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Establishing the Accuracy of Self-diagnosis in Psychiatry

Abstract:

Self-diagnosis in psychiatry is where individuals diagnose themselves rather than rely upon official diagnosticians to supply a psychiatric diagnosis. The accuracy of self-diagnosis is a contested topic. In this paper I outline what arguments are needed to see self-diagnosis as accurate and how different approaches to self-diagnosis require different arguments. I show how different arguments are required to justify accuracy for an autistic individual judging they are autistic compared to non-autistic individuals judging they are not autistic. Different arguments are required if a self-diagnosing individual accepts or rejects official diagnostic criteria. Finally, different arguments are required depending upon if diagnoses are seen as objective entities, the product of theoretical virtues or practically useful groupings. All these approaches require unique arguments to justify the accuracy of self-diagnosis. Identifying the required arguments for different approaches is a stepping stone towards establishing whether those arguments, and which of those arguments, can be successfully justified.

Keywords:

Self-diagnosis; Autism; Accuracy; Psychiatric Diagnoses; Philosophy of Psychiatry

1. Introduction

“Autistics know autism better than anybody else” (Enright 2021). This quote comes from a blog post by a self-diagnosed autistic individual. They use the notion that autistic people know autism best to justify self-diagnosis. In this article I consider what arguments are needed to understand the claim that 'autistic individuals know autism best' as entailing that self-diagnosis has high accuracy.

Self-diagnosis in psychiatry is where individuals diagnose themselves rather than rely upon official diagnosticians to supply a psychiatric diagnosis. The legitimacy of self-diagnosis has been supported and challenged by individuals who have been diagnosed by official diagnosticians. For example, in relation to autism, the “subject of self-diagnosis is a perennial one here [an internet forum for autistic individuals] and generally causes heated discussion” (unnamed autistic individual quoted in Sarrett 2016, p.27) and “[w]hether one can self-identify as autistic is a fierce topic of debate... within the autistic community” (Hens, Robeyns & Schaubroeck 2018, p.3). One debated issue is the degree someone can accurately establish they are or are not an instance of a particular diagnosis, such as whether they are or are not autistic. In this article I investigate what needs be established for self-diagnosis to be accurate.

I focus upon establishing what arguments are needed to take self-diagnosis as accurate. Very little philosophical work has been done on the accuracy of self-diagnosis so my aim is to establish which arguments advocates of self-diagnosis need justify and which arguments opponents of self-diagnosis need refute. Additionally, I outline four different approaches to justifying the accuracy of self-diagnosis and each approach justifies the accuracy of self-diagnosis on different grounds. This will help prevent advocates of self-diagnosis formulating an argument which is required for one approach and using it to justify a different approach to

self-diagnosis. Similarly, it will help prevent opponents of self-diagnosis countering arguments used to justify one approach to self-diagnosis and then taking this as impacting other approaches to self-diagnosis. I will outline how there are multiple steps to justifying each of the different approaches. Some of those steps are applicable to more than one approach, but each approach also requires specific arguments that are not applicable to other approaches. Therefore, good arguments for one approach would not then justify one of the other approaches.

There are three areas I will not analyse in this article. Firstly, having established what arguments are required to see self-diagnosis as accurate I will not then assess the prospects for supplying those arguments. I identify four different approaches to seeing self-diagnosis as accurate and detailed analysis is needed to show that different arguments are required to justify each approach. Secondly, I will not consider whether self-diagnosis is legitimate even if self-diagnosis is inaccurate. There might be good reason for thinking self-diagnosis is justified even if a significant minority or a majority of self-diagnosing individuals inaccurately self-diagnose but I shall not investigate this possibility. Thirdly, even if self-diagnosis is accurate separate ethical arguments are needed to claim self-diagnosis is justified. I will assume individuals have an ethical right to self-diagnose if they cannot access an official diagnosis or if official diagnosticians will not accurately diagnose them. This seems to mirror most arguments about self-diagnosis whereby the ethical principle is rarely challenged and the debate focuses upon accuracy.

2. Terminology

I have seen a variety of terminology used when self-diagnosis is being discussed. Terminology includes the reliability, the validity and the accuracy of self-diagnosis. I avoid the terms reliability and validity because they have technical meanings in psychiatry which are not fully applicable to self-diagnosis.

Reliability relates to the agreement between multiple clinicians about which diagnostic criteria is being met by a particular individual (Aragona, 2015; Spitzer, Endicott & Robins, 1978). In contrast self-diagnosis typically relates only to one person, the self-diagnosing individual. As such, reliability in the technical psychiatric sense does not seem applicable to self-diagnosis because there is no issue of agreement between multiple individuals. We could extend notions of reliability to include the self-diagnosing individual and ask what level of agreement there is between the self-diagnosing individual and official diagnosticians. This, however, would be hypothetical since most self-diagnosing individuals never get an official assessment. We could run a hypothetical thought experiment by considering the likely agreement between the self-diagnosing individual and official diagnosticians . However, people often self-diagnose because they expect official diagnosticians to not diagnose them. This suggests the level of agreement will be low and so, on this technical meaning, self-diagnosis would have low reliability.

Validity also has a technical usage in psychiatry. At most basic, validity relates to correlations whereby people with a psychiatric diagnosis can be correlated with other factors such as long term outcome and genetics (Solomon, 2022; Robins & Guze, 1970). Additionally, some take sufficiently high correlations as indicating the reality of the diagnosis or that the diagnosis is biomedical entity (Kendell & Jablensky, 2003; Pies, 2008). Whether this is or is not a good way to understand psychiatric diagnoses depends upon what we take psychiatric diagnoses to be (an issue I have discussed elsewhere (Fellowes, 2022)). However,

I will later outline ways in which self-diagnosing individuals can reject current DSM criteria and instead self-diagnose on alternative criteria without aiming to justify this on appeal to correlations, reality or biomedical entities.

As such, the technical meaning of reliability and validity in psychiatry does not map well onto questions of whether self-diagnosis is accurate. Instead, I will talk of the accuracy of self-diagnosis. I understand accuracy in the following two senses. Firstly, if the DSM criteria of autism is accepted then can the self-diagnosing individual accurately establish if they do or do not meet the diagnostic criteria? Secondly, if the DSM criteria is taken as not accurately describing autism then can a self-diagnosing individual produce a more accurate description of autism when self-diagnosing?

3. Arguments For and Against the Legitimacy of Self-diagnosis

The basic idea of self-diagnosis is that an individual relies upon their own judgment about whether they have a particular diagnosis rather than rely upon the views of designated medical professionals. The person who receives the diagnosis is also the person who makes the diagnosis. This contrasts with official diagnosis whereby a medical community designates official diagnosticians to provide official diagnoses. An official diagnosis is placed on a medical record and is typically required to access support services and receive state benefits.

The phrase self-diagnosis is potentially misleading. Firstly, the self-diagnosing individual may consult other individuals during the process of self-diagnosing, such as friends, family, online communities or even medical professionals. The key point is that a self-diagnosing individual does not hold an assessment with official diagnosticians or the self-

diagnosing individual rejects the views of official diagnosticians if they are assessed. Secondly, self-diagnosing should be seen as distinct from suspicion of diagnosis. Many people who are waiting for an official diagnosis will tentatively or strongly suspect they meet the diagnostic criteria prior to an official assessment. For my purposes when I refer to self-diagnosis I mean an individual who is not currently waiting for an official diagnosis.

I shall explore self-diagnosis through considering self-diagnosis in autism. Self-diagnosis seems quite a restricted phenomenon, primarily occurring in relation to a small number of diagnoses. For example, Sarrett notes that self-diagnosis seems to be "relatively unique to autism within... psychiatric, developmental, and intellectual disabilities" (Sarrett 2016, p.26). For empirical evidence of this claim, Sarrett consulted one internet forum which is intended for autistic individuals and another internet forum which is intended for schizophrenic individuals. She found regular discussions of self-diagnosis on the forum for autistic individuals whereas on the forum for schizophrenic individuals she found "self-diagnosis not to be an issue" (2016, p.26). Additionally, to my knowledge more academic studies have been done on autism compared to other diagnoses. As such, there is a stronger evidence basis when discussing autism compared to any other diagnosis (see however, Chan & Sireling 2010 and Giles & Newbold 2010 in relation to bipolar disorder). It is certainly possible that self-diagnosis is more common in other diagnoses than is represented by empirical literature. I see no reason why my argument will not be applicable beyond autism but I cannot rule out the possibility that focusing upon autism will mean some parts of my argument cannot be generalised to other diagnoses.

Despite having a stronger evidence basis than other diagnoses there are still relatively few studies on self-diagnosis of autism. McDonald writes that, "[l]ittle is currently known about this self-diagnosed group of [autistic] individuals" (McDonald 2020, p.15). To my

knowledge, there are two empirical studies which focus entirely (Lewis 2016; Sarrett 2016) or significantly (Lewis 2017; McDonald 2020) upon self-diagnosis of autism. As such, I have limited empirical data on the motives for self-diagnosing.

There are three main strands to justifying self-diagnosis. Firstly, an official diagnosis is inaccessible. Secondly, being diagnosed can be harmful or not helpful. Thirdly, that the official diagnostic process is inaccurate whereas self-diagnosis is accurate.

In relation to inaccessibility, there can be long waiting times to see official diagnosticians (McDonald 2020, p.15; Lewis 2016; Lewis 2017, p.578; Sarrett 2016, p.31). Seeing official diagnosticians can sometimes have a substantial financial cost (McDonald 2020, p.15; Lewis 2016; Lewis 2017, p.578; Sarrett 2016, p.31). Finally, some individuals struggle to navigate the healthcare system (Lewis 2016).

In relation to diagnosis being harmful or not helpful, some individuals (often based upon past experience) believe that medical professionals may harm them (Lewis 2016; Lewis 2017, p.578). There is concern that being diagnosed as autistic could harm future employment prospects (Lewis 2016; Lewis 2017, p.578; Sarrett 2016, p.31). Finally, the lack of available support services raises questions about whether it is worth actually getting officially diagnosed (Lewis 2016; Lewis 2017, p.578).

In relation to the diagnostic process being inaccurate, there is concern that official diagnosticians will mistakenly claim the individual does not meet the diagnostic criteria of autism (Lewis 2016; Lewis 2017, p.578). The danger is that official diagnosticians hold particular stereotypes of autism and fail to realise that autism can manifest in ways which exceed the boundaries of those stereotypes. As an example, intense interests on focused topics are typically considered a symptom of autism. Popular stereotypes portray autistic people as deeply focused upon transport or computers. As such, official diagnosticians might be looking

out for such interests when assessing if someone is autistic. However, these stereotypes seem more applicable to how some, though not all, western autistic boys manifest intense interests. In contrast, autistic girls are more likely to have an intense interest in ponies or boy bands (Moseley, Hitchiner & Kirby 2018, p.2). As such, official diagnosticians who take intense interest to only manifest in a limited number of stereotypical ways has a significant chance of missing detecting intense interests in individuals who manifest them in ways outside of those stereotypes. As such, there is a danger that official diagnosticians will fail to recognise that an individual is autistic. Also, some individuals find describing their symptoms to official diagnosticians difficult (Lewis 2016). As such, whilst the individual may understand which symptoms they exhibit and how they exhibit them, they may be unable to communicate this to official diagnosticians. Additionally, an autistic person might have little opportunity to present the manner in which they are autistic in a meeting with official diagnosticians (Sarrett 2016, p.31). They manifest autism in complicated and nuanced manners which vary depending upon the particular real-world situation they are in. In contrast, they will be far removed from those real-world situations when assessed by official diagnosticians so will have less opportunity to portray how they actually manifest autism. Finally, autistic individuals sometimes mask (Livingston & Happé (2017), p.732). This is where they effectively try and pass as normal. This typically leads to a suppression of behaviour that is present on diagnostic criteria.

Arguments that official diagnosis is inaccurate are typically supplemented with arguments that self-diagnosis is accurate. Autistic individuals have lived experience of being autistic whereas a non-autistic individual only has access to the experience of observing autistic individuals. As such, an autistic person is taken as having more direct access to autism than official diagnosticians have. Therefore, an autistic person is better able to assess that they are autistic compared to official diagnosticians (Sarrett, 2016, p.30). This intuition is

expressed in the quote which I used to start this article that is from a blog by an individual who self-diagnosed with autism: “Autistics know autism better than anybody else” (Enright 2021). This means that self-diagnosis can be as accurate or more accurate than an official diagnosis. Also, in relation to individuals being only able to manifest their characteristics in a limited number of ways when meeting official diagnosticians, the autistic individual is aware of those manifestations taking place in contexts outside the assessment so they have more knowledge of how they are autistic compared to official diagnosticians who cannot see those manifestations taking place in everyday settings.

Some counter arguments to self-diagnosis have been identified in the literature (Sarrett describes rather than endorses these counterarguments). The main concern is that a self-diagnosing individual lacks the training which official diagnosticians have (Sarrett 2016, p.27). The concern is that a level of knowledge and training is required to accurately diagnose autism. There is also a concern over potential bias when self-diagnosing. An individual who self-diagnoses might do so by falsely interpreting some of their characteristics as being instances of autism. They are looking for characteristics of autism and falsely end up seeing what they expect to see (Sarrett 2016, p.28). Finally, there is a belief that some people who self-diagnose as autistic are insufficiently disabled to be autistic. There is the concern that any individual who was sufficiently disabled to be autistic would have been already spotted by medical professionals. Therefore, some autistic individuals believe that self-diagnosing individuals cannot be autistic (Sarrett 2016, p.28).

There are two fundamentally different approaches to the accuracy of self-diagnosis which need be distinguished between. On one approach the individual intends to self-diagnose based upon official diagnostic criteria. They do not challenge official diagnostic criteria but consider themselves to be an accurate judge of whether they meet the official diagnostic

criteria. Additionally, they might consider themselves a better judge than official diagnosticians. For example, as discussed above, official diagnosticians might associate symptoms on the diagnostic criteria with a limited range of stereotypical manifestations. In contrast, a self-diagnosing individual can draw upon their lived experience to realise that their symptoms manifest in particular ways which official diagnosticians fail to realise. On a second approach the self-diagnosing individual rejects current diagnostic criteria. They believe that someone can be autistic despite not meeting the diagnostic criteria in the main official diagnostic manuals, the DSM (Diagnostic and Statistical Manual of Mental Disorder) and the ICD (International Classification of Disease). They believe current diagnostic criteria is flawed and are not an accurate guide of establishing who is autistic. As such, official diagnosticians being able to accurately establish that an individual does not meet the official diagnostic criteria for autism does not then entail that official diagnosticians are an accurate judge of who is autistic. Accurate diagnosis of autism requires modification of the diagnostic criteria of autism present in the DSM and ICD. Some arguments required to justify self-diagnosis when accepting official diagnostic criteria have no relevancy when rejecting the diagnostic criteria and visa versa. I will distinguish between these situations in the following discussion.

4. The accuracy of official diagnosis

As mentioned above, one significant motive for self-diagnosis is the belief that official diagnosis can be inaccurate. I do not intend to take a stand on this matter in this article for the following reasons. Firstly, debates about the reliability (in the technical sense described

above) of psychiatric diagnoses have been going on for many decades (Kendell, 1975; see Aragona, 2015 and Solomon, 2022 for history) and there is disagreement about how high the reliability of the DSM is (Chmieleski, Clark, Bagby, Watson, 2015; Vanheule, 2017). I have little to add to this debate. Many readers will come to this article with pre-existing views on the accuracy of official diagnosis. I likely have no greater ability to change anyone's mind on this issue than any of the literally hundreds of existing articles and books on the topic which have already been published. This is especially true given that I have no committed views upon this topic. Secondly, even if official diagnosis can be inaccurate that does not then prove the accuracy of self-diagnosis. It could be the case that official diagnosis can be inaccurate and self-diagnosis is even more inaccurate, or that both are equally inaccurate. We need establish the level of accuracy of self-diagnosis to make a comparison with official diagnosis regardless of whether official diagnosis is considered to have high or low accuracy.

However, given that advocates of self-diagnosis are often concerned over official diagnosticians holding inaccurate stereotypes of autism, it is briefly worth commenting upon this specific issue. There is good reason to believe that at least some official diagnosticians will be aware that some stereotypes of autism are misleading. For example, in relation to autism, common concerns that advocates of self-diagnosis hold are actually addressed in the DSM 5. Advocates are concerned that official diagnosticians lack awareness about autistic people masking and about under-diagnosis of autism in ethnic minorities and women. However, the DSM 5 entry for autism explicitly mentions that autistic people can mask (APA 2013, p.56), that autism can be under-diagnosed in ethnic minorities (APA 2013, p.57) and that autistic women may present differently by exhibiting "subtle" (APA 2013, p.57) social skills difficulties. The degree that official diagnosticians take note of these points, spend time considering them and ideally do further reading about them is something that, to my

knowledge, we have no data on. However, given that the DSM 5 itself mentions these issues it seems credible that at least some official diagnosticians have at least some awareness of these issues.

Also, official diagnosis can involve multi-disciplinary teams. For example, according to The National Institute for Health and Care Excellence (NICE) in England and Wales, "it is recommended that the assessment should be done by a multidisciplinary team" (Scattoni et al, 2021, p.4130). Different individuals on the team will be specialists in different areas of autism and they will interact with the person being assessed in different ways. As such, it seems plausible that diverse medical backgrounds and different styles of observations would help with recognising that autism can occur in ways beyond a limited set of stereotypes. An advocate of self-diagnosis could argue that all or most the members of the multi-disciplinary team hold misleading stereotypes but this claim would require showing that the stereotypes of autism are not just prevalent in one or a few disciplines but actually prevalent in many different disciplines. I am not aware of advocates of self-diagnosis having shown this and I think advocates of self-diagnosis should prioritise providing evidence for this. However, even if multi-disciplinary teams do increase the accuracy of autism diagnoses it should be noted that diagnosis often does not involve multi-disciplinary teams. In relation to autistic people who were officially diagnosed, a study of eleven European countries found less than forty five percent saw a multi-disciplinary team (Scattoni et al 2021, 4136) whilst a study of Austria found that sixty six percent only saw a single clinician (Huang, Arnold, Foley & Troller 2022, p.2991).

Additionally, official diagnosis can involve diagnostic instruments like DISCO, ADOS and ADI-R. Ideally, diagnostic instruments would reduce the level of subjectivity involved in official diagnosis. When using diagnostic instruments, judgements about whether the

diagnostic criteria made by the official diagnostician or the multi-disciplinary team is being supplemented by standardised diagnostic instruments which have been proven to be highly reliable (in the technical sense discussed above). In this reguard, the diagnostic process can be seen as involving less of a subjective judgement than advocates of self-diagnosis believe. However, the key problem here is that those diagnostic instruments might have only been shown to be accurate when we consider a relatively narrow range of presentations and they are not accurate at detecting a wider range of manifestations of autism. Whilst I will not assess this claim, it is worth mentioning that this claim has been made by official diagnosticians (Hayes, Ford, McCabe & Russell, 2022, p.494) and academic researchers (Harrison, Long, Tommet & Jones, 2017, p.2771) in articles that do not discuss self-diagnosis, meaning it is not just advocates of self-diagnosis who are concerned about this.

5. Identities and accuracy

The whole question of accuracy might be irrelevant if psychiatric diagnoses are seen as identities. I now address this possibility. Psychiatric diagnoses are traditionally understood to fall under the domain of medicine. A psychiatric diagnosis signifies the presence of a disorder, disease or illness. This then entails legitimacy for treatment, care, medication or therapy. However, movements like mad pride and neurodiversity partially or fully reject this. Rather, a psychiatric diagnosis like autism is primarily or entirely a difference and not a disorder. Additionally, psychiatric diagnoses can also be seen as an important aspect of personhood. To remove autism would be in some sense to remove the person. There is not a person plus autism, rather, autism is an integral aspect of who someone is. This raises the possibility of thinking of psychiatric diagnoses more as identities than diagnoses. Just as someone does not

self-diagnose themselves as homosexual or trans but rather identifies as these, so too we might say people should identify as autistic rather than self-diagnose as autistic. However, I do not believe that thinking in terms of identity rather than diagnosis makes a difference to my argument.

At least in relation to autism, many advocates of self-diagnosis use the phrase self-diagnosis whilst simultaneously thinking that autism is not a disorder. As such, they seem to think that diagnosis is separable from disorder, that people can be legitimately diagnosed despite not being disordered. Additionally, they typically think autism can or even should form part of a diagnosed person's identity despite seeing autism as a diagnosis. As such, many activists do not see a tension between diagnosis and identity. Whilst I also do not think this is problematic, I now explore the consequences for accuracy if we think something being an identity means it cannot be a diagnosis.

It could be argued that if psychiatric diagnoses are just identities then the issue of accuracy does not arise. To be autistic is to identify as autistic. If autism is nothing more than an identity then the only criterion for being autistic is identification. As such, self-diagnosing as autistic means you automatically meet the sole criterion for being autistic. We could say that questions of the accuracy of self-diagnosis simply do not arise or we could say that the accuracy is always one hundred percent. However, I now raise multiple problems with this approach.

Firstly, this approach seems to deny the possibility that someone can be mistaken about their identity but plausibly people can be mistaken about some types of identities. There is the possibility of delayed identification. Someone might identify as homosexual long after they regularly had same sex attraction, especially if they resist the notion that they are homosexual. Similarly, it seems plausible to say that someone is autistic either from birth or

within a few years of birth even if they only get diagnosed or self-diagnose aged forty. In both cases, the individual seems to be an instance of the identity long before they adopt the identity. Also, there is the possibility of being purposefully misled. An individual might grow up identifying as Scottish based upon being told they were born in Scotland but later found out they have been adopted and were actually born in England. They consequently think they should have always identified as English and were incorrect to identify as Scottish. Similarly, imagine that a child is diagnosed as autistic but their parents tell them they have been diagnosed with a different diagnosis that the parents consider less stigmatising. The child identifies as that other diagnosis but finds out much later that they were diagnosed as autistic. That person might think they mistakenly identified with that other diagnosis and actually should have identified as autistic. Finally, there is the possibility of accidental misunderstanding. Imagine that someone identified as a Trotskyist on the basis of holding strong left-wing principles, whilst also rejecting Stalinism. By rejecting Stalinism they default to a 'Stalin is bad, therefore Trotsky is good' principle. Much later, that individual reads about Trotsky and comes to the opinion that Trotsky as leader of the Soviet Union would have likely also lead to the deaths of millions. As such, they consider themselves mistaken to have identified as a Trotskyist. Similarly, imagine someone self-identified with one diagnosis because it seemed to fit better than the other diagnoses they were aware of, then they later learn of another diagnosis which they feel fits themselves. Consequently, they self-identify with the diagnosis they have recently learnt about and consider themselves to be mistaken to have self-identified with the earlier diagnosis. There seems to be a sense in which we can be wrong about some identities which then raises questions about the accuracy of self-identifying with psychiatric diagnoses even if psychiatric diagnoses are actually understood

as purely identities.

Secondly, Robert Chapman has also produced strong arguments against seeing autism as simply an identity. He mentions that "autism includes a small subset of individuals who have not yet been able to learn the level of language necessary to identify with other autistic individuals at all" (2020, p.809). Seeing autism purely as an identity consequently "would exclude those who clearly are autistic but are not currently able to identify as such" (2020, p.809). That being, if someone who is currently considered autistic but lacks, for whatever reason, the capacity to identify themselves as being autistic then they are not autistic if autism were purely an identity. This has the obvious consequence of potentially denying support and community to people who have relatively high support needs.

Thirdly, one motive for seeing autism as an identity is denying that autism is a scientifically legitimate entity (Chapman (2020) outlines but does not endorse this argument). Autism covers a heterogeneous collection of symptoms and causes, there are no clear boundaries between autism and other diagnoses and no clear boundary between autism and the general population. This can be taken to show that autism is not something that we discover, rather, it could be argued we have to decide what autism is. As such, to be autistic is to simply decide that you are autistic. I outline in sections 9.3 and 9.4 that we can see psychiatric diagnoses as the product of a decision making process but this is compatible with there being better and worse ways of deciding which psychiatric diagnoses there are. As such, someone could identify as being autistic through having made a poor decision about where the boundaries of autism lie. I later suggest this would mean they are mistaken to think of themselves as autistic.

6. Clarifying the Argument

I start by making the basic justification for self-diagnosis more precise. I start by considering the claim that self-diagnosis is accurate because self-diagnosing individuals have self-knowledge of the diagnosis. This discussion is applicable to both accepting and rejecting the DSM and ICD diagnostic criteria when self-diagnosing.

6.1. The Problem of Circularity

Self-diagnosis is deemed accurate because an autistic person has better access to autism than a non-autistic person so they are better able to judge if they are autistic than a non-autistic person. Without further development the claim that autistic people know autism best and therefore self-diagnosis is accurate is a circular argument. The problem with this argument is that it seems to assume what it sets out to prove. It seems that someone is assumed to be autistic when they are judging that they are autistic. We, firstly, need establish that the individual is autistic to, secondly, say that they are an autistic person who has direct access to autism so, thirdly, they can use that direct access to judge that they are autistic. Without first establishing they are autistic we lack reason to believe they have the privileged access to autism which justifies self-diagnosis.

The argument can be made non-circular through modification. Rather than saying 'autistic people know autism best therefore self-diagnosis is legitimate' it can be modified into 'if someone is autistic then they will know autism best therefore self-diagnosis is legitimate'. So instead the argument runs as follows: 'if someone is autistic then they will have direct

access to autism so will be the best person to judge if they are autistic'. The argument now claims that if they are autistic then they will be able to make this judgment. In this sense the argument no longer looks circular because there is no assumption that the person is autistic.

With this modification in mind there then follows two questions. Firstly, if someone is autistic then are they able to accurately judge that they are autistic? Secondly, if someone is not autistic then are they able to accurately judge that they are not autistic?

6.2. The Problem of the Gap

The claim that someone being autistic means they will recognise that they are autistic seems to rest on self-knowledge. By being autistic someone has self-knowledge of autism which means they can accurately judge that they are autistic. However, this argument, without further development, does not appear to work. The problem is that there is a gap between an autistic individual and autism itself. The gap arises because autism can take many different forms. When following the DSM and ICD there are multiple ways to meet the diagnostic criteria. That is, one person with one set of symptoms can meet the diagnostic criteria whilst a different person, with a different, if overlapping, set of symptoms can also meet the diagnostic criteria. Also, individuals who self-diagnose based on rejecting the DSM and ICD typically do so by arguing current diagnostic criteria is too restrictive. As such, self-diagnosing individuals who reject official diagnostic criteria still seem to think that autism can take many different forms. An autistic individual does not have direct access to autism itself. It is more accurate to say that an autistic person knows autism as it manifests in themselves rather than knowing autism per se. This leaves a gap between the first person knowledge of autism which the

individual has and knowledge of autism itself. An individual can be a manifestation of autism but they cannot be autism itself since that covers multiple people. As such, the claim that autistic people have direct access to autism needs be clarified. It should instead be understood as the claim that autistic individuals have direct access to autism as it manifests in themselves but not direct access to the more general notion of autism.

This has implications for self-diagnosis. Rather than self-diagnosis resting upon an individual having direct access to autism, it instead requires a comparison between an individual and something that is more extensive than the individual. Rather than an individual having direct access to autism they only have direct access to a limited part of autism and then need compare this to a criteria which is intended to cover the whole of autism. Whatever direct acquaintance they have it needs supplementing with a comparison to a criteria which extends beyond themselves, be that criteria the DSM and ICD criteria or some other criteria. I

7. Self-knowledge

All approaches to justifying the accuracy of self-diagnosis require making arguments relating to self-knowledge. I will outline the required arguments here. Note that justifying these arguments does not then by itself show self-diagnosis is accurate. Rather, these arguments relating to self-knowledge need justifying and then other additional arguments also need justifying (which ones depend upon the approach to self-diagnosis taken).

7.1. The Problem of Introspection

Since self-diagnosis requires a comparison there needs be a level of accurate knowledge of the self. A level of accuracy at self-understanding is needed. An individual ideally needs to accurately establish which symptoms they exhibit. They ideally need detect all the symptoms they do exhibit, not missing any of them. If an individual fails to detect a symptom then they might not realise they meet the diagnostic criteria for a particular diagnosis. Imagine if a psychiatric diagnosis requires someone to exhibit five symptoms on a diagnostic criteria, an individual exhibits five of the symptoms on the list but only detects four of them. They would inaccurately fail to recognise that they meet the diagnostic criteria. Also, they ideally need make sure they do not inaccurately believe they exhibit a symptom which they actually do not exhibit. If someone believed they exhibit a symptom which they actually do not then they might think they meet a diagnostic criteria when they actually do not. If a diagnosis requires five symptoms, an individual only exhibits four symptoms but mistakenly believe they exhibit five then they might inaccurately assess that they meet the diagnostic criteria. This is an issue for accepting and rejecting the DSM and ICD diagnostic criteria. Even when rejecting the DSM and ICD there still needs be some alternative criteria, even if implicit, which the self-diagnosing individual needs establish they meet.

This requirement for self-understanding is potentially problematic because modern psychologists suggest many people are bad at self-understanding. Experimental evidence suggests that many people are bad at accurately assessing themselves. One aspect of self-understanding is introspection. Psychologists generally think that

> "introspection is a form of direct and immediate access each person has to their own current and ongoing (or very recently past or future) mental states or

> processes... a fundamental capacity for knowing our emotions, formulating judgments about ourselves and the world around us, understanding how we feel, making plans, and so on" (Lo Dico 2018, 511).

Introspection seems to be an important tool for self-understanding behaviour, emotions, perception and thought, all of which are important when self-diagnosing.

Lo Dico outlines four popular approaches to cognitive and social psychology and outlines Freudian psychoanalysis, showing how all these five approaches all consider introspection to be largely unreliable (2018, p.517 & p.520). This then raises significant problems for notions that individuals have direct access to their own mental states. It challenges the notion that autistic people have direct access to how autism manifests within themselves. Introspection being unreliable would reduce the self-understanding of self-diagnosing individuals and so reduce the accuracy of self-diagnosis (see also Lewis (2016, p.579) for brief mention of this point). To argue that self-diagnosis is accurate there need be reason to believe introspection is reliable when self-diagnosing or that self-understanding when self-diagnosing is possible without relying upon introspection. Failure to establish this would significantly reduce the accuracy of self-diagnosis.

7.2. The Problem of Cognitive Biases

Direct access to mental states is only one aspect of self-understanding. We also need reason about the products of our introspection. For example, reasoning is needed to establish whether the characteristics the self-diagnosing individual believes themselves to exhibit fit a

diagnostic criteria (be it the DSM and ICD criteria or some other criteria).

Modern psychologists have suggested humans might often be flawed at reasoning. Modern psychologists employ a notion known as cognitive biases. Most reasoning in humans appears to occur in an unconscious manner. Some of that reasoning takes that form of unconscious strategies which produce judgments. Some of these unconscious strategies seem to be quite unreliable whereby they produce flawed reasoning. These unreliable unconscious strategies are cognitive biases. For example, there is confirmation bias which is tending "to search for confirming rather than for disconfirming evidence" (Ellis 2018, p.2). Also, there is overconfidence bias which is tending to "assess the accuracy of their answers or performance as greater than it actually is" (Ellis 2018, p.2). These are only examples of more common cognitive biases. Some psychologists have attempted to classify the number of different cognitive biases, with one estimate being one hundred and eighty seven different cognitive biases and another estimate being two hundred and eighty eight (Ellis 2018, p.2).

To my knowledge, there is no study that explores the consequences of cognitive biases for self-diagnosis. It is, however, easy to see how someone searching for confirming rather than disconfirming evidence or someone who is overconfident in their ability to self-diagnose could reduce the accuracy of self-diagnosis. For self-diagnosis to be accurate it seems that these problems with these cognitive bias must not be applicable, or be of limited applicability, to the process of self-diagnosis. The more cognitive biases have an impact the lower the accuracy of self-diagnosis will be.

8. Self-diagnosing when following the DSM and ICD

In this section I address self-diagnosing individuals who accept the diagnostic criteria present in the DSM and ICD. If they self-diagnose as autistic then they take themselves as being an instance of the notion of autism present in those diagnostic manuals. In this context, to say an autistic person knows autism best is to mean they are more accurately able to establish they meet official diagnostic criteria than official diagnosticians. When self-diagnosing based upon DSM or ICD notions of autism there is a diagnostic checklist which should be followed. This has a quite specific criteria whereby an individual needs exhibit multiple symptoms from one list (differences in social communication and social interaction) and multiple symptoms on a second list (restricted and repetitive behaviour). Consequently, an individual can exhibit multiple symptoms of autism but not meet the DSM and ICD diagnostic criteria for autism. This means a self-diagnosing individual who accept the DSM and ICD should consult the DSM and ICD diagnostic criteria for autism to see what the specific criteria is.

The diagnostic criteria are very easy to find through an internet search so arguably the vast majority of self-diagnosing individuals have the means to check the DSM and ICD diagnostic criteria. I am not aware of any statistical information about how many do check the diagnostic criteria. Even if, as seems likely, the vast majority do check the diagnostic criteria there is the issue of the impact on the accuracy of self-diagnosis if a small proportion do not check official diagnostic criteria. For self-diagnosis in line with the DSM and ICD to be accurate the vast majority of self-diagnosing individuals need check the diagnostic criteria and any small minority who do not must not result in a significant impact on the overall

However, self-diagnosing individuals arguably need do more than check the official diagnostic criteria because that diagnostic criteria only conveys limited information. The DSM specifies that the diagnostic criteria “are illustrative, not exhaustive; see [the rest of the]

text" (APA 2013, p.50). The diagnostic criteria covers only one and a half pages of the ten page entry on autism (APA 2013, p.50-59) whereas the rest of the text, which is not readily available on the internet, covers eight and a half pages. As such, official diagnosticians with access to a physical copy of the DSM will have more detail on how the DSM portrays the diagnostic criteria than is available to the general public. More fundamentally, most official diagnosticians will have read far more about autism than the DSM or ICD. They will typically have at minimum a working knowledge of the scientific literature on autism. As such, their knowledge of the scientific literature will likely influence their diagnostic practice. Some of this may increase accuracy through providing accurate knowledge about autism but some might instead decrease accuracy through reinforcing misleading stereotypes about autism.

Given the lack of details of the DSM and ICD diagnostic criteria the accuracy of self-diagnosis arguably requires knowledge of autism which extends beyond checking the diagnostic criteria. Four places where self-diagnosing individuals can gather potentially relevant information are scientific literature, websites, internet forums and social media. It is possible to find an immense level of information about autism through open access or pre-print scientific literature, through blogs, through healthcare websites and charity websites, through internet forums dedicated to mental health or particular psychiatric diagnoses and through general social media as well as social media dedicated to mental health or particular diagnoses. It is worth noting that these sources can provide differing levels of accurate information and have differing levels of relevance. It is contestable as to which sources are more accurate and more relevant. For example, it might seem intuitive that journal articles published by trained scientists will contain more accurate descriptions of autism than blog post written by people with no scientific training. However, it can be argued that scientists hold inaccurate stereotypes of autism meanwhile a blog post based upon lived experience can

be more accurate despite the author having no scientific training.Establishing which sources are best might depend upon wider questions that I have already raised. For example, if introspection is taken as highly reliable then a blogger with lived experience might be favoured whereas if introspection is highly unreliable then perhaps scientific observations of external behaviour might be favoured. As such, I restrict myself to analysing the consequences of someone who is self-diagnosing having good or bad information rather than specify which sources provide good or bad information.

Self-diagnosing individuals will vary in the degree they access this information and the quality of this information will also vary significantly. For those self-diagnosing individuals who do research psychiatric diagnoses through these means there becomes the question of the degree they read and understand the type of information which increases diagnostic accuracy. Also, there is the question of the degree they do not read the type of information which would decrease accuracy or they are able to recognise the problems in any of the flawed information they do read.

One potential way of avoiding this problem is by appealing to lived experience. It could be argued that an autistic person does not need gain significant information about autism through scientific literature, websites, internet forums and social media to understand autism because they can rely upon self-knowledge. Similarly, it can be argued that autistic individuals who do read flawed information from these sources can draw upon lived experience to recognise that it is flawed. However, this still presupposes that self-knowledge provides knowledge of autism. Using self-knowledge requires an interpretation. They need take their self-knowledge and correctly interpret it as relating to autism. This is potentially problematic because someone could have a very good understanding of how they behave, perceive, think and feel without accurately establishing which diagnosis they fit. The same

behaviour, perception, thought and feeling can be associated with multiple diagnoses (Fellowes 2022). For example, experimental and clinical evidence suggests that multiple diagnoses are associated with the simultaneous presence of both social communication differences and repetitive/restrictive behaviour. Both of these are simultaneously present in autism (APA 2013, p.50), ADHD (Antshel & Russo 2019, p.3), schizotypal personality disorder (Hurst et al, 2007, p.1712) and schizoid personality disorder (Sugihara, Tsuchiya & Takei 2008, p.1998) but they appear to manifest in subtlety different ways. As such, an individual might think they exhibit social communication differences in a manner associated with autism but actually exhibit them in a manner associated with ADHD, schizoid personality disorder or schizotypal personality disorder. This suggests that an autistic person can only accurately interpret self-knowledge in relation to self-diagnosis through having an understanding of autism and other relevant diagnoses.

Drawing upon self-knowledge only starts being accurate for self-diagnosis when a level of information about psychiatric diagnoses is already in place. Once that level of information is present then an autistic person can draw upon lived experience to interpret information about autism. Consequently, lived experience does not mean accurate information about autism is no longer needed. The advantage of lived experience means an autistic person would need read less high quality information about autism compared to a non-autistic person to generate a good understanding of autism. It also means an autistic person is better able to read low quality information about autism without then generating a flawed understanding of autism compared to a non-autistic person. As such, lived experience only partially resolves the problem that accurate self-diagnosis requires information about autism. An autistic individual needs less information about autism than a non-autistic individual needs but some is still needed.

This appeal to self-knowledge to mitigate the problem of limited or flawed information is harder to apply to non-autistic individuals. For self-diagnosis to have high accuracy it seems that non-autistic individuals need to be able to recognise that they are not autistic. However, for obvious reasons, individuals who are not autistic cannot draw upon lived experience of autism to realise that they are not autistic. Rather, non-autistic individuals will have lived experience of something else, such as being a typical member of the population. As such, they cannot appeal to lived experience of autism to reduce the level of high quality information about autism they need understand or appeal to lived experience of autism to help recognise the flaws in low quality information about autism. The lived experience of a typical member of the public may result in nuanced understanding of themselves but it is unclear how this could then result in subtle understanding of autism. As such, if lived experience of autism means that autistic individuals can accurately self-diagnose as autistic it is unclear that lived experience can play a similar role when non-autistic individuals assess if they are autistic. This would mean self-knowledge would decrease false negatives, reducing the number of autistic people failing to judge that they are autistic, but would not prevent false positives, not reducing the number of non-autistic individuals incorrectly judging that they are not autistic. Either an argument is needed that non-autistic individuals can use their self-knowledge of non-autism to understand the subtle nature of autism or some other means of understanding the subtle nature of autism is required. Failing this, the accuracy of self-diagnosis is reduced.

To summarise, when self-diagnosing whilst accepting the DSM and ICD, an individual needs avoid the problems of introspection and cognitive biases. They also need knowledge of the DSM and ICD notions of autism and this typically requires going beyond the diagnostic criteria itself. They need adequately understand good information about autism whilst not

being influenced by bad information. Someone who actually is autistic can potentially partially reduce the required level of good information and can more easily spot bad information whereas this resource does not appear open to someone who is not autistic. Unless a means of mitigating these issues is established the accuracy of self-diagnosis is reduced.

9. Self-diagnosing when Rejecting the DSM and ICD

I now focus on self-diagnosing individuals who reject official diagnostic criteria. The key idea of self-diagnosing when rejecting official diagnostic criteria is that the self-diagnosing individual has better knowledge than is conveyed by the official diagnostic criteria. As such, the debate is not over whether the self-diagnosing individual meets the official diagnostic criteria. Instead, the debate is about what the diagnostic criteria should be. The claim that a self-diagnosing person knows something which is not reflected in the diagnostic criteria works differently depending upon what psychiatric diagnosis are taken to be. I will outline three possibilities, namely psychiatric diagnoses as objective entities, as the product of theoretical virtues and as the product of practical values.

9.1. Diagnoses as Objective Entities

I firstly consider the claim that self-diagnosis when rejecting the DSM and ICD is accurate because the DSM and ICD fail to track an objective entity whereas the self-diagnosing

individual has access to an objective entity. One common way of thinking about real psychiatric diagnoses is that they are naturally forming objective parts of the world. They exist out there waiting to be discovered and they exist regardless of whether we do or do not discover them. As an analogous example, horses and elephants are real and exist regardless of our views on them. They would exist even though no human had ever seen a horse or an elephant. The notion that psychiatric diagnoses exist as objective entities seems to have been adopted implicitly by the authors of the DSM (Cooper 2007, p.46), the general public (Haslam 2000, p.1043) and psychiatrists (Horwitz 2002, p.5). Philosophers of psychiatry typically use the term natural kinds when they think of psychiatric diagnoses as potentially referring to something in the external world (for discussion see Beebee & Sabbarton-Leary 2010, p.23; Cooper 2007, p.46; Kendler, Zachar & Craver 2011, p.1146). These philosophers typically endorse a non-essentialist notion, whereas psychiatrists and members of the public are more likely to endorse essentialist notions.

This understanding of psychiatric diagnoses leaves open the possibility that authors of the DSM and ICD could hold mistaken views about psychiatric diagnoses. Firstly, the DSM and ICD could contain psychiatric diagnosis which actually has no corresponding entity in the external world. The authors of the diagnostic manuals would have posited an entity that does not exist. Secondly, the DSM and ICD might not include a diagnosis for an objective entity which actually does exist. The authors of the diagnostic manuals have failed to posit an entity that they should have posited. Thirdly, the DSM and ICD do contain a diagnosis which has a corresponding entity in the external world but the DSM and ICD assign inaccurate characteristics to that entity. The authors of the DSM and ICD have some mistaken beliefs about that entity, believing it has characteristics which it actually lacks or have failed to detect characteristics which it actually does have. These three possibilities suggest the significant

possibility that the diagnostic criteria in the DSM and ICD inadequately describe objective entities. As such, diagnosing using the DSM and ICD results in limited accuracy.

The accuracy of self-diagnosis when rejecting diagnostic manuals could be justified through claiming the self-diagnosing person has better access to the objective entity than the authors of those diagnostic manuals. In this context, to say autistic people know autism best means that through being an instance of that objective entity, the self-diagnosing individual has lived experience of that objective entity. This gives a level of access to that objective entity which people without that lived experience lack. Since the majority or even all the authors of the DSM and ICD lack that lived experience the self-diagnosing individual has a better understanding of that objective entity compared to that conveyed in the DSM and ICD . This means self-diagnosing when rejecting the DSM and ICD is more accurate than consulting an official diagnostician who follows the DSM and ICD.

However, there is the problem of self-diagnosing individuals accurately establishing which objective entity they are an instance of. Even if the self-diagnosing individual has full understanding of which characteristics they exhibit they still need a criteria to establish which diagnosis they are an instance of. This problem works in three different ways.

Firstly, imagine the diagnostic criteria of autism did not reflect an objective entity but other diagnoses in the DSM and ICD do reflect objective entities. For example, imagine there is an objective entity which we call autism and an objective entity we call ADHD but the DSM and ICD have inadequately described autism whereas they accurately describe ADHD. Since psychiatric diagnoses overlap with one another, a self-diagnosing individual might self-diagnose on an altered criteria for autism when they actually better fit an alternative diagnosis. For example, imagine an individual self-diagnosing as autistic based upon accurately assessing that they have social communication differences and repetitive/restricted behaviour.

However, these can be found in diagnoses other than autism, such as ADHD (Antshel & Russo 2019, p.3), Schizotypal Personality Disorder (Hurst et al, 2007, p.1712) and Schizoid Personality Disorder (Sugihara, Tsuchiya & Takei 2008, p.1998). Individuals with those diagnoses sometimes also struggle in social situations and exhibit repetitive/restricted behaviour but of a subtly different form compared to that exhibited by autistic individuals. Thus, a self-diagnosing individual who rejects the DSM and ICD criteria for autism might actually be an instance of a different objective entity which has been accurately described by the DSM and ICD. Avoiding this problem requires the self-diagnosing individual to consult those other diagnoses, distinguish between subtle differences in manifestations of those symptoms and accurately establish whether they are actually an instance of one of them. Failing to do this reduces the accuracy of self-diagnosis.

Secondly, imagine all the diagnoses in the DSM and ICD which an individual could plausibly fit are flawed. There is a corresponding entity for each of those diagnoses in the objective world but the DSM and ICD diagnostic criteria of each diagnosis fail to adequately describe the objective entity. As such, the diagnostic criteria for diagnoses like autism, ADHD, schizoid personality disorder and schizotypal personality disorder are all mistaken in the DSM and ICD. For example, imagine each of those objective entities involves social communication differences and repetitive/restrictive behaviour, but the descriptions in the diagnostic manuals fail to describe how social communication differences and repetitive/restrictive behaviour manifest for each objective entity. Now imagine someone self-diagnoses with autism based upon a different criteria to that present in the DSM and ICD after accurately assessing themselves as exhibiting social communication differences and repetitive/restricted behaviour. How could a self-diagnosing individual establish that their social communication differences and repetitive/restricted behaviour take the form present in

the objective entity of autism rather than that present in the objective entities of ADHD, schizoid personality disorder or schizotypal personality disorder? They cannot check the official diagnostic criteria for these because each diagnosis inaccurately describes the social communication and repetitive/restrictive behaviour which is present in the actual objective entity. They cannot appeal to lived experience of autism without first knowing they are an instance of the objective entity autism rather than an instance of a different objective entity such as ADHD, schizoid or schizotypal personality disorder. It is unclear how they could establish which objective entity they are an instance of but without doing so the accuracy of self-diagnosis is reduced.

Thirdly, there is the possibility that a self-diagnosing individual is actually an instance of a currently undiscovered entity. Imagine that there is an objective entity which the diagnostic criteria for autism fails to accurately describe. However, also imagine that there is one or more undiscovered entities that exist but have not been discovered. They have not been discovered in the sense that the DSM and ICD, psychiatrists or anyone who has lived experience of that objective entity does not correctly recognise which entity it is. This raises the possibility that the self-diagnosing individual is actually not an instance of the objective entity of autism and are instead an instance of an entity which has not yet been discovered. Given that the correct diagnostic criteria for this unknown entity is obviously unknown it is unclear how an individual can rule out the possibility that they are an instance of an undetected entity rather than manifesting autism in a manner not described by the DSM and ICD.

To summarise, self-diagnosing in line with an objective entity when rejecting DSM and ICD criteria requires avoiding problems with introspection and cognitive biases and also requires establishing which objective entity you are an instance of. This is challenging

because there appears to be no obvious external criteria to establish that you are autistic in a manner not described by the DSM and ICD rather than an instance of another objective entity which has also been inaccurately described in the DSM and ICD or an instance of a currently undiscovered objective entity. Failing to avoid these problems would reduce the accuracy of self-diagnosis.

9.2. Psychiatric Diagnoses as the Product of a Decision Making Process

Rather than seeing psychiatric diagnoses as objective entities that exist independently of our views, we can instead understand them as being dependent on our views. Which diagnoses there are depends upon the conscious or unconscious views we hold. This is not to claim that nothing exists but rather it is the claim that psychiatric diagnoses involve categorisation whereby we group people together based upon loose similarity. I outline two different approaches to seeing psychiatric diagnoses as being the product of a decision making process.

9.3. Psychiatric Diagnoses as the Product of Theoretical Virtues

Psychiatric diagnoses can be seen to be the product of applying what philosophers of science call theoretical virtues. These are criteria of what a good scientific theory consists of (Psillos 1999, p.171; Solomon, 2001 p.19-20). A theory which exhibits more of these theoretical virtues is a better theory. Examples of theoretical virtues are internal consistency (the elements of the theory or entity are internally consistent), external consistency (the theory or

entity coherently fits other theories and entities), identified causal mechanism (a causal mechanism has been identified for the theory or entity), sitting within a wider theoretical network (the theory or entity is embedded within other theories), simplicity (the theory or entity is simple or, alternatively, the theory or entity contributes to making a domain of science simple), coverage (the theory or entity covers a lot of phenomena or, alternatively, the theory or entity contributes to making a domain of science have high coverage) and accuracy to the phenomena (how much does the theory or entity accurately describe the phenomena it covers).

The notion of autism present in the diagnostic manuals exhibits theoretical virtues to one degree whereas a notion of autism which differs from the DSM and ICD will have a different degree of theoretical virtues. The notion of autism formulated by the self-diagnosing individual might, for example, be simpler, more internally coherent or has a closer connection to causes compared to the DSM and ICD notion of autism. If we understand psychiatric diagnoses as the product of theoretical virtues then, in this context, to say the self-diagnosing individual knows autism best is to say they have formulated a more theoretically virtuous notion than the authors of the DSM and ICD.

Assessing theoretical virtues typically requires considering an immense level of information across multiple areas. For example, saying autism is internally coherent requires assessing how any particular symptom of autism coheres with any particular cause of autism. Similarly, saying autism is externally coherent would require knowledge of other psychiatric diagnoses and wider theoretical claims about human biology, psychology and sociology. Applying theoretical virtues without being aware of a particular piece of relevant scientific evidence or being aware of that relevant scientific evidence but misunderstanding it would reduce the accuracy of self-diagnosis when formulating a notion of autism on theoretical

virtues.

Additionally, these theoretical virtues sometimes conflict whereby increasing one theoretical virtue could decrease others. For example, one way to make a theory or entity simple is to restrict the phenomena it covers. By covering less phenomena, the theory or entity needs have less components. However, this then reduces the theoretical virtue of coverage. As such, an individual may formulate a notion of autism which increases one theoretical virtue, meaning they think they have formulated a notion of autism which is superior to that in the DSM and ICD when measured by that theoretical virtue, without realising they have decreased another theoretical virtue. A good balance between different theoretical virtues needs be struck or the accuracy of self-diagnosis will be reduced.

9.4. Psychiatric Diagnoses as Practically Useful Groupings

Psychiatric diagnoses can be understood as the product of attempting to create practically useful groupings (Kendler, Zachar and Craver 2011, p.1149). There can be practical advantages to diagnosing individuals, both for the individual who receives the diagnosis and for other individuals. In relation to the diagnosed individual, receiving a psychiatric diagnosis can potentially enhance self-understanding (Sadler 2005), it can provide an explanation for their behaviour (Sadler 2005), it can be the basis for an identity, it can be used to help find other people who are similar to themselves for socialising (Abel, Machin, & Brownlow 2019), for forming political movements (Orgota 2013), for taking part in participatory scientific research (Tekin 2022) and for forming cultural movements (Jaarsma & Welin 2012). In relation to other individuals, someone being diagnosed can enhance the understanding others

have of the diagnosed individual (Sadler 2005), it can help establish who is eligible for state benefits and state funded therapy (Sadler 2005), it can help establish what medication or therapies are helpful (Sadler 2005) and it helps guide making reasonable adjustments to society (Orgota 2013).

In this context, to say a self-diagnosing individual knows autism best means that they have formulated a more practically beneficial notion of autism compared to the DSM and ICD notion. It is more practically useful to individuals who receive the diagnosis, or is more practically useful to those who do not receive the diagnosis, or both. For example, a notion of autism which an individual self-diagnoses with might increase self-understanding or might be of greater guidance over reasonable accommodations compared to the DSM and ICD notion. To say an autistic person knows autism best means they have produced a more practically useful notion of autism compared to the DSM and ICD.

For a self-diagnosing individual to accurately make this judgment they need judge what is practically useful and how best to realise that practical usefulness in the form of a psychiatric diagnosis. They first need accurately establish a set of practical factors, making sure not to mistakenly think that something is a practical factor when it actually is not. They then need formulate a diagnosis which realises those practical factors. We can formulate psychiatric diagnoses in many different ways and any particular way of formulating them will vary in the degree to which they realise a particular practical factor. The self-diagnosing individual needs formulate a notion of autism which covers multiple practically useful factors. The greater number of practical factors covered increases the degree to which the self-diagnosing individual knows autism best. A self-diagnosing individual failing to make accurate judgments over what practical factors to incorporate and how best to realise them through a diagnosis would reduce the accuracy of self-diagnosis.

Also, there is the issue that making a diagnosis more practically useful in one manner may reduce its practical usefulness in another manner. For example, making a psychiatric diagnosis broader to cover more people means more people can gain the benefit of being diagnosed but this then means the diagnosis is now less specific, covering a wider range of diverse symptoms. This might mean that the diagnosis is less suitable for making effective reasonable accommodations compared to covering all those diverse symptoms under two different diagnoses. Failing to establish a good balance would reduce the accuracy of self-diagnosis if psychiatric diagnoses are seen as the product of practical factors.

Psychiatric diagnoses can be formulated simultaneously on both theoretical virtues and practical factors. On this approach an individual knows autism best when they formulate a notion of autism which covers a range of both theoretical virtues and practical factors and finds a balance between them. This situation is identical to my above discussion except that more factors need be covered and more factors can conflict with one another.

To summarise, when self-diagnosing based upon theoretical virtues or practical factors (or both together), an individual needs avoid the problems with introspection and cognitive biases whilst formulating a psychiatric diagnosis based upon good values. This requires establishing a good set of values and formulating a psychiatric diagnosis which realises those values. Failing to do this reduces the accuracy of self-diagnosis.

10. Conclusion

I have considered what arguments are needed to show that self-diagnosis is accurate. I have identified four different approaches to claiming that self-diagnosis is accurate. These are,

firstly, accurately assessing they meet the diagnostic criteria in the DSM and ICD, accurately assessing they are an instance of an objective entity, accurately formulating a diagnosis that is theoretically virtuous and accurately formulating a diagnosis that realises practical factors. Some of the required arguments to justify the accuracy of self-diagnosis are applicable to all the different approaches, namely those arguments relating to introspection and cognitive biases. However, all the approaches also need some unique arguments which are not present in other approaches. I hope this article has contributed through identifying different approaches to justifying the accuracy of self-diagnosis and by showing that different arguments are needed for different approaches. I hope this will be a stepping stone towards establishing whether those arguments, and which of those arguments, can be successfully justified.

If self-diagnosis is inaccurate then the question of whether legitimate self-diagnosis requires accuracy becomes important. Relevant issues here are establishing the exact degree of inaccuracy, whether only some types of self-diagnosis is inaccurate (such as autistic people can accurately establish that they are autistic but non-autistic people cannot accurately establish that they are not autistic), whether the accuracy of self-diagnosis is lower than the accuracy of official diagnosis, whether individuals mis-diagnosing themselves as autistic is harmful to themselves and whether individuals mis-diagnosing themselves as autistic is harmful to others. An important possibility to consider is that self-diagnosis is legitimate even though it is inaccurate. I hope this paper will inspire further work on these questions.

Conflicts of Interest:

The author declares that the research was conducted in the absence of any commercial or

financial relationships that could be construed as a potential conflict of interest.

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