personality, and anxiety disorder (Abdelnour, E., et al., 2022; Katzman, M. A., et al., 2017), can be found in ADHD patients, leading to poorer outcomes and a lower quality of life (Agarwal, R., et al., 2012; Biederman, J., et al., 2004; Katzman, M. A., et al., 2017). When ADHD is treated at an early stage, potential consequences (financial, social, scholar, etc.) can be prevented or mitigated, and an improvement of comorbid disorders may also be observed (Agarwal, R., et al., 2012; Katzman, M. A., et al., 2017; Poon, C. V., 2024). This illustrates the importance of accurate diagnosis, treatment, and support, which are frequently absent in cases of self-diagnosis (David, A. S., & Deeley, Q., 2024; Knuutila, A., et al., 2022; Solis, R., et al., 2021).

2.2 Self-Handicapping and Neuroticism

Self-handicapping is a psychological strategy in which individuals create obstacles to their success in order to protect their self-concept and rationalize poor performance (Bowden, O., 2023; Ross, S. R., et al., 2022). An example of self-handicapping behavior is using a disorder as an excuse for not completing tasks correctly in order to protect one's self-esteem. Having a "disorder" is particularly appealing as it often elicits understanding and reduces blame when tasks are left unfinished (David, A. S., & Deeley, Q., 2024). Studies indicated that self-handicapping is a convenient excuse for failure (Bowden, O., 2023; Zuckerman, M., & Tsai, F. F., 2005). Bowden found out that self-handicapping is the strongest predictor of self-diagnosis (2023), suggesting individuals use self-diagnosis as a form of self-handicapping to rationalize their poor performance by attributing it to a medical condition (Bowden, O., 2023; David, A. S., & Deeley, Q., 2024). Attributing such difficulties to a psychological disorder can provide a useful justification and shield their self-esteem (Bowden, O., 2023; Zuckerman, M., & Tsai, F. F., 2005). Other papers found that high scores on the neuroticism scale also correlated with self-handicapping (Bonsaksen, T., et al., 2017; Ross, S. R., et al., 2022). *Neuroticism* is a personality trait characterized by the tendency towards "anxiety, depression, self-doubt and other negative feelings", often also known

as low emotional stability. Neuroticism exists on a dimensional spectrum, with individuals differing in the intensity of its expression (psychology Today Staff, 2025). Individuals with low emotional stability, those who score high on the neuroticism scale, are more likely to create artificial obstacles in their lives for themselves. They "tend to rely on avoidant coping strategies of withdrawal and negative focus" (Ross, S. R., et al., 2022). This tendency could potentially originate from a desire to protect their self-esteem, leading to self-handicapping behavior, since a diagnosis is a valid reason for failure (Bonsaksen, T., et al., 2017; David, A. S., & Deeley, Q., 2024; Ross, S. R., et al., 2022). Considering the associations between neuroticism and self-handicapping, as well as between self-diagnosing and self-handicapping behaviors, it is plausible to assume that self-diagnosis may also be linked to higher levels of neuroticism. Individuals scoring high on neuroticism may be more inclined to engage in self-diagnosing behavior.

2.3 Self-Diagnosing and its Advantages

The trend of self-diagnosing is fueled by the abundance of information found on social media, much of which is misleading or pure misinformation. "Anxiety shivers", or "random noise making" were listed as symptoms of ADHD, none of which appear in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (Bowden, O., 2023; Davis, J. E., 2022; Hartnett, Y., & Cummings, E., 2024; Shu, K., et al., 2020; Yeung, A., et al., 2022). The #selfdiagnosis had 62 million views on TikTok in April 2025, #mentalhealth 144.3 billion, and #ADHD 39.7 billion (Free TikTok Hashtag Generator, 2025). In just about two years, #ADHD increased from 21.6 billion views on TikTok in February 2023 (Bowden, O., 2023) to 39.7 billion views in April 2025. Karasavva et al. found that over 50% of the top 100 #ADHD videos on TikTok did not align with the diagnostic criteria (2025). Yeung et al. also found that 52% of the 100 most viewed videos with the #ADHD were misleading, as assessed by the *Patient Education Materials Assessment Tool for Audiovisual Materials* (PEMAT-A/V) and *Journal of American Medical Association* (JAMA) (2022). Furthermore, in the study conducted by Yeung and colleagues only 11% of the

100 #ADHD videos with the highest views were uploaded by healthcare professionals, and 89% by non-healthcare professionals (Yeung, A., et al., 2022). Additionally, another study found that among the top 50 #ADHDtest videos, those categorized as "useful", such as ones featuring ADHD screener (ASRS) criteria, received the least attention and engagement from viewers. These videos represented only 8% of the sample, indicating that the remaining 92% were classified as misleading (Verma, S., & Sinha, S. K., 2024). Moreover, self-diagnosis can lead individuals to overlook potential underlying factors, like stress or nutritional deficiencies, that could be contributing to their symptoms (Korol, C., 2024; Saletin, J. M., et al., 2019; Zielińska, M. et al., 2023) or to miss alternative diagnoses with overlapping symptomology (Corzine, A., & Roy, A., 2024; Davis, J. E., 2022; Korol, C., 2024). For example, an individual experiencing difficulty with concentration may attribute these symptoms to ADHD without considering other contributing factors such as sleep deprivation, nutritional deficiencies, inadequate hydration, or stress. In addition to the misattributions, normal behaviors are increasingly over-pathologized and treated as disorders (Korol, C., 2024; Padberg, T., 2025; Richmond, L. M., 2023; Slay, B.-A., 2021; Suhr, J. A., & Johnson, E. E. H., 2022). The psychiatrist Rettew said: “Some kids describe their (normal) hobbies and fidgeting during a boring class, and yet they’ve latched on to psychiatric terms saying ‘I have these special interests, and I’m stimming, clearly I have autism.’ … I find myself gently de-diagnosing the teenagers I see in my office at least a few times a month.” (Richmond, L. M., 2023). This self-diagnosing behavior could potentially reinforce beliefs leading to more symptoms attributed to the self-diagnosed condition (Haltigan, J. D., et al., 2023; Moulder, M., & Moulder, M. H., 2023; Suhr, J. A., & Johnson, E. E. H., 2022), and ending in a sick role identity (Corzine, A., & Roy, A., 2024; Dewak, H., 2023; Foster, A., & Ellis, N., 2024; Poon, C. V., 2024) This identity often comes with social support as a form of secondary disease gain (Corzine, A., & Roy, A., 2024). Some social media users even glorified mental illnesses for their own gain and used self-fulfilling prophecies to create maladaptive behaviors (Moulder, M., & Moulder, M. H., 2023;

Padberg, T., 2025). The concept of the "born this way" attitude deemphasizes personal responsibility. While it can be very exonerative, it may also serve as an excuse to avoid accountability (David, A. S., & Deeley, Q., 2024; Kapp, S. K., 2020). An increasing number of self-diagnosing individuals avoid professional assessment or treatment, as doing so could eliminate the perceived advantages of a disorder (David, A. S., & Deeley, Q., 2024; Foster, A., & Ellis, N., 2024; Richmond, L. M., 2023). However, these individuals often continue to attribute their difficulties to the disorder, which may result in ineffective or misguided treatment when they eventually seek help (Corzine, A., & Roy, A., 2024; Poon, C. V., 2024). Individuals who self-diagnose verbalize that they suffer from a disorder as a way to protect their self-esteem (Kapp, S. K., 2020). Similarly, getting a diagnosis disconfirmed could attack their self-esteem and identity, leaving them with no explanation for their daily challenges but their personality (Kapp, S. K., 2020; Richmond, L. M., 2023).

2.4 The Role of Social Media in the Context of Self-Diagnosing

Social media platforms such as TikTok and Instagram play a significant role in the phenomenon of self-diagnosing behavior. The algorithms of social media platforms promote engaging, emotionally relatable content, often prioritizing entertainment over accuracy (Gillespie, T., 2014; Karasavva, V., et al., 2025; Poon, C. V., 2024; Suhr, J. A., & Johnson, E. E. H., 2022; Yeung, A., et al., 2022). As a result, users may be misled into believing they have met the criteria for a condition when in fact they just reacted to a sensationalized portrayal of ADHD symptoms (Davis, J. E., 2022; Poon, C. V., 2024; Solis, R., et al., 2021). A common tactic in self-diagnosis content is the usage of the *Barnum effect*, where individuals interpret vague and generalized statements as highly personal and accurate (Moulder, M., & Moulder, M. H., 2023). Moulder and Moulder discovered that vague statements of mental illnesses were perceived to be more trustworthy and had a higher chance of being used for self-diagnosis (2023). A clear example of the Barnum effect can be seen in a TikTok posted by the psychiatrist Agam Dhawan, called "Put

a finger down, ADHD edition". The video utilizes an interactive format, requiring you to place a finger down each time a statement applies to you. Once a certain number of fingers are down, you are implicitly identified as having, in this case, ADHD. Dhawan employs broad statements like "put a finger down if you've ever been called stupid, lazy or dumb", "… if you have ever been fired from a job" or "… if you only do well in exciting jobs" (https://vm.tiktok.com/ZNdYHmgd8/). While the video may appear credible due to Dhawan's professional title (Pérez-Escoda, A., et al., 2021; Pretorius, C., et al., 2019), it oversimplifies complex diagnostic criteria and presents statements that could apply to a broad audience. This example illustrates how interactive content on platforms like TikTok can encourage self-diagnoses by presenting oversimplified criteria that do not accurately reflect the clinical diagnostics. Such videos are widespread on social media (Dewak, H., 2023) and are often created by individuals without healthcare expertise who prioritize monetization over education (Karasavva, V., et al., 2025; Knuutila, A., et al., 2022; Pérez-Escoda, A., et al., 2021). Many young adults utilize social media as a source of education, further compounding this issue (Pérez-Escoda, A., et al., 2021). Pretorius, C., et al. discovered that 12.1% of young adults used social media as their definite source for information, and 82.5% used it for searches on mental health (2019). As a result, the line between credible and misleading information becomes increasingly blurred, reinforcing self-diagnosis behaviors among impressionable users (Knuutila A., et al., 2022). When content is presented by seemingly trustworthy figures or viral formats, it can strongly influence users' perceptions and behaviors, leading to self-diagnoses without proper clinical guidance (Dewak, H., 2023; Yeung, A., et al., 2022).

2.5 Dangers of Self-Diagnosing

Karasavva et al. found that students believed that the ADHD prevalence in adults is 33% (2025). The assumed prevalence was significantly different from the true prevalence (2.5% in adults), which highlights the number of self-diagnoses in daily conversations and on social media

(Karasavva V., et al., 2025). This increasing prevalence of self-diagnosis leads to several concerns. One concern is that individuals who diagnose themselves may either avoid professional help in fear of not getting the diagnosis verified (Corzine, A., & Roy, A., 2024), they enter therapy with incorrect assumptions about their condition (Poon, C. V., 2024; Solis, R., et al., 2021; Stukus, D. R., 2019), or due to long waiting lists as well (Slay, B.-A., 2021; Solis, R., et al., 2021). Furthermore, some patients were upset or unaccepting when professional diagnoses did not align with their perception (Corzine, A., & Roy, A., 2024). Both considerations could lead to problems regarding the appropriate treatment (Poon, C. V., 2024; Slay, B.-A., 2021). The self-diagnosis phenomenon also has the potential to change how society views mental health conditions, affecting both professionals and the general public (Corzine, A., & Roy, A., 2024; Haltigan, J., et al., 2023; Padberg, T., 2025). For example, Aronson found that peer influence could confound the assessment of inattention, a core symptom of ADHD. Certain behaviors included in the diagnostic criteria, such as excessive talking or fidgeting, were amplified even mimicked through social interactions (Aronson, B., 2016). The finding suggests that some symptoms may not originate from a neurodevelopmental disorder but rather may result from learned behaviors influenced by peer groups or exposure to social media content (Aronson, B., 2016; Bowden, O., 2023; Padberg, T., 2025). As a result, young adults seeking an ADHD diagnosis may exhibit symptoms that closely resemble those of individuals they have observed on platforms like TikTok, rather than those based on their own clinical history (Bowden, O., 2023; Padberg, T., 2025). The resemblance to observed symptoms may distort the understanding of core symptoms and consequences, as misdiagnosed individuals may be included in research samples (Hartnett, Y., & Cummings, E., 2024; Suhr, J. A., & Johnson, E. E. H., 2022; Padberg, T., 2025). If ADHD, autism, or other disorders are overgeneralized or trivialized, it could contribute to stigma by making these diagnoses seem like quirky personality traits or social trends rather than recognizing them as serious conditions requiring clinical attention (Davis J. E., 2022; Haltigan, J., et al., 2023; Richmond, L. M., 2023).

A study conducted by Jadayel and colleagues stated that young adults described mental disorders as normal, relatable, and even desirable (2018). Additionally, Haltigan and colleagues observed a sometimes sexualized portrayal of mental disorders online (2023). This misrepresentation can lead to skepticism towards individuals who truly struggle with these disorders, which can further complicate access to adequate treatment and support, for example, due to long waiting lists (Slay, B.-A., 2021; Solis, R., et al., 2021; Poon, C. V., 2024).

2.6 Good Side of Self-Diagnosis

It is crucial to acknowledge that self-diagnosing is not always harmful (David, A. S., & Deeley, Q., 2024). For some individuals who have struggled with symptoms for years without recognition, discovering a potential diagnosis through social media can be validating and empowering (Poon, C. V., 2024; Slay, B.-A., 2021). It is critical that people who think they suffer from ADHD and show a psychological strain seek help from qualified mental health professionals (NeuroLaunch, 2024; David, A. S., & Deeley, Q., 2024*)*. After the assessment, the diagnosis can be either confirmed or disconfirmed, and a tailored treatment plan that addresses the specific needs of an individual can be created (Agarwal, R., et al, 2012; Poon, C. V., 2024). On a positive note, many people with ADHD seek help from a diagnostic center (Poon, C. V., 2024) when their problems become severe. At the Alexianer Krefeld institution, for example, approximately 70% of individuals seeking help are true positives, indicating that 30% falsely believe they have ADHD (personal reference from the Alexianer Krefeld ADHD diagnostic center).

2.7 The Contrast Between Clinical Diagnosis and Self-Diagnosis

The ADHD diagnosis typically involves a comprehensive process lasting approximately four hours. During this time individuals consult with a psychiatrist, psychologist, provide urine samples, and complete five to seven questionnaires, which are reviewed by two professionals before the diagnosis is made. It is a long process, ensuring a high degree of diagnostic accuracy (*HASE - Homburger ADHS-Skalen für Erwachsene | Hogrefe*). In contrast, self-diagnosing solely

relies on information obtained from social media, where it takes about a minute (approximately three TikToks/ Instagram reels videos) to diagnose only via self-assessment (Aaiz A., & Stephen S., 2017; Foster, A., & Ellis, N., 2024). Additionally, labeling normal experiences as a disorder results in unnecessary distress, such as increased anxiety and sleep disturbances (Korol, C., 2024).

2.8 Research questions and hypotheses

2.8.1 Comparison of ASRS Scores

First, I compare the *ADHD Self-Report Scale* (ASRS) scores across three groups: individuals who self-diagnose based on online content, individuals who *self-diagnose after a disconfirmation* from a diagnostic center or psychiatrist (SDAD) and clinically diagnosed ADHD patients. I assume that the self-diagnosing groups score significantly lower, as their symptom attribution to ADHD may originate from misinformation or simplified symptom portrayals found online (Abdelnour, E., et al., 2022; Bowden, O., 2023; Moulder, M., & Moulder, M. H., 2023; Padberg, T., 2025). In contrast, individuals with a formal ADHD diagnosis typically report consistent symptomatology since early childhood and experience substantial functional impairments (Agarwal, R., et al., 2012; Poon, C. V., 2024).

2.8.2 Perceptions of Self-Diagnosis Videos and Their Relation to Neuroticism

Secondly, I examine whether individuals with higher levels of neuroticism are more likely to view self-diagnosis videos positively. Given that neuroticism is linked to emotional instability, I hypothesize that such individuals may find validation and comfort in these videos, perceiving them as helpful rather than misleading (Bonsaksen, T., et al., 2017; Ross, S. R., et al., 2022).

2.8.3 Social Media Use and Attitudes Toward Self-Diagnosis

Thirdly, I analyze whether frequent social media use, especially engagement with mental health-related content, is associated with a greater tendency toward self-diagnosis and more favorable attitudes toward self-diagnosis content. Due to algorithmic personalization, individuals

engaging with such content may enter a feedback loop, where they are continually exposed to similar videos that reinforce their existing beliefs (Bippert, A. et al., 2023; Gillespie, T., 2014; Solis, R., et al., 2021). This may further blur the line between legitimate symptoms and misleading information, when not having the knowledge nor the education to differ between the (mis-)information (Knuutila, A., et al., 2022)

2.8.4 The Link Between Neuroticism and Self-Diagnosing

Finally, I assess whether neuroticism alone can predict self-diagnosing behavior or if self-handicapping serves as a necessary mediator. As outlined earlier, prior research suggests that individuals who score high in neuroticism and those who self-diagnose are more likely to engage in self-handicapping behavior (Bonsaksen, T., et al., 2017; Bowden, O., 2023; Ross, S. R., et al., 2022). I explore whether self-handicapping is a necessary mechanism in this relationship or whether neuroticism alone can predict self-diagnosing behavior.

3 Methods

3.1 Participants

For this study, 418 participants were recruited. Participants were required to be at least 18 years old and fluent in German. In accordance with legal guidelines, eight participants had to be excluded from the analysis due to being underage. Participants who completed the survey in less than 200 seconds were excluded from the sample, as this was considered an indicator that they likely did not take the necessary time needed to respond accurately. This specification affected four participants. As a result, I removed the data of 12 participants for the analysis, which led me to end up with a total number of 406 participants. Initially I planned to only recruit 130 participants based on a prior GPower sample size calculation (Faul, F., et al., 2007). However, upon reaching 130 participants, it became evident that none of them had a verified ADHD diagnosis. Consequently, I continued to collect the data until I reached 30 verified ADHD diagnoses, ensuring the suitability of inferential analysis in accordance with the central limit theorem (Kwak, S. G., & Kim, J. H., 2017; Mascha, E. J., & Vetter, T. R., 2018). In total, the final sample consisted of 30 verified ADHD diagnoses, 54 self-diagnoses, five self-diagnoses after disconfirmation (SDAD), and 322 with neither (control group). I recruited participants via a flyer (see appendix), through friends and family, through fellow psychology students, and through social media, as well as from the Alexianer Krefeld ADHD diagnostic center at a later stage. The questionnaire was administered electronically and could be completed on a device of the participant's choice (e.g. mobile phone, computer).

3.2 ADHD Self-Report Scale (ASRS)

The ASRS included 18 items based on the DSM-IV criteria of ADHD symptoms. The items were measured on a five-point scale, ranging from 0 = "never" to 4 = "very often". The questionnaire was administered in German in the survey. Part A, also referred to as screener, consisted of six items. In the screener, four or more checks in the shaded area were an indication

of the presence of possible adult ADHD (***Figure 2***). The items in part A were evaluated as unweighted and dichotomous, in accordance with the provided guidelines (see appendix) (Ustun, B., et al., 2017).

Figure 2 ASRS part A (Screener)

The figure shows the ASRS part A (Screener). Four or more checks in the shaded area were an indication for the probability of an adult ADHD, necessitating further clinical evaluation

	nie (0)	selten (1)	manch-mal (2)	oft (3)	sehr oft (4)
1. Wie oft haben Sie Schwierigkeiten sich auf das zu konzentrieren, was andere sagen, selbst wenn sie direkt mit Ihnen sprechen?	☐	☐	☐	☐	☐
2. Wie oft verlassen Sie ihren Sitzplatz in Situati-onen, in denen von Ihnen erwartet wird, dass Sie sitzen bleiben?	☐	☐	☐	☐	☐
3. Wie oft haben Sie Schwierigkeiten zur Ruhe zu kommen und sich zu entspannen, wenn Sie Zeit für sich haben?	☐	☐	☐	☐	☐
4. Wie oft beenden Sie in Unterhaltungen den Satz anderer Personen, bevor diese ihn selbst zu Ende sprechen können?	☐	☐	☐	☐	☐
5. Wie oft verschieben Sie Dinge bis auf die letzte Minute?	☐	☐	☐	☐	☐
6. Wie oft brauchen Sie die Unterstützung ande-rer, um Struktur in ihren Alltag zu bringen und auf Details zu achten?	☐	☐	☐	☐	☐

Section B of the ASRS could provide additional information and was considered critical with a total score of ≥ 32 (weighted items) (Ustun, B., et al., 2017). If both sections showed notable results, further diagnostic evaluation by a specialist should be initiated (Kessler, R. C., et al., 2005). The reliability of the ASRS in general was considered internally consistent and reliable (Kessler, R. C., et al., 2005). Especially, the first six questions outperformed the total of 18 items in several areas: sensitivity (68.7% vs. 56.3%), specificity (99.5% vs. 98.3%), overall classification accuracy (97.9% vs. 96.2%), and Cohen's κ (0.76 vs. 0.58) (Kessler, R. C., et al., 2005). In conclusion, the screener was the better method for predicting adult ADHD than the complete ASRS. However, it should be noted that further studies are needed to calibrate and refine a weighted version of the ASRS, which could potentially outperform the screener (Kessler, R. C., et al., 2005; Ustun, B., et

al., 2017). The objectivity of scoring and interpretation of the ASRS could be ensured. Furthermore, the construct validity was significant and strongly correlated with other ADHD diagnostics, “but varied substantially in concordance (Cohen's κ in the range 0.16 – 0.81)” (Kessler, R. C., et al., 2005). Cohen’s κ (kappa) is a statistical measure of inter-rater agreement and tells one how much two raters agree, beyond what would be expected by chance. The range 0.16 – 0.81 means that, depending on the context or comparison, agreement varied from very low (κ = 0.16) to fairly high (κ = 0.81). This wide range indicated substantial variability in how consistently two sources or methods agreed on the same diagnosis or categorization.

3.3 Big Five Inventory-SOEP (BFI-S)

This short scale measured the Big Five, which included neuroticism, extraversion, openness, conscientiousness, and compatibility. The scale contained a total number of 15 items, so three items per subscale. The BFI-S was based on the Big Five Inventory by John et al. (1991). The questionnaire was designed and implemented as part of the *Socio-Economic Panel* (SOEP). The SOEP is the largest and longest-running multidisciplinary longitudinal panel study in Germany. The items were measured on a seven-point scale, ranging from 1 = "Does not apply at all" to 7 = "Fully applies." Four of the five scales included one reverse-coded item to minimize or detect response biases (Items 3: compatibility, 6: extraversion, 8: conscientiousness, and 15: neuroticism). To evaluate the total score, the reverse-coded items needed to be recoded. Then the responses for the three items on each scale were summed up (Schupp, J., & Gerlitz, J.-Y., 2008). For the interpretation, scale scores of 15 out of 21 points were considered a strong expression of the scales (Gerlitz, J.-Y., & Schupp, J., 2005). The questionnaire was administered in German in the survey. Gerlitz and Schupp provided the calculation and the interpretation guidelines, allowing for the assumption of scoring and interpretation objectivity (2005). The reliability of the subscale varied between a Cronbach’s alpha of .51 and .73. Different studies show different results; that is why the numbers are shown in ranges. The highest internally consistent subscale was openness (α

= .63 - .73), followed by conscientiousness (α = .62 - .67), extraversion (Cronbach α = .61 - .66), neuroticism (α = .57 - .62), and agreeableness (α = .50 - .51) (Dehne, M., & Schupp, J., 2007; Schupp, J., & Gerlitz, J.-Y., 2008; Richter, D., et al., 2013). Items were generally considered internally consistent or reliable when they achieved a Cronbach's alpha of > .70. Thus, openness demonstrated sufficient internal consistency; the items of neuroticism, extraversion, conscientiousness, and agreeableness did not. It needs to be considered that the size of coefficient alpha can vary substantially depending on the number of items included (Cortina, 1993), and the conventional critical value was established for tests with significantly more items than the BFI-S. The consistently high correlations between the BFI-S and BFI-25 indicated that the shortened version closely reflected the structure of the longer scales, which concluded in indications of convergent and divergent validity (Schupp, J., & Gerlitz, J.-Y., 2008). The construct validity and the reliability of the BFI-S were satisfactory concerning the SOEP pretest (Gerlitz, J.-Y., & Schupp, J., 2005) and in the SOEP main survey in 2005 (Dehne, M., & Schupp, J., 2007).

3.4 Questions Used to Identify Self-Diagnosis

The four questions to evaluate the self-diagnosis could be answered binary, with “yes” or “no”. Participants were asked to respond to the following questions “Do you think you have ADHD?”, “Have you ever been to an ADHD diagnostic center or received medical consultation regarding an ADHD diagnosis or assessment?”, “Have you received an ADHD diagnosis?” and “Do you suffer from another diagnosed mental disorder?”. The last question had the additional option “do not want to answer” to choose from. Participants who believed they had ADHD but had not received a formal diagnosis were categorized as self-diagnosed. Participants who believed they had ADHD and who had undergone an assessment at a diagnostic center but did not receive a confirmed ADHD diagnosis were categorized as SDAD.

3.5 Design and Procedure of the Survey

The online survey was made as well as data collected via Soscisurvey. Except for the age and anonymization cipher, each item could be answered by selecting an option. The questionnaire contained a total of 48 questions: Nine items were dedicated to collecting demographic data, including social media usage and whether they had been exposed to health-related content online; 18 were the ASRS; 15 were the BFI-S; one was the cipher for anonymization; one was for the compensation for students; and four items were the questions that evaluated the self-diagnosis. A full version of the survey can be found in the appendix. The survey took about 15 minutes, depending on participants' reading speed. As compensation for participating in the survey, psychology students from the Heinrich-Heine-Universität Düsseldorf and Fresenius University received 0.5 subject hours (credits). All survey items were mandatory in order to meet the criteria for a valid completion.

3.6 Statistical Analysis

Statistical analyses were conducted to evaluate the relationship between neuroticism, self-diagnosing ADHD, and social media usage. Prior to analysis the dataset was screened for outliers, concerning underage and "click throughers", which were subsequently excluded from the sample. Firstly, I looked at the descriptive statistics. Later, independent t-tests were used to compare the scores achieved in the ASRS in the different samples (ADHD & self-diagnoses, ADHD & SDAD). In addition, an independent t-test was conducted, comparing the attitude towards self-diagnosing videos in relation to high and low neuroticism. Additionally, a t-test was computed to examine the relationship between social media usage and the likelihood of self-diagnosing. Furthermore, a Pearson correlation was conducted to explore the relationship between the social media usage in relation to the attitude towards self-diagnosis videos. Moreover, chi-square tests were conducted to compare the groups (self-diagnosis vs. control) in terms of their exposure to self-diagnosis content and their engagement with health-related content. At last, a chi-square test was performed

to compare the mean scores of neuroticism between the self-diagnosing group and the control group. All statistical analyses were conducted using IBM SPSS Statistics (version 29.0.1.0, IBM Corp., Armonk, NY), with statistical significance set at $p < 0.05$.

4 Results

I collected the data from 406 participants with an average age of 24,07 years (*SD* = 8.13 years) with a minimum age of 18 and a maximum age of 60. 306 identified as female, 97 as male, and three as diverse. **Table 1** shows the results of the descriptive statistical analyses for the ASRS scores.

Table 1 Descriptive Statistics ASRS

Descriptive statistic ASRS (part A and B), and neuroticism

	Mean ASRS part A	SD ASRS part A	Mean ASRS part B	SD ASRS part B	Mean neuroticism	SD neuroticism
ADHD (*n* = 30)	4.63	1.03	34.13	5.27	16.07	3.72
Self-diagnosers (*n* = 54)	3.44	1.51	27.07	6.78	16.28	2.99
SDAD (*n* = 5)	4	1.87	30.20	7.33	19.60	1.52

As seen in **Table 1**, the ADHD group scored the highest across parts A (*M* = 4.63) and B (*M* = 34.13) of the ASRS and was the only one to meet the clinical threshold for both sections (part A ≥ 4, part B ≥ 32). The self-diagnosis-after-disconfirmation group (SDAD) (*n* = 5) met the threshold of part A with their mean score (*M* = 4), but not for part B (*M* = 30.20). Due to the relatively small sample size, these results should be interpreted with caution. The self-diagnosis group (*n* = 54) did not meet the threshold for either diagnostic criterion based on their mean score. Inferential statistical analyses were conducted to test the significance of these results. An independent t-test comparing the ASRS scores from part A of the ADHD group (*M* = 4.63, *SD* = 1.03) and the self-diagnosis group (*n* = 54, *M* = 3.44, *SD* = 1.51) revealed a significant difference, *t* (78.38) = 4.26, *p* < .001 (one-tailed), Cohen's *d* = 1.36. Similarly, an independent t-test comparing the ASRS part B scores from the ADHD group (*M* = 34.13, *SD* = 5.27) and the self-diagnosing group (*n* = 54, *M*

= 27.07, *SD* = 6.78) showed a significant difference, *t* (73.07) = 5.30, *p* < .001 (one-tailed), Cohen's *d* = 6.29. Additionally, an independent t-test comparing the ASRS score from part A from the ADHD group (*M* = 4.63, *SD* = 1.03) and the SDAD group (*n* = 5, *M* = 4, *SD* = 1.87) was conducted and revealed no significant difference, *t* (33) = -1.12, *p* = .135, (one-tailed), Cohen's *d* = 1.17 . Likewise, for part B, the independent t-test between the ADHD group (*M* = 34.13, *SD* = 5.27) and the SDAD group (*n* = 5, *M* = 30.2, *SD* = 7.33) showed no significant results, *t* (33) = -1.46, *p* = .076 (one-tailed), Cohen's *d* = 5.56. However, due to the small sample size, the SDAD results should be treated with caution. Secondly, I evaluated the view of the participants on self-diagnosis videos and the differences between the high-neuroticism group (BFI-S score ≥ 15, *n* = 207) and low-neuroticism group (BFI-S score < 15, *n* = 199) group.

Table 2 Descriptive Statistics by High and Low Neuroticism

Age and gender distribution of the sample divided by high and low neuroticism scores

	Age (Mean)	Age (SD)	Identifying as male	Identifying as female	Identifying as divers
Low neuroticism scores (*n* = 199)	22.62 years	8.69 years	31,7% (*n* = 36)	68.3% (*n* = 199)	0% (*n* = 0)
High neuroticism scores (*n* = 207)	23.54 years	7.54 years	16.4% (*n* = 34)	82.1% (*n* = 170)	1.4% (*n* = 3)

The mean neuroticism score of the high-neuroticism group was 17.44 (*SD* = 2.01), for the low-neuroticism group, it was 11.01 (*SD* = 2.68). Their rating of the videos showed clear group differences in the descriptive statistical analysis. In the high-neuroticism group, 20.7% rated the videos positively, 14.0% responded neutrally, and the majority of 65.3% rated the videos negatively. In the low-neuroticism group, 14.5% had a positive attitude, 6.5% responded neutrally, and 78.9% rated the videos negatively (**Table 3**). Both groups rated the videos overall negatively,

but those with high neuroticism were more inclined to rate the self-diagnosis videos positively (20.7% compared to 14.5%) and were less likely to rate them negatively or think about the risks (65.3% compared to 78.9%) than participants with lower neuroticism scores (***Figure 3,*** **Table 3**).

Table 3 Attitude Towards Self-Diagnosis Videos

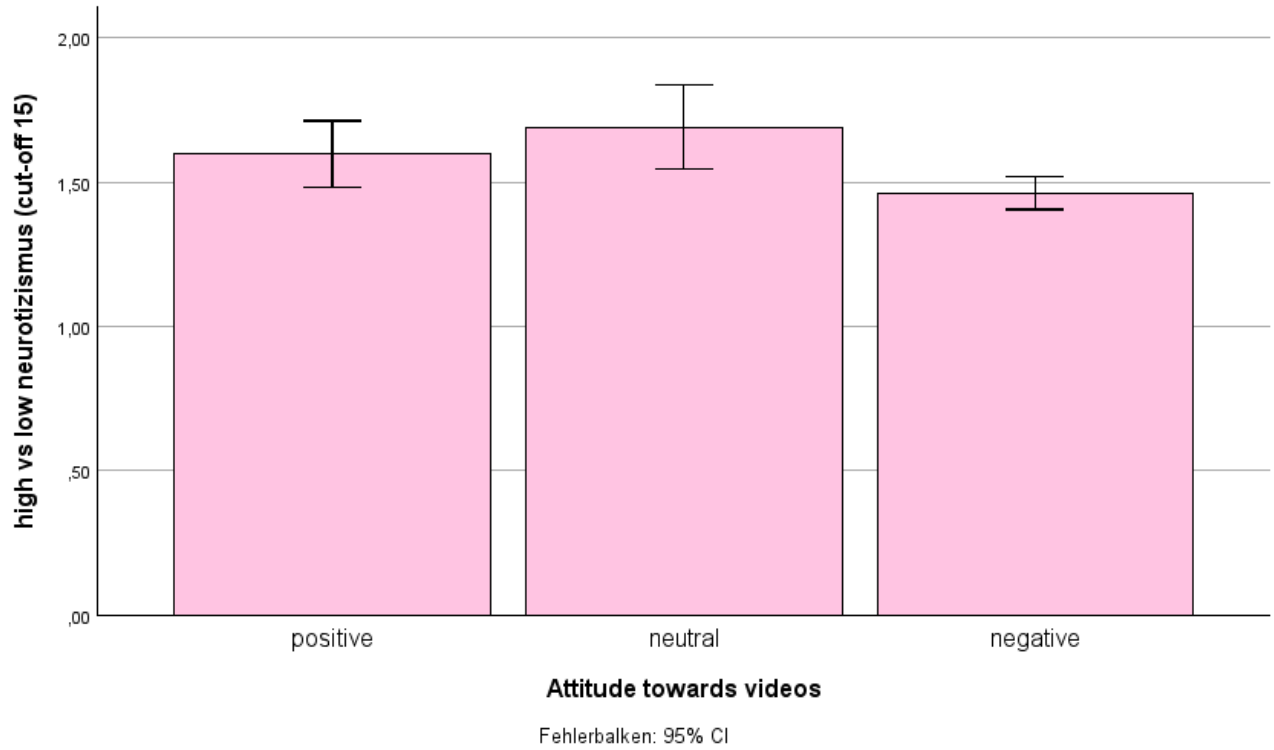
Attitude towards the videos depending on their neuroticism scores

		Neuroticism			
		low		High	
		number	number as %	number	number as %
Attitude videos	1 pos.	11	5,5%	16	7,7%
	2 pos.	12	6,0%	17	8,2%
	3 pos.	6	3,0%	10	4,8%
	4 neutral	13	6,5%	29	14,0%
	5 neg.	47	23,6%	49	23,7%
	6 neg.	42	21,1%	43	20,8%
	7 neg.	68	34,2%	43	20,8%

Figure 3 Bar Graph of Mean Neuroticism Scores and Attitudes Toward Self-Diagnosis Videos

Mean neuroticism (1 = low neuroticism, 2 = high neuroticism) per group for attitude toward self-diagnosis videos (positive, neutral, negative)
The Y-axis represents the mean neuroticism group (cut-off score >= 15), with higher values

indicating membership in the high neuroticism group. The x-axis shows the attitude towards self-diagnosing content in three categories (positive, neutral, negative).



To assess the significance of our results, I employed inferential statistical methods. An independent t-test was performed to compare the attitudes towards self-diagnosing videos (on a scale 1 to 7, 1-3: positive, 4: neutral, 5-7: negative) between the low-neuroticism sample (M = 5.39, SD = 1.75) and the high-neuroticism sample (M = 4.83, SD = 1.83). A significant difference emerged between these two groups, t (404) = .411, p = .001 (one-tailed), Cohen's d = 1.79, indicating that those with higher neuroticism viewed the videos more favorably. Additionally, I compared the social media usage and the frequency of self-diagnoses. The average usage of social media in the sample was about two hours per day. Most of the self-diagnosing individuals, 83.3% (n = 45) used social media for over two hours per day, and only 16.7% (n = 9) showed a usage of under two hours. One can, descriptively, see that self-diagnosers spent more time above our sample's average on social media (**Table 4**).

Table 4 Social Media Usage of Different Groups (Control vs. Self-Diagnosis)

The table shows descriptive data for the different groups in relation to their social media usage

	Groups

		Control (no ADHD/ no self-diagnosis)		self-diagnosis (n = 54)	
		number	number as %	number	number as %
Social media usage	<1h	45	14,0%	2	3,7%
	1h	69	21,4%	7	13,0%
	2h	109	33,9%	19	35,2%
	3h	61	18,9%	9	16,7%
	4h	30	9,3%	10	18,5%
	5h	5	1,6%	2	3,7%
	>5h	3	0,9%	5	9,3%

Statistical tests were computed to determine whether the observed effects were significant. An independent t-test was conducted between the self-diagnosing group (M = 3.81, SD = 1.54) and the control group (no verified ADHD nor self-diagnosis) (M = 2.97, SD = 1.28) to examine differences in social media usage. The t-test revealed a significant difference, t (65,71) = -3.83, p < .001 (one tailed), Cohen's d = 1.32, suggesting higher social media engagement among self-diagnosing individuals. In addition, the attitude towards these videos of people with high social media usage was also more positive compared to those who spent less time on social media and interacted less with mental health content (**Table 5**). **Table 5** shows the comparison of attitudes towards self-diagnosing videos among participants with high and low social media usage.

Table 5 Attitude Towards Self-Diagnosing Content in Relation to Social Media Usage

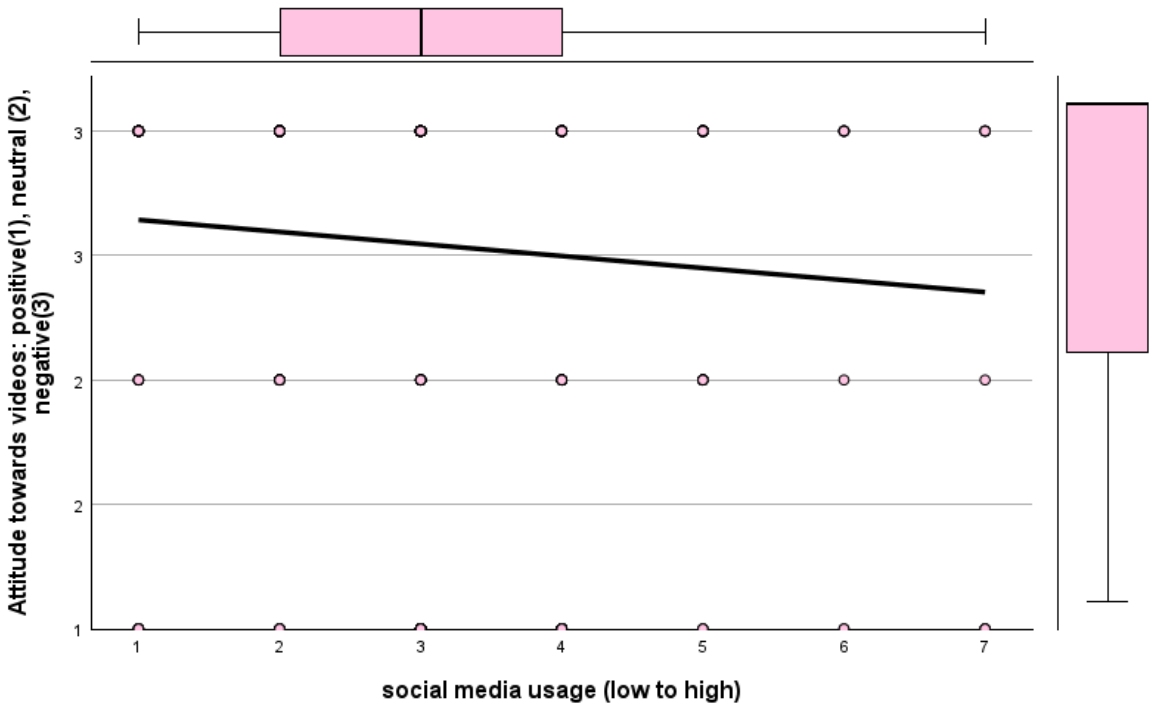
Attitude towards the self-diagnosis videos in relation to one's social media usage

		Attitude					
		positive		neutral		negative	
		number	number %	number	number %	number	number %
Social media usage	<1h	7	9,7%	5	11,9%	42	14,4%
	1h	10	13,9%	8	19,0%	59	20,2%
	2h	29	40,3%	11	26,2%	98	33,6%
	3h	17	23,6%	9	21,4%	52	17,8%
	4h	3	4,2%	7	16,7%	31	10,6%
	5h	2	2,8%	1	2,4%	6	2,1%
	>5h	4	5,6%	1	2,4%	4	1,4%

To test the significance of the finding, a Pearson correlation between the social media usage (M = 3.09, SD = 1.37) and their attitude towards the self-diagnosing videos was computed (M = 2.54, SD = .78). A significant negative correlation, r (406) = -.85, p = .044 (one tailed, significance at .05), was revealed, indicating that more time spent on social media was associated with a more favorable view of self-diagnoses content (***Figure 4***).

Figure 4 Correlation Between Social Media Usage and Attitudes Toward Self-Diagnosing Videos

Figure 4 shows a negative correlation between the social media usage (ranging from low to high) and the perception towards self-diagnosis videos (categorized in positive (1), neutral (2), negative (3)).

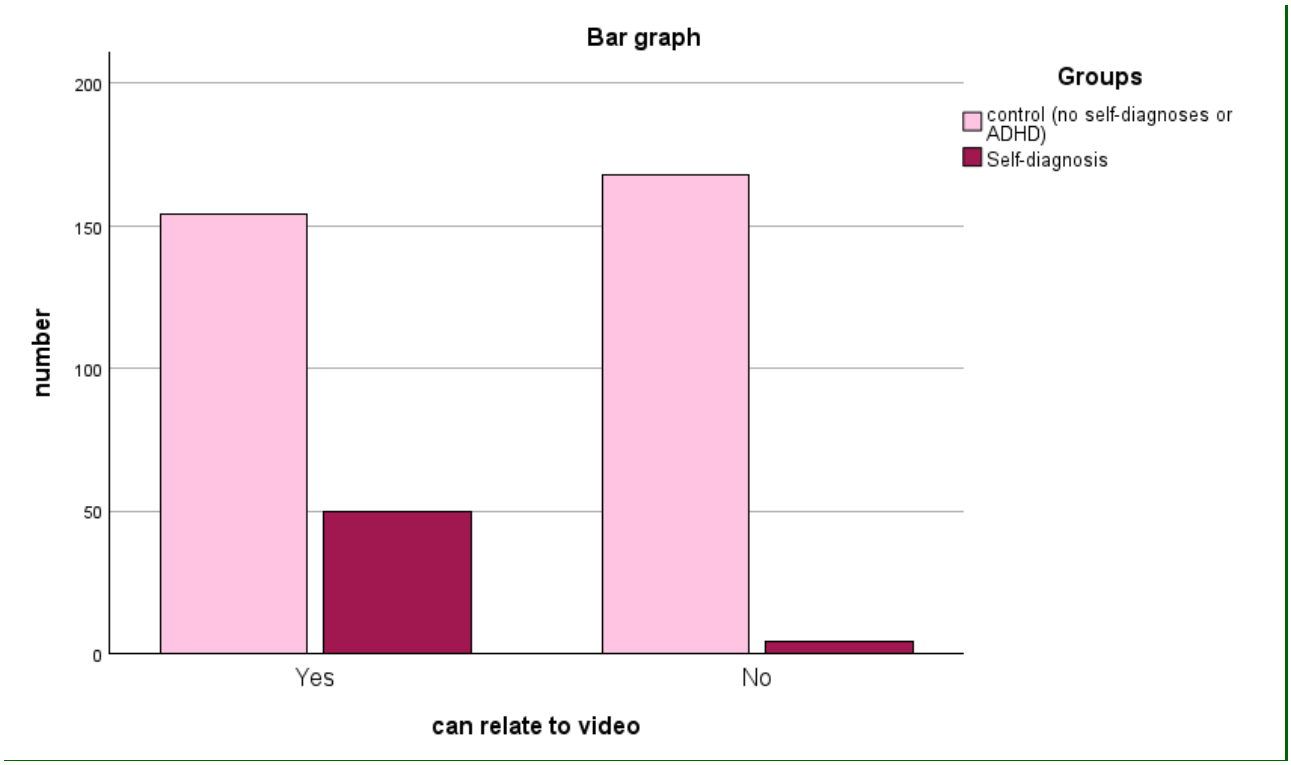


Next, the social media usage depending on health-related content was analyzed. In the total sample (n = 406), 48% (n = 195) reported watching mental health content online, and 56.2% (n = 228) stated that they could relate to self-diagnosis content. When participants with a verified ADHD diagnosis were excluded and the self-diagnosing group was compared to the control group, descriptive differences became visible. Among the self-diagnosing group (n = 54), 66.7% (n = 36) reported watching mental health content, and 92.6% (n = 50) indicated they related to this content. In contrast, within the control group (no ADHD, no self-diagnosis), 45.2% (n =

159) reported watching mental health content, and 50.6% (n = 178) felt they could relate to self-diagnosis content. Overall, these results suggested that individuals who self-diagnosed consumed more mental health-related content compared to the control group. Additionally, self-diagnosed individuals reported a higher frequency of relating to self-diagnosis content compared to other groups. The data were analyzed using inferential statistics to test our hypotheses for significance. A 2x2 chi-square test revealed a significant association between the self-diagnosis group and the control group and whether they had related to self-diagnosis content (yes, no), X^2 (1, N = 376) = 37.34, p < .001 (***Figure 5***).

Figure 5 Chi-square Test between Self-Diagnosers and the Control Group

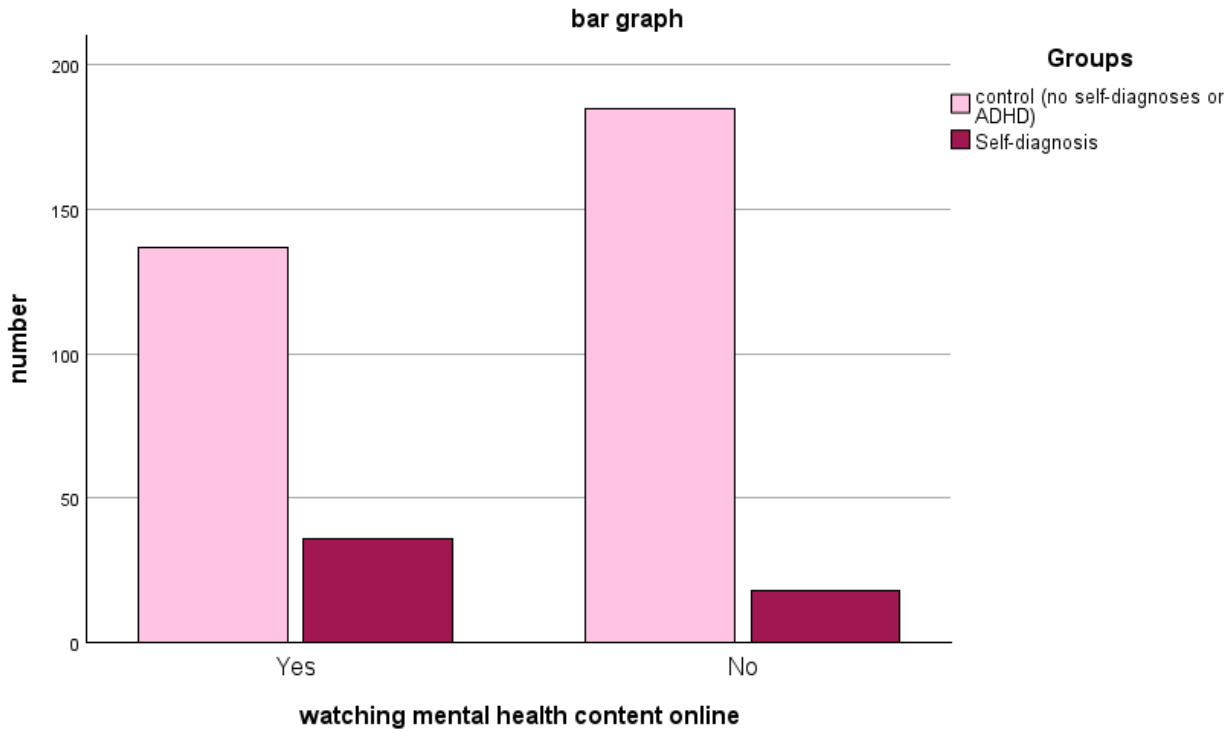
The bar graph shows the results of the chi-square test between self-diagnosers and the control group and whether they had related to self-diagnosis content.



Additionally, a 2x2 chi-square test was conducted and revealed a significant difference between watching mental content (yes, no) and self-diagnosis vs. the control group, X^2 (1, N = 376) = 10.83, p < .001 (***Figure 6***).

Figure 6 Chi-Square Test Comparing Control Group and Self-Diagnosis Groups on Watching Health-Related Content

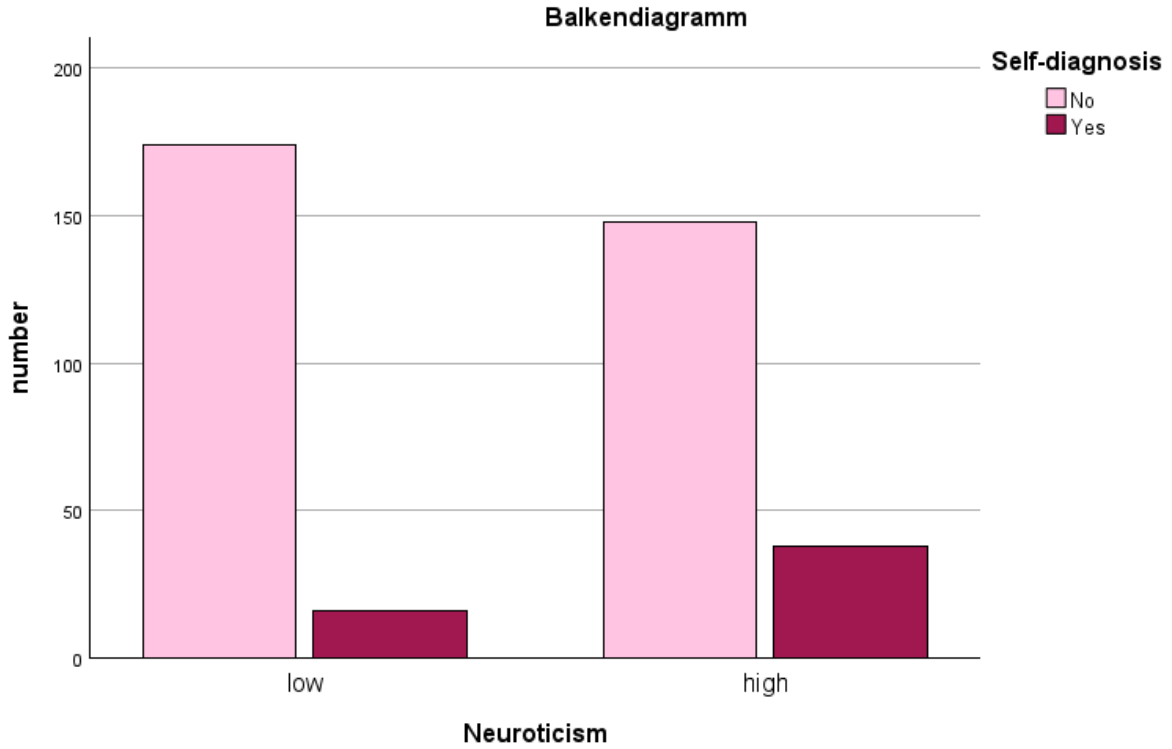
The bar graph displays the results for the chi-square test between watching mental health content (yes, no) and self-diagnosis group vs. the control group



Finally, I examined the descriptive association between neuroticism and self-diagnosis. Of all the self-diagnoses (n = 54), 38 out of 54 had scored 15 or higher on the BFI-S and were considered neurotic. 16 had scored lower than 15, which was below the cut-off on the neuroticism scale. The proportions showed a descriptive increase in the group that scored higher than 15 on the neuroticism scale. The proportion of self-diagnosis in the low-neuroticism sample was 8%, in the high-neuroticism sample, it increased up to 18.4%. It multiplied by the factor 2.4, the highest in this sample. 2.4 surpassed even the ADHD subgroup, which had a factor increase of 2.2. The ADHD subgroup incremented from 4.5% to 10.1%. A 2x2 chi-square test revealed a significant association between neuroticism level (high, low) and the presence of a self-diagnosis (yes, no), X^2 (1, N = 376) = 11.2, p < .001. The results indicated that individuals with high scores on the neuroticism scale rather tend to self-diagnose (***Figure 7***) than people with low scores on the neuroticism scale.

Figure 7 Chi-square Test Between Self-Diagnosing and Neuroticism

The bar graph shows the results for the chi-square test between the high and low neuroticism groups and whether they had self-diagnosed (yes vs. no)



5 Discussion

The primary aim of the study was to explore the trend of self-diagnosing ADHD, focusing on its associations with social media usage and neuroticism.

5.1 Interpretation of Results

In line with my first hypothesis, the self-diagnosis group (n = 54) scored significantly lower than the ADHD group on both part A and part B of the ASRS. Only the group with a confirmed ADHD diagnosis met the clinical threshold for both sections, supporting concerns that self-diagnosing individuals tend to attribute mild or unrelated symptoms to ADHD. A hypothesis is that the attributions of these symptoms are based on the misinformation found online (David, A. S., & Deeley, Q., 2024; Suhr, J. A., & Johnson, E. E. H., 2022). In contrast, verified ADHD patients reported firsthand experience problems consistent with clinical diagnoses (Poon, C. V., 2024). However, the SDAD group did not statistically differ from the ADHD group. But since the number of individuals was only five, these results should be treated with caution (Wolf, E. J., et al., 2013). Consistent with previous studies, I found a significant correlation between social media usage and the attitudes toward self-diagnosis content (Bippert, A., et al., 2023; Bowden, O., 2023; Moulder, M., & Moulder, M. H., 2023). Individuals who spent longer on social media and engaged more frequently with these videos tend to exhibit a more positive attitude rather than recognizing the potential risks associated with the content (Bippert, A., et al., 2023; Moulder, M., & Moulder, M. H., 2023). One potential explanation could be the normalization of social media as the primary source of (mis)information or education (Bippert, A., et al., 2023; Pérez-Escoda, A., et al., 2021; Pretorius, C., et al., 2019). Information online was often perceived as credible, reducing the need for professional evaluation (Pretorius, C., et al., 2019). Aligned with my second hypothesis, I found that people with higher scores on the neuroticism scale were more likely to view self-diagnosing videos more favorably. These findings support my hypothesis that neuroticism is associated with higher emotional instability (Bonsaksen, T., et al.,

2017; Ross, S. R., et al., 2022). Furthermore, individuals with high neuroticism scores may be more likely to find validation in self-diagnosis videos rather than perceiving them as misleading or harmful (Foster, A., & Ellis, N., 2024; Hartnett, Y., & Cummings, E., 2024). Individuals with high scores on the neuroticism scale might seek external explanations for their emotional instability and may find validation through such content (Bonsaksen, T., et al., 2018; Bowden, O., 2023; Corzine, A., & Roy, A., 2024). People who tend to self-diagnose spent significantly more time on social media compared to the control group. As previously stated, a higher usage correlated with a more positive attitude towards these videos. These findings indicate that there might be the problem of a feedback loop: individuals who spend more time on social media engage more often with health-related content; therefore, the algorithm shows more similar content (Aaiz, A., & Stephen S., 2017; Bowden, O., 2023; Solis, R., et al. 2021). This loop leads to reinforcements of their beliefs and eventually to a misdiagnosis due to the amount of false information online (Bowden, O., 2023; David, A. S., & Deeley, Q., 2024; Karasavva, V., et al., 2025; Padberg, T., 2025). People with high levels of neuroticism might have an increased likelihood of being influenced by misleading self-diagnosis content due to their anxiety or distress (Bowden, O., 2023), which may also affect how much they could benefit from this type of self-handicapping. (Ross, S. R., et al., 2022; Zuckerman, M., & Tsai, F. F., 2005). This hypothesis is further supported by the results of significant chi-square tests, which revealed that individuals who self-diagnosed were more likely to engage in mental health-related content and reported a stronger sense of identification with self-diagnosis videos compared to the control group. An alternative explanation could be that people experiencing psychological strain watched more health-related content than those without such strain or a verified diagnosis, as they did not feel the need to engage with health-related content. Furthermore, a significant chi-square test between neuroticism and self-diagnosing behavior was found, meaning that individuals with high neuroticism scores were more likely to self-diagnose. One possible

explanation, derived from previous literature, is that individuals with high levels of neuroticism might use self-diagnosing as a form of self-handicapping (Ross, S. R., et al. 2002) or avoidant coping mechanism to protect their self-esteem (Zuckerman, M., & Tsai, F. F., 2005), since often only the advantages of a disorder are expressed (secondary disease gain, explanation for failing, born this way narrative, validation, sense of identity) (Corzine, A., & Roy, A., 2024; David, A. S., & Deeley, Q., 2024; Hartnett, Y., & Cummings, E., 2024). Descriptively, I was also able to find that 38 out of 54 self-diagnoses scored 15 or higher on this trait. When comparing proportions, the prevalence of self-diagnoses increased by a factor of 2.4 in the neuroticism group. A significant chi-square test further supported this finding. A correlation analysis was not performed, as the use of nominal variables alongside metric data did not meet the requirements needed for such a test. As a result, it was not possible to confirm or refute whether neuroticism serves as a mediating variable in the relationship with self-diagnosing.

5.2 Implications

The findings highlight the growing societal relevance of self-diagnosis trends. *Der Spiegel*, *ZDF* and *Stern*, mainstream media outlets, have published articles addressing the dangers of online self-diagnoses (Populäre TikTok-Videos zu ADHS enthalten oft Fehlinformationen - DER SPIEGEL, https://www.instagram.com/p/DHbH1fmKIUf/?igsh=MXZjZWRuaDM2cDZiNQ==) and its potential impact on public perception and mental health literacy. The oversimplification (Corzine, A., & Roy, A., 2024; Korol, C., 2024; Richmond, L. M., 2023; Suhr, J. A., & Johnson, E. E. H., 2022) and glamorization of diagnoses (Corzine, A., & Roy, A., 2024; Haltigan, J. D., et al., 2023) as well as the over-pathologizing of normal behavior (David, A. S., & Deeley, Q., 2024; Suhr, J. A., & Johnson, E. E. H., 2022) distort the view on diagnoses in society, especially “trendy” ones like ADHD or autism (Alper, M., et al., 2025; Bowden, O., 2023; Padberg, T., 2025). This perspective on disorders reduces serious conditions to personality traits (Poon, C. V., 2024), makes

certain aspects of these conditions so desirable that professional assessment is often avoided (Bowden, O., 2023; Poon, C. V., 2024) and can lead to their portrayal in sexualized contexts online (Haltigan, J. D., et al., 2023). This mindset may exacerbate stigma against individuals with verified diagnoses (Haltigan, J. D., et al., 2023; PlushCare Content Team., 2022), hinder access to appropriate and effective treatment (Dewak, H., 2023; Poon, C. V., 2024; Suhr, J. A., & Johnson, E. E. H., 2022), and extend waiting times in diagnostic centers (Dewak, H., 2023; Slay, B.-A., 2021; Solis, R., et al., 2021). This mindset makes it harder for individuals with a true diagnosis to be heard and feel validated with their struggles (Corzine, A., & Roy, A., 2024; Foster, A., & Ellis, N., 2024). The spread of misinformation on platforms such as TikTok or Instagram, where short, easily consumable content dominates, poses a significant concern to public health (Corzine, A., & Roy, A., 2024; Hartnett, Y., & Cummings, E., 2024; Poon, C. V., 2024). Users are often exposed to symptom lists or "relatable" behaviors without context, promoting misdiagnoses (Davis, J. E., 2022; Solis, R., et al., 2021). This surge of information could even lead to altering diagnostic criteria (Bowden, O., 2023; Padberg, T., 2025; Suhr, J. A., & Johnson, E. E. H., 2022) or an inflation of symptoms (Corzine, A., & Roy, A., 2024; Davis, J. E., 2022) when, for example, thousands of individuals mention the same new symptom in diagnostic appointments, one they encountered in online videos (Bippert, A., et al., 2023; Suhr, J. A., & Johnson, E. E. H., 2022; Padberg, T., 2025). The commercial thought of social media platforms does not align with transparency and validity, which are needed for health-related content. Profit and entertainment are more important (Moulder, M., & Moulder, M. H., 2023; Poon, C. V., 2024; Solis, R., et al., 2021). Individuals with no professional healthcare background can upload and share content on these platforms, leading to the rapid spread of misinformation. This spread is particularly concerning for younger audiences who may lack the critical thinking skills necessary to assess the credibility of such content. Furthermore, as long as misinformation generates engagement and revenue, platforms have little incentive to remove or ban such users. The same applies to the option

to make spreading misinformation unattractive by not paying the creators, which could eventually stop them from posting this type of content (Karasavva, V., et al., 2025; Knuutila, A., et al., 2022; Poon, C. V., 2024). AI made such beneficial progress with the algorithm (Bowden, O., 2023; Gillespie, T., 2014; Solis, R., et al., 2021), that one could use it to stop the spread of health-related misinformation online. However, the proposed approaches would require social media platforms to prioritize public health over engagement metrics, as such measures may lead to reduced viewership and, consequently, lower profits (Poon, C. V., 2024). Another more realistic way is to increase the minimum age for social media usage from 13 to 16 (Lavaraju, B., & Narasimhan, L., 2024; Livingstone, S., et al., 2011; R&A Therapeutic Partners., 2014). Children should first learn how to deal with the loads of information and differentiate between useful and misleading content before being exposed to it (Knuutila, A., et al., 2022). Additionally, the prefrontal cortex, which is responsible for higher-order cognitive functions such as impulse control, critical thinking, and the ability to evaluate the reliability of information (Frith, C., & Dolan, R., 1996), is not fully developed until the mid-twenties (Kolk, S. M., & Rakic, P., 2021), further supporting the need for a delayed exposure. However, culturally and socially, it is unrealistic to expect individuals to abstain from using social media until this stage of neurological development, given its fundamental role in modern communication and its pervasive presence in contemporary society (Statista, 2025), Therefore, setting the minimum age at 16 represents a more practical compromise, which has been associated with positive effect (Lavaraju, B., & Narasimhan, L., 2024; Livingstone, S., et al., 2011; R&A Therapeutic Partners., 2014). While subjects like “Internet Security and media literacy” had already been implemented in school curricula (MDR.de, 2024, UNSECO, 2024), where young adults learned to navigate the abundance of (mis)information and distinguish between them (Dewak, H., 2023, Pérez-Escoda, A., et al., 2021; Pretorius, C., et al., 2019), these programs did not necessarily cover the critical engagement with unverified information. Introducing or expanding education to specifically promote critical thinking skills for navigating health

misinformation could help reduce the spread of false information (Knuutila, A., et al., 2022; Christner, R. W., 2024). It is important that changes are implemented to ensure that individuals who believe they need help due to a suspected diagnosis realize that there are other contributing factors and explanations that do not require an ADHD assessment. That has the potential to shorten waiting times in diagnostic centers for true ADHD cases as well as benefit therapy sessions. It would also help people with ADHD to feel validated and understood with their diagnosis. At last, it is important to consider that attention problems to a specific amount are normal human behaviors (Poon, C. V., 2024). Studies indicated that TikToks or Instagram reels, due to their short video format (e.g., 15 seconds), contributed to a reduction in users' attention spans, subsequently leading to difficulties in maintaining concentration during longer tasks (Alfatih, M. F., et al., 2024; Hartnett, Y., & Cummings, E., 2024; Opara, E., et al., 2025). This reduction in one's attention span can lead individuals to experience ADHD-like symptoms that are artificially created (Alfatih, M. F., et al., 2024; Opara, E., et al., 2025). Maybe when confronted with these kinds of information, many would understand the difference between artificially created reversible symptoms due to the environment and true ADHD symptoms created by an imbalance in the brain metabolism (Tripp, G., & Wickens, J. R., 2009).

5.3 Limitations

Despite the robust design and careful execution of the study, several limitations must be acknowledged. Other psychological disorders are similar to ADHD symptoms (Abdelnour, E., et al., 2022; Agarwal, R., et al., 2012; Katzman, M. A., et al., 2017) and in order to differentiate between other diagnoses or comorbidities, additional diagnostic questionnaires would have been required; however, these were not included in the survey. This omission occurred because the inclusion of additional questionnaires would have exceeded the scope of a single-author bachelor thesis. Participants were asked whether they had other diagnoses, but no information was collected about the specific type of diagnoses. As a result, it was not possible to determine

whether the symptoms reported on the ASRS were due to ADHD or to another psychological disorder with similar symptoms, e.g., depression. This represents a limitation of my study, as it prevented a clear distinction between the potential sources of the ADHD-like symptoms. Without knowledge of the participants' exact diagnosis, it was difficult to accurately interpret the relationship between ADHD and the symptoms observed, which may have affected the validity of our findings (Abdelnour, E., et al., 2022; Agarwal, R., et al., 2012; Katzman, M. A., et al., 2017). Additionally, the study relied entirely on self-reports, which introduces the risk of response bias and distortion (McDonald, J. D., 2008). Moreover, studies found that ADHD questionnaires can be manipulated when individuals are aware of the assessment's purpose (Edmundson, M., et al., 2017; Fisher, A. B., 2007; Richmond, L. M., 2023). It must be considered that some individuals who had done ADHD or Big Five tests before were familiar with the ASRS or the BFI-S, allowing them to intentionally bias their responses. Furthermore, the sample may have been large enough, but the SDAD group consisted of only five people, increasing the risk of Type II errors (Wolf, E. J., et al., 2013). That was the reason I used the larger self-diagnoses group for the statistical analyses. The homogeneity of the participants (primarily psychology students) may have introduced a bias to our study as well (Peterson, R. A., 2001; Wolf, E. J., et al., 2013). Another limitation is that ADHD patients who were medicated might have reported fewer or less strong symptoms than before, leading to lower ASRS scores (O'Connor, L., et al., 2023). The survey did not include any questions regarding medication use, which may have contributed to an underestimation of symptom severity and therefore inflated effect sizes. Environmental factors, such as distractions and participant stress, could have introduced confounding variables, as it was not possible to control when or the setting and timing of the survey completion (Staal, M. A., 2004).

5.4 Further Research

While a formal diagnostic assessment is essential for confirming ADHD, a qualitative study could provide deeper insights into individuals' personal experiences, beliefs, and reasons for self-diagnosing, and could include a HASE diagnostic (*HASE - Homburger ADHS-Skalen für Erwachsene | Hogrefe*). This approach would allow one to explore how people understand their symptoms, the barriers they face in accessing diagnostic services, and the contexts behind self-diagnosing behaviors. These detailed descriptions could complement standardized diagnostic tools by highlighting real-world complexities that an entirely quantitative assessment might miss. Combining qualitative interviews with standardized diagnostic tools could offer both the clinical rigor and personal context necessary for a more comprehensive understanding of self-diagnosis in ADHD. Furthermore, a self-handicapping questionnaire should be added to the ADHD diagnostic to find out if one could support Bowden (2023). A self-handicapping questionnaire could have also help one to answer the question of whether self-handicapping or neuroticism acts as the mediator for self-diagnosing or which one has a stronger correlation with self-diagnosing. Future research should place greater emphasis on differential diagnostics, since some symptoms from ADHD and depression, autism, etc., overlap fairly strongly (Abdelnour, E., et al., 2022; Agarwal, R., et al., 2012; Katzman, M. A., et al., 2017). One should ensure that the symptoms originate from ADHD and not the other disorders, which diagnostic centers typically verify (*HASE - Homburger ADHS-Skalen für Erwachsene | Hogrefe*). In addition, future samples should include a larger number of participants from the SDAD group to increase the statistical power, potentially uncovering effects masked by individual variability (Wolf, E. J., et al., 2013). If another quantitative study is to be conducted, the questionnaire should be updated to incorporate the recommendations outlined in the limitations section. These approaches, individually or in combination, could significantly advance our understanding of neuroticism,

social media use, and self-diagnosis in relation to ADHD and potentially lead to more robust findings in future studies.

5.5 Conclusion

In conclusion, the findings highlighted the psychological and assumed societal implications of the rising trend in self-diagnosing mental health conditions due to social media platforms. The study was able to confirm that individuals who self-diagnose ADHD generally exhibit lower clinically relevant symptoms compared to those with verified ADHD diagnoses. Furthermore, high neuroticism scores and high social media usage appeared as significant predictors of a more favorable perception of self-diagnosis content and increased probability of self-diagnosing behavior. These findings suggest that self-diagnosis may serve as a coping mechanism, potentially driven by high levels of neuroticism, helping individuals protect their self-esteem or regulate emotional instability. However, due to some methodological limitations, such as the reliance on self-report data and a small SDAD sample, some results should be interpreted with caution. Despite these limitations, the study emphasizes the need for urgent media literacy and critical evaluation of mental health content online. Future research should focus on qualitative studies, the triangle relationship between self-handicapping, self-diagnosis, and neuroticism, and investigating differential diagnoses. Ideally, these implications will help society ensure that legitimate psychological conditions are neither trivialized nor misrepresented in digital spaces.

6 Disclosure statement

Ich habe für die Erstellung meiner Bachelorarbeit

☐ keine KI-basierte Unterstützung verwendet

☒ KI-basierte Unterstützung verwendet. In der folgenden Liste sind alle von mir verwendeten Programme und Apps sowie eine Beschreibung der genauen Verwendung enthalten.

Art des Programms (z.B. Rechtschreibkorrektur, Übersetzungsprogramm, Chat-Bot):

_Rechtschreibekorrektur, Übersetzungsprogramm, Chat-Bot_____

Genauer Name des Programms oder der App (z.B. Grammarly, DeepL, GPT 3.5):

_Grammarly, Scribbr, GPT 3.5, DeepL_____

Verwendung:

_Korrektur von Grammatikfehlern und Übersetzungsfehlern, Formulierungshilfen, Satzbauhilfen_____

Düsseldorf, den 05.06.2025

_____ [redacted]

(Ort, Datum) (Unterschrift)

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8 Appendix

8.1 Figures

8.2 Tables

8.3 Questionnaire

soSci
oFb - der onlineFragebogen

0% ausgefüllt

Herzlich willkommen zu unserem Fragebogen „Beyond the Screen“!

Vielen Dank, dass Sie sich die Zeit nehmen, an dieser Studie im Rahmen meiner Bachelorarbeit teilzunehmen. Der Fragebogen dauert etwa 15 Minuten und behandelt verschiedene Aspekte des Themas.

Ihre ehrlichen und reflektierten Antworten sind entscheidend für den Erfolg dieser Forschung. Es gibt keine richtigen oder falschen Antworten – Ihre persönliche Meinung und Einschätzung stehen im Vordergrund.

Selbstverständlich werden alle Angaben anonym behandelt und ausschließlich zu wissenschaftlichen Zwecken verwendet.

Nochmals vielen Dank für Ihre Unterstützung und Teilnahme!

Weiter

Svenja Helms, Heinrich Heine Universität – 2024

8.3.1 Full Questionnaire without ASRS and BFI-S (found in 8.3.2 and 8.3.3)

17% ausgefüllt

1. Chiffre Erstellung

Bitte geben Sie den
- Ersten Buchstabe Ihres Vornamens,
- Erster Buchstabe Ihres Geburtsmonats,
- die zwei Ziffern Ihres Geburtstages (Tag im Monat),
- Vierte Ziffer Ihres Geburtsjahres,
- Letzte Ziffer Ihrer Postleitzahl ein.

Bsp. Anna, Oktober, 25.10.2004, 40421 = AO2541

2. Welchem Geschlecht gehören Sie an?

[Bitte auswählen]

3. Wie alt sind Sie?

Bitte geben Sie ihr Alter in dem Feld ein.

4. Was ist ihr höchster Bildungsabschluss?

- ◯ Hauptschulabschluss
- ◯ Realschulabschluss
- ◯ Fachhochschulreife
- ◯ Allgemeine Hochschulreife

- ◯ Bachelor
- ◯ Master
- ◯ Promotion
- ◯ Kein Abschluss
- ◯ Anderer

5. Welche Social Media Plattformen nutzen Sie am meisten?

Wählen Sie alle aus die zu treffen

- ☐ TikTok
- ☐ Instagram
- ☐ Snapchat
- ☐ X (ehem. Twitter)
- ☐ Facebook
- ☐ Threads
- ☐ reddit
- ☐ Sonstige
- ☐ Gar keine

6. Wie viele Stunden am Tag nutzen Sie ihre bevorzugte Social Media Plattform?

- ◯ <1Stunde
- ◯ 1h
- ◯ 2h
- ◯ 3h
- ◯ 4h
- ◯ 5h
- ◯ >5h

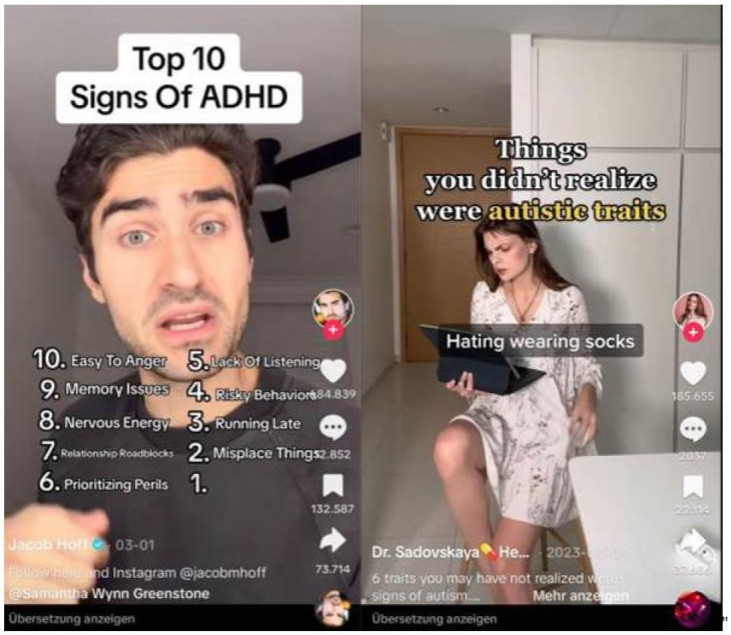
7. Was für Beiträge/ Inhalte werden Ihnen am ehesten vorgeschlagen

Wählen Sie alle aus die zutreffen?

- [ ] Fitness/ Sport
- [ ] Beauty/ Schminke
- [ ] Kochen/ Food/ Restaurants
- [ ] Famous People/ Promi News
- [ ] Politik/ Nachrichten aus aller Welt
- [ ] Tiervideos
- [ ] mental Health/ physical Health
- [ ] Comedy
- [ ] Sonstiges

8. Hatten Sie schon einmal „POV: DU hast Austismus, Borderline,...“ oder " Das sind 5 Anzeichen, dass du Depressionen hast/ schizophren bist/ ...“ Beiträge auf ihrem Feed/ For you page?

- ◯ Ja
- ◯ Nein



alt="Bild einer Frau">

9. Haben Sie sich von solchen Videos schonmal angesprochen gefühlt?

- ◯ Ja
- ◯ Nein

10. Welcher Aussage stimmen Sie am meisten zu? Markieren Sie die Aussage, die für Sie am wichtigsten ist.

- ◯ Solche Beiträge helfen, Bewusstsein für psychische Störungen und die Symptome davon zu schaffen, besonders bei Menschen, die sich sonst nicht informieren würden.
- ◯ Social Media bietet einfachen Zugang zu Informationen, die Menschen möglicherweise helfen, eigene Symptome zu erkennen und sich verstanden zu fühlen.

- ◯ Betroffene finden oft Unterstützung und Gemeinschaft in Online-Foren, was das Gefühl der Isolation mindern kann.
- ◯ Für viele Menschen kann der Kontakt mit solchen Beiträgen ein erster Schritt sein, um professionelle Hilfe zu suchen und eine formale Diagnose zu erhalten.
- ◯ Gefährlich, da die Beiträge dazu führen können, dass Menschen falsche Schlüsse über ihren Zustand ziehen, ohne professionelle Hilfe in Anspruch zu nehmen.
- ◯ Gefährlich, da das Teilen von den Inhalten das Problem banalisieren und den Eindruck erwecken kann, dass psychische Störungen leicht diagnostiziert werden können, ohne die Komplexität der Störungen zu berücksichtigen.
- ◯ Die Identifikation mit einer Diagnose aufgrund von Social Media-Beiträgen könnte dazu führen, dass Menschen Symptome überinterpretieren oder sich selbst in eine Rolle drängen, die nicht zutrifft.

Weiter

67% ausgefüllt

44. Haben Sie das Gefühl, ADHS zu haben?

- ◯ Ja
- ◯ Nein

45. Waren Sie je in einem ADHS Diagnostikzentrum oder bei einer ärztlicher Beratung in Bezug auf eine ADHS Diagnose/ Beratung?

- ◯ Ja
- ◯ Nein

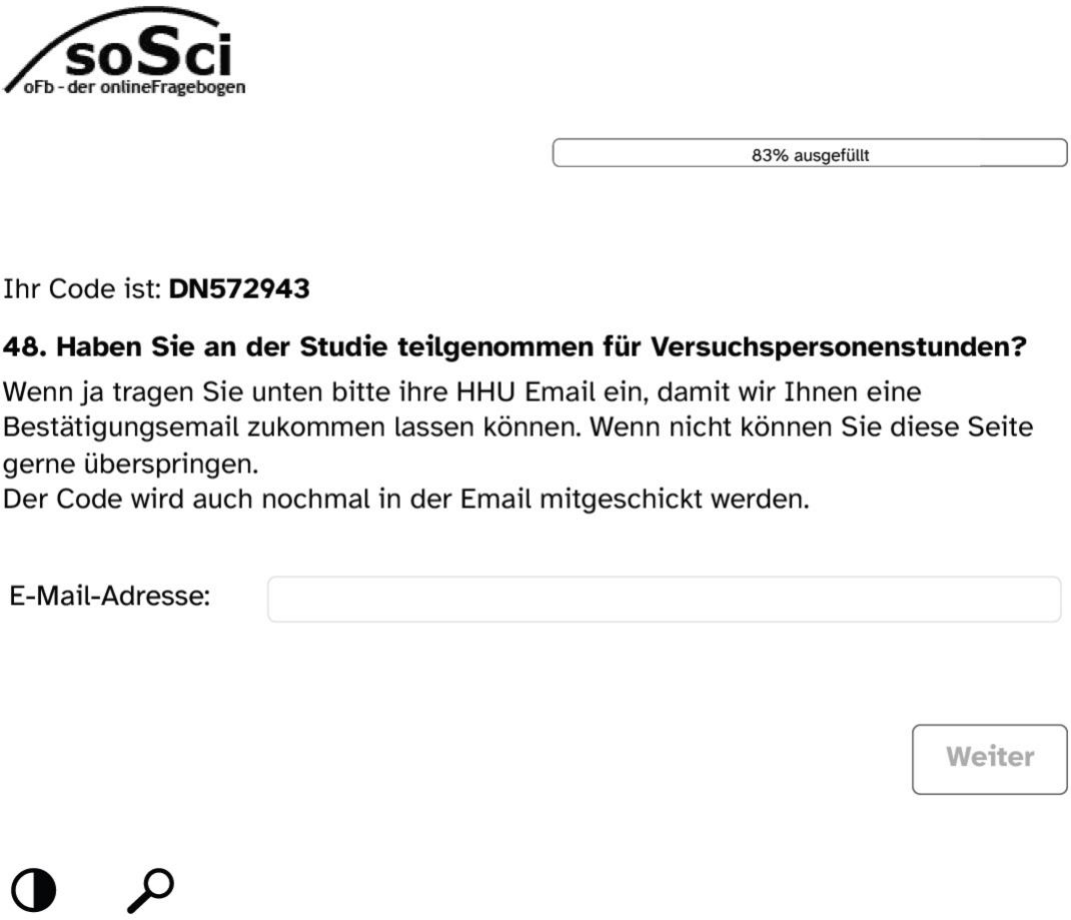
46. Wurde Ihnen die Diagnose ADHS gegeben?

- ◯ Ja
- ◯ Nein

47. Leiden Sie unter einer anderen diagnostizierten psychischen Störung?

- ◯ Ja
- ◯ Nein
- ◯ möchte ich mich nicht zu äußern

Weiter


soSci
oFb - der onlineFragebogen
83% ausgefüllt
Ihr Code ist: DN572943
48. Haben Sie an der Studie teilgenommen für Versuchspersonenstunden?
Wenn ja tragen Sie unten bitte ihre HHU Email ein, damit wir Ihnen eine Bestätigungsemail zukommen lassen können. Wenn nicht können Sie diese Seite gerne überspringen.
Der Code wird auch nochmal in der Email mitgeschickt werden.
E-Mail-Adresse:
Weiter

8.3.2 The ASRS Part A and Part B, as well as the Evaluation

ASRS-5 V1.1 – Teil A
Fragebogen für Patient:innen

Name: _____	**Alter:** _____	**Datum:** _____

Markieren Sie das Kästchen, das am besten beschreibt, wie Sie sich in den letzten 6 Monaten gefühlt und sich benommen haben. Wenn Sie unsicher sind, welche Antwortoption Sie auswählen sollen, kreuzen Sie das an, was am ehesten typisch für Sie ist.

	nie (0)	selten (1)	manch-mal (2)	oft (3)	sehr oft (4)
1. Wie oft haben Sie Schwierigkeiten sich auf das zu konzentrieren, was andere sagen, selbst wenn sie direkt mit Ihnen sprechen?	☐	☐	☐	☐	☐
2. Wie oft verlassen Sie ihren Sitzplatz in Situationen, in denen von Ihnen erwartet wird, dass Sie sitzen bleiben?	☐	☐	☐	☐	☐
3. Wie oft haben Sie Schwierigkeiten zur Ruhe zu kommen und sich zu entspannen, wenn Sie Zeit für sich haben?	☐	☐	☐	☐	☐
4. Wie oft beenden Sie in Unterhaltungen den Satz anderer Personen, bevor diese ihn selbst zu Ende sprechen können?	☐	☐	☐	☐	☐
5. Wie oft verschieben Sie Dinge bis auf die letzte Minute?	☐	☐	☐	☐	☐
6. Wie oft brauchen Sie die Unterstützung anderer, um Struktur in ihren Alltag zu bringen und auf Details zu achten?	☐	☐	☐	☐	☐

Gesamtpunktzahl: ____

ASRS-5 V1.1 – Teil B
Fragebogen für Patient:innen

Name: _____	Alter: _____	Datum: _____

Markieren Sie das Kästchen, das am besten beschreibt, wie Sie sich in den letzten 6 Monaten gefühlt und sich benommen haben. Wenn Sie unsicher sind, welche Antwortoption Sie auswählen sollen, kreuzen Sie das an, was am ehesten typisch für Sie ist.

	nie (0)	selten (1)	manch-mal (2)	oft (3)	sehr oft (4)
7. Wie oft machen Sie Flüchtigkeitsfehler, wenn Sie an einem langweiligen oder schwierigen Projekt arbeiten müssen?	☐	☐	☐	☐	☐
8. Wie oft haben Sie Schwierigkeiten, aufmerksam zu bleiben, wenn Sie langweilige oder sich wiederholende Arbeiten verrichten?	☐	☐	☐	☐	☐
9. Wie oft haben Sie Schwierigkeiten, sich auf das, was man Ihnen sagt, zu konzentrieren, selbst wenn man Sie direkt anspricht?	☐	☐	☐	☐	☐
10. Wie oft verlegen Sie Dinge zuhause oder bei der Arbeit bzw. haben Schwierigkeiten, sie zu finden?	☐	☐	☐	☐	☐
11. Wie oft lassen Sie sich durch Aktivitäten oder Geräusche in Ihrer Umgebung ablenken?	☐	☐	☐	☐	☐
12. Wie oft verlassen Sie Ihren Platz bei Besprechungen oder in anderen Situationen, wo von Ihnen erwartet wird, dass Sie sitzen bleiben?	☐	☐	☐	☐	☐
13. Wie oft sind Sie unruhig oder zappelig?	☐	☐	☐	☐	☐
14. Wie oft haben Sie Schwierigkeiten, abzuschalten und sich zu entspannen, wenn Sie Zeit für sich haben?	☐	☐	☐	☐	☐
15. Wie oft passiert es Ihnen, dass Sie in geselligen Situationen zu viel reden?	☐	☐	☐	☐	☐

16. Wie oft kommt es in einer Unterhaltung vor, dass Sie die Sätze Ihrer Gesprächspartner beenden, bevor diese sie selbst beenden können?	☐	☐	☐	☐	☐
17. Wie oft haben Sie Schwierigkeiten zu warten, bis Sie an der Reihe sind?	☐	☐	☐	☐	☐
18. Wie häufig unterbrechen Sie andere Leute, wenn diese arbeiten oder mit anderen Dingen beschäftigt sind?	☐	☐	☐	☐	☐

Gesamtpunktzahl: ___

Auswertung ADHD – ASRS V1.1
Adult Attention-Deficit/Hyperactivity Disorder Self-Report Screening Scale

Der Fragebogenteil A kann als Screeninginstrument Hinweise für das Vorliegen einer adulten ADHS geben. Die sechs Screeningfragen aus Teil A zeigen sich hoch prädiktiv. Es wird die Anzahl der Kreuze im grau hinterlegten Bereich gezählt. Zudem kann eine Gesamtsumme der einzelnen Items berechnet werden. Dies gilt für beide Teile.

Interpretation:

- Bei Teil A weisen 4 oder mehr Kreuze im grau hinterlegten Bereich bzw. Gesamtpunktzahl Teil A von ≥ 14 auf das Vorliegen einer adulten ADHS hin.
- Der ASRS Teil B kann zusätzliche Informationen liefern eingesetzt werden, der ab einer Gesamtpunktzahl von ≥ 32 als auffällig gilt. Zudem sollte die Anzahl an Kreuzen im grau hinterlegten Bereich berücksichtigt werden.
- Sollten sich beide Teile auffällig zeigen, so ist eine weitere fachärztliche diagnostische Abklärung einzuleiten.

Orginalarbeit: Ustun, B., Adler, L.A., Rudin, C., Faraone, S.V., Spencer, T.J., Berglund, P., Gruber, M.J., Kessler, R.C. (2017). The World Health Organization Adult Attention-Deficit/Hyperactivity Disorder Self-Report Screening Scale for DSM-5. JAMA Psychiatry, 74(5), 520-526. (https://www.ncbi.nlm.nih.gov/pubmed/28384801).

8.3.3 BFI-S Questionnaire

Big Five Inventory-SOEP (BFI-S)

Hier sind unterschiedliche Eigenschaften, die eine Person haben kann. Wahrscheinlich werden einige Eigenschaften auf Sie persönlich voll zutreffen und andere überhaupt nicht. Bei wieder anderen sind Sie vielleicht unentschieden. Antworten Sie bitte anhand der folgenden Skala. Der Wert 1 bedeutet "trifft überhaupt nicht zu". Der Wert 7 bedeutet "trifft voll zu". Mit den Werten zwischen 1 und 7 können Sie Ihre Meinung abstufen

Ich bin jemand, der…

	trifft überhaupt nicht zu						trifft voll zu
gründlich arbeitet.	1	2	3	4	5	6	7
kommunikativ, gesprächig ist.	1	2	3	4	5	6	7
manchmal etwas grob zu anderen ist.	1	2	3	4	5	6	7
originell ist, neue Ideen einbringt.	1	2	3	4	5	6	7
sich oft Sorgen macht.	1	2	3	4	5	6	7
zurückhaltend ist.	1	2	3	4	5	6	7
verzeihen kann.	1	2	3	4	5	6	7
eher faul ist.	1	2	3	4	5	6	7
aus sich herausgehen kann, gesellig ist.	1	2	3	4	5	6	7
künstlerische Erfahrungen schätzt.	1	2	3	4	5	6	7
leicht nervös wird.	1	2	3	4	5	6	7
Aufgaben wirksam und effizient erledigt.	1	2	3	4	5	6	7
rücksichtsvoll und freundlich mit anderen umgeht.	1	2	3	4	5	6	7
eine lebhafte Phantasie, Vorstellungen hat.	1	2	3	4	5	6	7
entspannt ist, mit Stress gut umgehen kann.	1	2	3	4	5	6	7

8.3.4 Flyer of the Study to Promote it