DIY vs. PRO: Unveiling self-labeling, stigma, and attitudes towards help seeking in young adults

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Abstract: With information on mental disorders readily available to young adults, this study delved into the dynamics of self-labeling and help-seeking attitudes. Using a mixed methods approach it examined why some individuals prefer to self-diagnose while others approach mental health professionals to deal with their concerns. The sample comprised 58 self-diagnosed and 45 clinically-diagnosed individuals between the ages of 18 and 30 years. The participants were administered the Self-identification of Mental Illness Scale and the Stigma Scale. Subsequently, interviews were conducted with 20 participants (10 from each group) to assess attitudes towards seeking professional help. Statistical analysis revealed no significant difference in self-labeling tendencies and stigma towards mental illness for the two groups. Thematic analysis of the interviews uncovered an overall positive attitude toward seeking help. The other facets that emerged focused on barriers in accessing help and the impact of self-diagnosis or seeking professional help. Implications are discussed.

Keywords: Self-diagnosis; Professional help; Self-labeling; Stigma; Attitude

In recent years, there has been a notable transformation in the landscape of mental health awareness, characterized by a growing inclination towards self-diagnosis (Oswalt et al., 2018). This is particularly prevalent among young adults who navigate a complex array of emotions and experiences (Mojtabai et al., 2002). Noticeably, there has been an increasing prevalence of serious psychiatric diagnoses among the youth (Moreno et al., 2007), though we know little about how they interpret their concerns or deal with the stigma they encounter (Hinshaw, 2005; Wahl, 2002). Understanding these phenomena is crucial due to the established link between stigma and negative outcomes such as treatment avoidance, under-utilization, and poor adherence (Sirey et al., 2001; Vogel et al., 2007). Self-diagnosis or self-labeling represents a deliberate choice made by an individual (Pillay, 2010). Here the person, without seeking medical consultation, identifies and attributes specific symptoms they have to a particular disease or disorder (Ahmed & Samuel, 2017). The practice of self-diagnosis, although not a recent development, has gained prominence over the years, due to the enhanced accessibility of information on the internet (Avery et al., 2012; Yan & Sengupta, 2013). Engaging in self-diagnosis has the potential to act as a catalyst for de-stigmatizing discussions surrounding mental health. Although it can empower individuals to actively engage in their mental health journey, it concurrently presents the risk of misinterpretation and unwarranted anxiety, emphasizing the need for enhanced mental health literacy. The phenomenon of confirmation bias is relevant in the context of self-diagnosis, as individuals may unconsciously seek information that aligns with their preconceived notions (Schweiger et al., 2014). This bias can impede effective communication with mental health professionals (MHPs) and increase the chances of misdiagnosis and inappropriate treatment choices. Given these risks, most mental health professionals maintain that a clinical diagnosis conducted by a licensed mental health professional such as a psychiatrist or clinical psychologist is imperative. This process incorporates the application of standardized diagnostic criteria and involves an act of categorization, resulting in the assignment of a precise 'diagnostic label' as the ultimate outcome.

Factors underlying self-diagnosis

Recognizing one's symptoms as potential indicators of mental illness represents a crucial initial step towards seeking professional help. Thoits' model (1985) rooted

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in labeling theory suggests that individuals may engage in self-labeling by observing their own behaviors, thoughts, and feelings, which can motivate help-seeking behavior. Help seeking behavior includes an individual's disposition, beliefs, and perceptions regarding the acceptability, desirability, and efficacy of reaching out for professional assistance to address mental health concerns. It encompasses one's willingness, openness, and comfort level in seeking help (Picco et al., 2016). The attitude towards help seeking among young adults is shaped by evolving societal perceptions and increased awareness (Lipson et al., 2019). Today the youth in urban areas, exhibits a growing recognition of mental health issues, reflecting a positive shift in attitudes towards seeking help (Rickwood et al., 2007). An increasing number of young individuals are acknowledging the importance of addressing psychological well-being. This evolving mindset is fostering a more proactive approach, creating the foundation for improved mental health outcomes and resilience (Milin et al., 2016).

However, some young adults may still be hesitant to approach professionals due to fears of being labeled and subsequently stigmatized (Yeh et al., 2003). The process of being assigned a label can have various kinds of impacts on a person. How a label is perceived is dependent on numerous internal (medical history, age, sex, culture) and external (service availability, country) factors, and differs by perspective (Coggon et al., 2003). Nevertheless, labels tend to have the ability to activate stereotypes and negative behaviors towards those perceived to be part of a uniform, undesirable group, a phenomenon termed 'public-stigma' (Corrigan & Watson, 2002; Link & Phelan, 2001). Young people are particularly susceptible to stigmatizing labels due to youth being a time of identity consolidation characterized by a compelling need for competence, social acceptance, and autonomy (Wisdom et al., 2006). Stigma is a symbolic indication signifying to others that an individual possesses a quality diminishing them from a state of being perceived as "whole and normal" to one of being considered "tainted and devalued" (Goffman, 1963). Stigma is an established barrier to help-seeking for mental illness (Clement et al., 2014; Eisenberg et al., 2009). It impacts the willingness to seek help (Mojtabai et al., 2002) and even seeking information about mental health and counseling (Lannin et al., 2016). Additionally, a psychiatric label can give rise to self-stigma, indicating the shame and self-directed prejudice experienced by the 'marked' individual, who internalizes negative stereotypes (Corrigan, 2007). Self-stigma is prevalent among those with mental illness, where individuals internalize societal stereotypes and integrate them into their self-perception. This process, known as self-concurrence, results in a decline in self-esteem as negative beliefs about oneself become entrenched (Werner, Aviv & Barak, 2008). A correlation between self-stigma and reduced self-esteem, social isolation, and reluctance to seek help is highly evident. (Corrigan, Watson, & Barr, 2006; Link & Phelan; 2001). Here it must be mentioned that there are some individuals who do not endorse or accept for themselves the negative stereotypes associated with mental illness (Camp et al., 2002; Moses, 2009). Labels can also yield positive effects, partially counteracting the stigmatizing and demoralizing impact. Certain psychiatric patients express relief in having a label that can capture their psychological symptoms, validate their experiences, and provide guidance on what to expect and how to cope (Hayne, 2003; Karp, 1996). Recognizing and accepting a mental health problem for many is a dynamic and protracted process that may not neatly align with the formal diagnosis process (Aneshensel et al., 2012).

The dynamics of self-labeling and attitudes toward seeking help exhibit variability across cultures, influenced by distinct societal norms and beliefs. There remains a noticeable gap in literature concerning these variables within the Indian context, particularly among the young adult population. This study endeavors to address this gap by exploring self-labeling tendencies, conceptions around stigmatization and attitudes towards professional help seeking among self-diagnosed and clinically diagnosed young adults in India. The research delves into the stigma surrounding labels acquired through formal or informal diagnostic processes and examines how attitudes toward seeking professional help are framed.

Method

The following hypotheses were developed for the present study:

H1: Individuals who are self-diagnosed will

demonstrate significantly higher self-labeling tendencies than those who have sought clinical diagnosis.

H2: Individuals who are self-diagnosed will demonstrate significantly higher stigma towards mental illness than those who have sought clinical diagnosis.

Sample

The sample comprised 103 individuals, between the ages of 18 and 25 years, divided into two groups based on their approach to diagnosing their mental health conditions. Within the sample, 58 (56.31%) participants had self-diagnosed, while 45 (43.68%) had sought and received a clinical diagnosis. Further, utilizing convenience sampling, 10 participants from each group were selected for in-depth interviews. In the self-diagnosed group, the highest number of participants (43.10%) reported anxiety-related issues. In the clinically diagnosed group, the highest number of participants (55.56%) experienced a comorbidity of anxiety and depression. Approximately 49.01% of the participants resided in Tier 1 cities and the remaining participants were from Tier 2 and Tier 3 cities.

Tools

The study utilized the Self-Identification as Having a Mental Illness Scale (SELF-I), the Stigma Scale, and an interview as its tools. The scales and interview were both administered online.

Self-Identification as having a mental illness scale (SELF-I). The 5-item scale developed by Schomerus et al. (2012) was used to assess subjective perceptions of one's own identity in relation to mental illness (Stolzenburg et al., 2017). Items are answered on a 5-point Likert scale and reverse coded when necessary. SELF-I has acceptable levels of test-retest reliability and internal consistency (Cronbach's α = .85 to .87) in untreated individuals with mental health problems (Schomerus et al., 2019). Construct, criterion and discriminant validity for the tool have also been established (Schomerus et al., 2019).

The Stigma Scale. This is a 28-item measure with 5-point Likert-type response format developed by King et al. (2007) used to measure the construct of stigma. It is composed of 3 sub-scales (viz. discrimination, disclosure, and positive aspects), of which nine items are reverse coded. Cronbach's α for the stigma scale is 0.87 (King et al., 2007).

The interview

For the clinically diagnosed group, the interview schedule explored several key domains: the onset and personal understanding of their mental health concern, the journey and experiences in seeking professional help, insights into the treatment process and its implications, and the impact of treatment on their personal lives as well as attitudes towards receiving help. For the self-diagnosed participants, the schedule focused on the onset and personal understanding of their mental health issues, the process and experiences related to self-diagnosis, and the overall impact of self-diagnosis. These domains were identified and refined through an exhaustive review of relevant literature. English and Hindi versions of the schedule were devised and pilot-tested before use.

Data Analysis

To ascertain the differences in stigma levels, as well as self-labeling tendencies between the self-diagnosed and clinically diagnosed groups, an independent t-test was conducted employing the IBM Statistical Package for the Social Sciences (SPSS), Version 20 for Windows. The interview data was transcribed and analyzed using the six-phase thematic analysis framework as outlined by Braun and Clarke (2006). This comprehensive methodological approach encompasses the following phases: (a) Familiarization with the data (b) Generation of initial codes (c) Searching for themes (d) Reviewing themes (e) Defining and naming themes (f) Producing the report. The analytic process was grounded in the data itself, rather than conforming to predetermined categories or theoretical frameworks.

Results

The results indicated that there were no significant differences between both groups with respect to self-labeling. Thus, the first hypothesis for the study was rejected (Table 1).

Table 1

Comparison of groups on Self-Labeling

Diagnosis	N	Mean (SD)	t -value (df)	p-value
Self	58	14.67 (2.19)	0.877 (101)	0.191
Clinical	45	14.31 (1.90)		

There were no differences found for stigma across both the groups, leading to the rejection of the second hypothesis (Table 2).

Table 2

Comparison of groups on level of Stigma

Diagnosis	N	Mean (SD)	t -value (df)	p-value
Self	58	49.26 (15.18)	-1.57 (101)	0.059
Clinical	45	53.96 (14.96)		

Thematic Analysis Results

There were five broad themes that came to light after the thematic analysis of the interviews.

Theme 1. Process of Self-Labeling

The Self-Diagnosed group. All the individuals who self-diagnosed made use of information on websites or employed online assessments. One participant expressed her route of diagnosing herself as follows- *"Psychological tests that there are on the internet, I took like a million of those tests to just confirm that maybe I- I may be going through something bad."* Additional routes to diagnosis were relating one's symptoms to others who received a diagnosis and learning about symptoms in psychology classes attended in college. The interviews highlighted some risks of engaging in soliciting information through the internet. A participant reported that she had body image issues and thus, was fascinated to see a woman suffering from anorexia losing weight so quickly. Therefore, she hoped to have the same disorder. *"It's a girl talking about an eating disorder and how they've lost so much weight drastically day after day suffering from an eating disorder. So, I thought it would be good if I had that disorder…I wanted to have an eating disorder because I wanted to lose weight."*

Clinically Diagnosed group. In this group it was found that people chose to deal with some problems on their own and for others, they added the element of professional help. One person said *"Although have received a clinical diagnosis for depression and anxiety; eating disorder has been self-diagnosed since I felt the prior two were more serious. And thought I could manage eating disorder by myself."* Lack of proper psycho-education from the professional led participants to resort to online websites to address their queries. A participant explained with regard to the medicine prescribed to her *"she did not tell me but I was very curious about it. I was going to take something that would change certain stuff in my brain. So I googled up everything, every side effect possible."* In addition, participants had used their prior exposure to psychology and read websites to understand their condition better.

Theme 2. Impact of the approach chosen for diagnosis

The Self-Diagnosed group. The positive impacts of self-labeling were found to revolve around increased self-awareness and accurate labeling of symptoms and

experiences. The accuracy in identification contributed to a better understanding of one's conditions and reduced self-blame. A participant said *"stuff which made me blame myself earlier...like why I'm so weak or like, I can't even do this thing... has obviously reduced quite a bit because I know that it's not like weakness but rather anxiety."* The process of self-diagnosis fostered a balanced perception of personal strengths and weaknesses. A participant who self-diagnosed with anxiety described this shift, stating, *"surprisingly this diagnosis has made me think of myself from a pretty weak to somewhat strong person."* This reevaluation led to a kinder self-view, enabling individuals to *"cut some slack"* for themselves. This gentler self-assessment was coupled with the acquisition of effective coping strategies, as one participant explained: *"it has the pros because I learnt something new about my body and myself. I understand that you know, some things are to be dealt with more delicately."* Additionally, self-diagnosis appeared to alter participants' perceptions of others. One participant observed a newfound empathy and patience in their interactions: *"if somebody out of the blue is being a little rude to me... I would take a moment and think that ...okay, something must have happened with them so I should deal with it more delicately"*

However, some participants experienced negative repercussions, such as increased self-pity and overreaction, attributed to the knowledge of their conditions, as one explained: *"I started self-pitying and started overreacting to things, because of the knowledge of being, anxious, or being depressed."* For some participants, self-diagnosis of anxiety lead to diminished efforts in facing challenges *"earlier I was very anxious but, I didn't know I had anxiety. So I would still try to like force myself a lot to do these things. But ever since I've like diagnosed myself, I like play it off as because I have anxiety so I can't really do anything about it."*

Clinically Diagnosed group. One significant positive impact of approaching mental health professionals was the role of diagnosis in facilitating acceptance and understanding of one's mental health challenges. Many participants expressed gratitude for the assistance provided by MHPs. For instance, one participant's interaction with her college counselor marked the beginning of her journey toward acceptance and seeking therapy ahead. *"I reached out to my college counselor and then I discussed things with her as to how to navigate through this"* Participants also emphasized the progress and personal growth following their diagnosis and engagement with MHPs. Through therapy and psychiatric visits, individuals reported gaining insights into their thoughts and behaviors, fostering a deeper understanding of themselves. One participant said, *"I'm taking therapy and I'm consulting a psychiatrist from my hometown. And both are extremely good. They diagnosed me further with rapid cycling bipolar disorder. And based on that they changed my medication and I have been doing really well since then".* Furthermore, participants described significant changes in their self-perception and coping strategies post-diagnosis. Changes in self-management and increased awareness about the mental health severity around themselves were also evident. *"Now I think I have answers to a lot of my questions and I understand people's situations better"* Engagement with MHPs contributed to enhancing confidence and improving emotional regulation. Therapy sessions helped them gain confidence and manage their emotions more effectively in various situations. On the other hand, the lack of a personalized treatment approach and prescription of heavy medications without considering lifestyle or potential side effects led to uncertainty and fear about continuing seeking help. One participant explained *"I knew that if I go back to a psychiatrist or at least the same psychiatrist, I know I will mess up my entire career because of the medications."* Additionally, participants shared instances of receiving incorrect diagnoses or inadequate assessment processes and reliance on parental input without thorough questioning which were cited as contributing factors to misdiagnosis. *"My first psychiatrist didn't diagnose me properly. He just said that I might have panic disorder; whereas later it turned out to be BPD. I wasn't questioned properly. All the questions were asked to my parents. And my parents didn't know me."* Participants expressed dissatisfaction with treatment approaches that were imposed without regard for their preferences and needs which resulted in feelings of discontent.

Theme 3. Outlook towards the approach opted

Self-diagnosed group. Participants who self-diagnosed acknowledged both the advantages and shortcomings of it. Self-diagnosis was also deemed essential for those lacking resources, aiding in clarity and identifying root issues: *"self-diagnosis is really essential for people who don't*

have the means. I feel like it takes away a lot of like confusion and, doubt about yourself. And it can actually make you aware of things that's causing your problems. It's not you, it's your illness." Yet the process of self-diagnosis seemed to stand in a *"grey area"* as acknowledged by many. *"Google kuch bhi dikha deta hai, ek choti si cheez ko cancer bata deta hai."* Participants also highlighted that self-diagnosis might not work for everyone.The shortcomings of self-diagnosis included risks (of not getting proper treatment) or having self-doubt that *"Sometimes you do end up doubting yourself like am I just making it up in my head because I read about it"*. Additionally, one participant highlighted how social media has made the process of self-diagnosing worse by taking away the seriousness of it as everyone on the internet is 'suffering' from a mental disorder: *"You see people online being like, 'oh, I have autism. And like I have ADHD but…Do I have an ADHD quiz?' does not really equate as diagnosis."*

Clinically Diagnosed group. Despite recognizing the necessity of seeking professional help, the participants said they often encountered resistance and disbelief from family members, as evidenced by accounts of familial dismissal of their mental health struggles as mere phases. *"I pushed them to visit a psychiatrist. But still, there was a restriction from my father and my father still believes that bipolar disorder is nothing and it is just a phase"*. Moreover, they grappled with the fear of judgment and sometimes had to hide the fact that they were seeing a professional. A participant mentioned, *"But some part of me could not really get to tell her(mother) that I am, you know, seeking out therapy."* Another issue was the difficulty in finding the right therapist. As one person said, *"you know you'd gonna meet to a bunch of shitty therapists before you find the one for you."* However, amid these challenges, almost all participants also exhibited resilience and determination in seeking professional help and pursuing treatment. Despite facing societal and familial resistance, many participants acknowledge the necessity of therapy and medication in managing their mental health conditions. Additionally, some highlighted the importance of early intervention by MHPs, recognizing the potential benefits of timely and expert intervention in mitigating the adverse effects of mental health disorders.

Theme 4. Barriers to seeking help

Self-Diagnosed Group. The fear of others finding out, along with factors like unaffordability, uncertainty about reaching out, and lack of support acted as major barriers to seeking professional help for self-diagnosed participants. Another significant barrier identified was the invalidating of issues, where participants perceived their mental health concerns as insufficiently severe to warrant professional intervention. *"Its not that much that help would be needed"*. Parental attitude also emerged as a critical factor, with mental health-related stigma within families inhibiting help-seeking. *"My father doesn't really believe, thinks that therapy is for the weak minded."* Negative experiences with MHPs also deterred individuals from seeking further help. A participant shared, *"I would have considered college counsellor but then one of my friends with depression told me that her experience with the counsellor was really horrible."* Finally, some individuals found it difficult to foster a positive change for themselves and thus remained stuck in old patterns. A participant said, *"it feels like sometimes you just don't want to be better. Like you feel like hiding behind your illness and you feel like, oh, I'm anxious, so I have free time, like not doing stuff that others do."*

Clinically Diagnosed Group. Finances came as a barrier to seeking help in both groups. For those who had sought treatment in the past, the costs involved made it difficult for them to continue the treatment. Lack of adequate resources further exacerbated this issue, as individuals faced limited options for accessing affordable or subsidized mental health services. Additionally, at times the absence of support from friends, emerged as a barrier, leaving individuals feeling isolated and unsupported in their efforts to seek or continue treatment.

Theme 5. Attitude towards Professional Help

Self-diagnosed group. Individuals predominantly exhibited positive attitudes towards MHPs, emphasizing a sophisticated understanding of therapy's benefits. Trust in MHPs was clearly evident amongst self-diagnosed participants, as they believe experts can efficiently address their issues. Some participants expressed regret about not seeking professional help sooner, highlighting the importance of early intervention by MHPs. "*I would have been better*

off with professional help from the start." Many acknowledged the limitations inherent in self-diagnosis. However, various barriers hindered their access to help, including financial constraints, unsupportive familial contexts, and a lack of awareness regarding available resources. Reluctance and hesitation towards medication were highlighted by concerns about potential side effects and changes induced by medication. *"I've heard things about medication, bringing people down in different ways. And it feels very overwhelming."* Misconceptions and skepticism also surfaced in a participants' statement *"I feel that sometimes I can also read minds and what is the work of psychiatry...that is reading your mind."* Some expressed doubts about finding someone who understands the gravity of their issues. The notion that there is no one *"good enough"* to comprehend or help (9.72% of the total participants) *"they are not intelligent enough to actually be able to understand what I'm trying to push through."*

Clinically Diagnosed group. Participants presented a multifaceted perspective on MHPs. On the positive side, there was a strong endorsement of therapy as an effective tool, with participants willing to recommend it to others. This reflected a belief in the potential benefits of therapy and a compassionate approach towards helping others access mental health support. A cautious approach to therapy selection was acknowledged, emphasizing the trial-and-error process in finding the right therapist. *"it's always hit and trial until you find someone who gets you... that would work out best for you"*. Moreover, the act of sponsoring therapy for others, as mentioned by one participant, illustrated a sense of social responsibility and a desire to contribute positively to mental health enhancement.

Discussion

The findings of the study reveal important aspects of self-diagnosing practices as well as the choice of approaching MHPs. Although to start with the study focused on the differences that could emerge between both groups, several similarities were encountered. Both groups were inclined towards a tendency of self-diagnosis to a similar extent as well as have shown similar levels of stigma. Some of the similarities discovered in the interviews were that all the participants used some information on the internet to understand their conditions better and they all recognized the benefits of consulting mental health professionals. Financial constraints and a lack of mental health resources, also emerged as common barriers to seeking help, along with the prevalent stigma surrounding mental health among family and friends. Another similarity between the groups was the negative experiences they had with MHPs. Despite these shared challenges, a positive attitude towards seeking help was exhibited by both the groups.

The results carry the implication of there being the need to create higher levels of mental health literacy and improving some of the practices followed by professionals in the country when they are approached by young people for assistance. The term 'mental health literacy' was first introduced in 1997, and it was defined as 'knowledge and beliefs about mental disorders which aid their recognition, management or prevention' (Jorm et al., 1997). It is composed of several components, including (a) the ability to recognize specific disorders of types of psychological distress; (b) knowledge and beliefs about risk factors and causes; (c) knowledge and beliefs about self-help interventions; (d) knowledge and beliefs about professional help available; (e) attitudes which facilitate recognition and appropriate help-seeking; and (f) knowledge of how to seek mental health information. Not only is this literacy important at the individual level, it is also important at the family and community level. This is because participants in both groups spoke of how familial attitudes and the fear of how they would be perceived by others were barriers to seeking therapy. Fear of labels or anticipation of stigma is a common barrier to adolescents' help-seeking and mental health (MH) service utilization (Moses, 2009; Boldero & Fallon, 1995; Yeh et al., 2003). These diverse barriers collectively highlight the complex interplay of personal, familial, societal, and systemic factors that influence young adult's decisions regarding professional help-seeking. Diagnostic labels given by clinicians provide a convenient means for describing patients that includes the presentation of symptoms and may imply the expected course and prognosis. Despite the benefits of diagnostic labels, they often serve as cues to signal stereotypes (Garand, 2010) and these need to be checked. Regarding the improvement in services, it is important for therapists to clarify the effects of medication to their patients and explain their condition to them. Research by Olfson et al. (2016)

emphasizes the importance of considering individual factors and potential side effects when prescribing psychiatric medications as one prominent issue highlighted by clinically diagnosed individuals is the challenges associated with medication. There is also the need for more affordable therapy and treatment options. Financial aspects as indicated by Kaur et al. (2023), are a formidable obstacle in accessing mental health care, particularly in contexts like India where resources may be limited. According to the Indian Council for Market Research (2009), the lack of resources and resistance to online therapy is another barrier as many districts in India do not have a minimum number of trained MHPs in primary and secondary care settings and discomfort with online therapy options acts as a significant barrier for both groups in less urbanized areas.

The pitfalls of self-diagnosis have to be communicated to young people who may be engaging in this practice and thus may be facing some risks. Research has shown that credibility of websites is less important for users in practice as they largely ignore the source of their medical information (Eysenbach & Köhler, 2002) with treatment avoidance being a real risk associated with online help-seeking (Pretorius et al., 2019). Content exists online that can be stigmatizing, triggering, or that may reinforce harmful behaviors and thoughts (Bell et al., 2018; Frost et al., 2016). This risk is exacerbated as young people may incorrectly attribute certain sources as helpful when in fact, they are dangerous (Best et al., 2016; Horgan & Sweeney, 2010). Research indicates that while online help-seeking seems to act as a gateway behavior to further help-seeking (Pretorius et al., 2019; Best et al., 2016; Collin et al., 2011), it also harbors risks like misinformation, delayed treatment, low-efficacy, or dangerous self-treatment through recreational drugs (Charlton, 2005).

Limitations & Future Implications

The study findings must be considered within the confines of certain limitations. Potential response bias may have impacted the sample representativeness, given the inherent differences in attitudes towards mental health between participants who volunteered to participate in this study compared to those who declined. Social desirability bias in self-report measures could have influenced outcomes. Sampling bias from convenience-based methods might restrict generalizability. Moreover, the study lacked a comprehensive examination of a disorder's impact on self-labeling tendencies, neglecting symptom severity and duration. Moving forward, the study underscores critical implications. While participants exhibited positive attitudes towards MHPs, structural barriers such as affordability and accessibility, alongside negative encounters with professionals, impeded help-seeking behaviors. Hence, interventions are warranted to enhance accessibility and affordability of mental health services, coupled with ensuring comprehensive training and licensing for professionals. Additionally, addressing mental health stigma and stereotypes among family and friends is imperative, as their negative attitudes and lack of support deter individuals from seeking or continuing treatment.

Conclusion

The present study explored the self-labeling tendencies, stigma and attitude towards help seeking in self-diagnosed and clinically diagnosed young adults. The quantitative results revealed that both groups engage in self-labeling and have no significant differences with respect to stigma. The thematic analysis of the interviews revealed critical insights into the processes and implications of self-diagnosis versus clinical diagnosis in the context of mental health challenges among young adults. The identified themes shed light on the multifaceted nature of individuals' experiences, ranging from the pathways to diagnosis, the impact of the chosen approach, barriers to seeking help, and attitudes toward professional assistance. In light of these findings, it is evident that a comprehensive approach to mental health care is imperative, one that integrates both mental health literacy and improved professional guidance. By addressing the identified barriers and promoting a collaborative model of care, stakeholders can better support young adults in navigating their mental health journeys and fostering resilience and well-being.

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