

# Neurodiversity Awareness or Diagnostic Contagion in the Age of TikTok: A Digital Qualitative Study of ADHD Autism and Self Diagnosis Content

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## ABSTRACT

TikTok has become a prominent site where users encounter psychological language about ADHD, autism, masking, sensory strain, executive dysfunction, and neurodivergent identity. Short-form videos can make neurodevelopmental experiences more visible and socially intelligible, especially for users whose difficulties have been dismissed, misnamed, or treated as personal failure. Yet the same accessibility can blur the boundary between self-recognition and clinical assessment. Using secondary digital qualitative content analysis, public TikTok videos were examined as communicative units composed of spoken narration, captions, on-screen text, hashtags, creator positioning, engagement indicators, and visible audience responses. The analysis found three connected patterns. First, neurodiversity content often worked as accessible psychological language by translating clinical categories into everyday experiences of work, school, family, and social interaction. Second, symptom generalisation and diagnostic cueing emerged when ordinary difficulties were framed through viewer-directed captions, checklist structures, and weak clinical qualification. Third, audience uptake shaped diagnostic meaning after publication, as comments could intensify peer validation, invite assessment-oriented inquiry, or reintroduce caution through lay correction. Diagnostic contagion is therefore better understood as a discursive pathway rather than a claim about the social spread of ADHD or autism. The findings shift attention from content accuracy alone to diagnostic usability, showing how platform form can make psychological labels emotionally persuasive and socially available before clinical uncertainty has been examined.



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## INTRODUCTION

Short-form social media has become a routine entry point into psychological language. Many platform users now encounter terms associated with ADHD, autism, masking, sensory overload, executive dysfunction, and autistic burnout before they meet a clinician, school counsellor, or formal psychoeducational source. TikTok matters in this shift because psychological meaning is not delivered through long explanation. Short videos arrange voice, caption, facial expression, on-screen text, and comment response into compact claims that feel personal and easy to reuse. A video framed as “things you thought were normal” can make a private difficulty feel newly legible, while the same format can make a clinically complex condition appear recognisable through a few everyday signs. The problem begins where ordinary recognition borrows the authority of diagnostic language without carrying the assessment work that diagnosis requires (Su et al., 2021; Zenone et al., 2021).

Neurodiversity content gains much of its appeal from the limits of formal recognition. Adults missed in childhood, women whose difficulties were folded into anxiety or personality descriptions, and users who grew up around stigma may find online language less dismissive than many institutional encounters. Personal accounts of social fatigue, sensory overload, or the effort of masking can help users name experiences that clinical resources may describe in detached or deficit-centred terms. Recent work on neurodivergent TikTok users suggests that the platform can support identity work, community formation, and a more accessible vocabulary for self-understanding rather than functioning only as a poor substitute for clinical consultation (Leveille, 2024). Such visibility matters because

neurodevelopmental difference is not experienced only through diagnostic criteria (McMillan, 2025). Daily life gives these categories emotional and social meaning long before a formal report gives them administrative force.

The clinical difficulty appears because TikTok's communicative form rewards recognisability more than diagnostic precision. ADHD and autism require attention to developmental history, impairment, differential diagnosis, and comorbid conditions. Short-form content compresses that complexity into signals that can be processed quickly, shared easily, and attached to the viewer's own life. Studies of ADHD-related TikTok content have reported substantial levels of misleading information, while research on autism-related videos has raised concerns about inaccurate and overgeneralised claims (Aragon-Guevara et al., 2025). Recent analyses also complicate the picture by noting that highly engaged content often comes from creators with lived experience, whose posts may be personally valid even where they remain clinically incomplete (Brown et al., 2024). A narrow misinformation frame would miss that tension. A creator can describe a genuine neurodivergent experience, yet the platform can detach the description from its diagnostic boundaries.

Self-diagnosis sits inside this tension rather than outside it. For some users, self-identification may be a provisional step toward assessment, particularly where services are costly, waiting lists are long, or clinicians remain inattentive to less stereotypical presentations. For others, TikTok can encourage a thinner form of diagnostic belonging in which stress, disorganisation, social discomfort, or emotional exhaustion is gathered under neurodevelopmental labels before alternative explanations have been considered (Kadir et al., 2025). A psychological account of TikTok-inspired self-diagnosis needs to avoid two mistakes. Treating users as gullible recipients of misinformation ignores their active search for language, recognition, and relief. Treating self-diagnosis as purely emancipatory ignores how recommendation systems, peer validation, and repeated exposure can make a provisional interpretation feel settled before it has been tested against clinical standards (Yeung et al., 2022).

Diagnostic contagion is used here in a restricted discursive sense. The term does not imply that ADHD or autism spreads socially, nor does it treat neurodivergent identity as a fashionable error. Diagnostic contagion refers to the circulation of simplified diagnostic cues through repeated narrative formats that invite users to translate broad experiences into possible clinical identity. The process is not reducible to false content. A video may include a correct description of executive dysfunction, but a caption, hashtag, or comment thread may still invite viewers to treat recognition as evidence. TikTok is especially important because its recommendation system can repeat adjacent content after small signals of interest, while comments often supply immediate social confirmation. Diagnostic meaning is shaped through that interaction between creator claim, platform repetition, and audience uptake (Foster & Ellis, 2024).

Existing research has begun to assess the quality of ADHD and autism content on TikTok, the role of lived experience in digital neurodiversity communities, and the psychological reasons young people may use social media for self-diagnosis (Alvares et al., 2025). A weakness remains in how the debate is organised. Accuracy-focused studies can turn lived experience into defective clinical information, while identity-centred accounts can leave underexamined the ways platform form thins diagnostic categories into relatable micro-signs (Karasavva et al., 2025). The sharper gap concerns how content can be affirming and diagnostically unstable at the same time. Personal testimony may reduce stigma, encourage help-seeking, and widen access to psychological language, yet the same communicative style can blur the difference between recognising oneself in a story and having sufficient grounds for a clinical label (Chen et al., 2025).

A secondary-data design can examine that instability without making claims about the clinical status of creators or viewers. Public TikTok videos, captions, on-screen text, hashtags, spoken transcripts, engagement indicators, and visible comment patterns give access to how neurodiversity is represented and how diagnostic suggestion is built into platform communication. Captioned symptom lists matter because they condense clinical language into portable cues. Comments matter because they reveal how viewers move from recognition to identification, doubt, correction, or requests for confirmation. Engagement patterns matter because they mark which forms of psychological language become publicly amplified, even though they cannot prove individual psychological effect. The analysis asks how public TikTok content makes neurodivergence recognisable, how diagnostic cues become attached to ordinary experience, and how viewers are invited to move between reflection, identification, and possible self-diagnosis. Neurodiversity awareness and diagnostic contagion are treated as

overlapping processes, not opposing categories, because platformed self-understanding often develops in the unsettled space between personal recognition and clinical meaning.

## RESEARCH METHODS

The research used a secondary digital qualitative content analysis with structured descriptive mapping. Public TikTok videos were treated as digital texts in which psychological meaning was produced through spoken narration, captions, on-screen text, hashtags, creator positioning, engagement indicators, and visible audience responses. The corpus consisted of publicly accessible videos related to ADHD, autism, neurodiversity, and self-diagnosis, collected through hashtag-based and search-based sampling rather than personalised For You Page exposure. This choice reduced dependence on the researcher's algorithmic profile and made the sampling trail easier to audit. Search terms were drawn from widely used neurodiversity discourse, including ADHD, autism, neurodivergence, AuDHD, masking, executive dysfunction, and self-diagnosis. Duplicate posts, purely promotional material, videos without substantive neurodiversity content, and clips whose meaning could not be reconstructed from available text or audio were excluded. The final corpus was designed to capture publicly visible discourse, not to represent TikTok as a whole.

Each video was analysed as a complete communicative unit rather than as a caption or transcript alone. Data extraction recorded the spoken transcript, on-screen wording, caption, hashtags, stated creator identity where publicly available, visible engagement metrics, and selected comment patterns that related directly to self-identification, correction, doubt, or advice-seeking. The coding procedure began with pilot coding on a smaller subset of videos to refine the codebook before full analysis. Codes covered content orientation, creator positioning, diagnostic explicitness, symptom generalisation, clinical qualification, identity framing, and audience uptake. Particular attention was given to moments where everyday experience was linked to possible ADHD or autism through checklist-style narration, emotionally relatable wording, or peer confirmation in the comment space. A second coder reviewed a portion of the corpus to check consistency in the descriptive categories, while interpretive differences were resolved through analytic discussion rather than forced agreement (Braun & Clarke, 2021).

The analysis combined descriptive content coding with reflexive thematic interpretation. Descriptive mapping was used to identify how often particular patterns appeared, such as diagnostic cueing, professional referral, lived-experience narration, and overgeneralised symptom framing. Thematic analysis then examined how these patterns shaped the boundary between neurodiversity awareness and diagnostic contagion. Diagnostic contagion was not treated as evidence that ADHD or autism spreads through social media, but as a discursive process in which simplified diagnostic cues circulate through short-form content and become available for self-interpretation.

## RESULTS AND DISCUSSION

### 1. Neurodiversity as Accessible Psychological Language

Across the coded corpus, awareness-oriented videos were most visible where creators translated neurodivergence into ordinary scenes of social, sensory, and executive difficulty without making direct diagnostic claims. The videos did not usually begin with formal criteria for ADHD or autism. Creators tended to start from a recognisable difficulty, such as needing several hours to recover after a routine conversation, abandoning a task because the first step felt mentally blocked, or feeling physically strained by lighting and noise in a crowded room. These scenes mattered because they shifted neurodiversity from an abstract clinical category into a usable vocabulary for everyday self-description. Spoken narration usually carried the affective weight of the claim, while captions and on-screen text condensed the experience into short psychological labels. The result was a form of public translation in which neurodivergence became easier to name before it became easier to clinically assess.

The awareness function was clearest when creators positioned their accounts as personal rather than diagnostic. A video might describe masking as the effort of rehearsing facial expressions before a workplace meeting, then frame that experience as part of a broader neurodivergent pattern without telling viewers to adopt the same label. In such cases, TikTok operated as informal psychoeducation rather than direct diagnostic instruction. The content gave viewers language for discomfort that may have been explained elsewhere as laziness, oversensitivity, poor discipline, or weak social confidence. Visible audience responses often intensified this recognition. Comments did not only praise the creator; they sometimes converted the video into a shared interpretive space where viewers expressed relief,

doubt, or the intention to seek further assessment. That movement from recognition to possible inquiry was different from immediate self-diagnosis, although the boundary remained thin (Turuba et al., 2024).

**Table 1. Awareness-oriented neurodiversity content and observable platform cues**

| Analytic pattern           | Observable platform cue                                                | Audience uptake                                              | Diagnostic boundary                                                       |
|----------------------------|------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------------------------|
| Lived experience narration | Spoken first-person account supported by brief on-screen wording       | Recognition, relief, and shared personal memory              | Lower diagnostic pressure when the creator avoids generalising to viewers |
| Identity affirmation       | Hashtags and captions that name neurodivergent belonging               | Community validation and reduced shame                       | Becomes less stable when belonging is treated as evidence                 |
| Informal psychoeducation   | Short explanation of masking, executive dysfunction, or sensory strain | Requests for clarification and further resources             | Depends on whether assessment and impairment are mentioned                |
| Corrective awareness       | Content challenging narrow public stereotypes of ADHD or autism        | Agreement, correction, and comparison with prior assumptions | More contained when complexity is kept visible                            |

The table makes the first finding more concrete because awareness appeared through several platform cues rather than a single communicative style. Lived experience narration relied heavily on voice and autobiographical detail. Identity affirmation was more likely to appear through captions, hashtags, and comment-based belonging. Informal psychoeducation often depended on the creator's ability to translate a psychological term without flattening it into a checklist. Corrective awareness appeared when creators pushed back against narrow images of ADHD and autism, especially the assumption that ADHD must look like visible hyperactivity or that autism must be obvious in every social encounter. These patterns overlapped within individual videos. A creator could begin with a careful personal story, add a caption that widened its relevance, and receive comments that moved the content closer to self-identification than the spoken narration alone had suggested.

Creator positioning also shaped how awareness was received. Videos by self-identified neurodivergent creators often carried credibility through personal detail, while professional creators used clinical vocabulary and disclaimers to maintain distance between reflection and diagnosis. Neither position was automatically more reliable. Lived experience sometimes offered nuance that professional summaries lacked, especially around masking, exhaustion, and delayed recognition in adulthood. Professional content, on the other hand, sometimes became too compressed for the platform and ended up resembling the simplified formats it tried to correct. This finding matters because the credibility of TikTok neurodiversity content was not located only in professional status. Credibility emerged from the relation between the creator's position, the specificity of the experience described, the clinical qualification provided, and the way viewers were invited to respond.

Awareness content also challenged stereotypes in ways that carried genuine psychological value. ADHD was not always framed around disruption or visible restlessness, and autism was not limited to social withdrawal or obvious impairment. Several videos made less publicly familiar experiences more legible, particularly the exhaustion of appearing socially fluent, the cost of constant self-monitoring, and the frustration of being competent in public while struggling with basic routines privately. Such narratives can reduce self-blame and widen the language available for help-seeking. Yet the same accessibility created analytic risk. The closer a video came to the viewer's ordinary life, the easier the video could be read as personally diagnostic. A claim such as "this can be part of autism" could slide toward "this means autism" once condensed into a caption, paired with a hashtag, or reinforced by repeated viewer comments (Gilmore et al., 2024; Skafle et al., 2024).

The first finding therefore concerns awareness as a fragile mode of psychological translation. TikTok made neurodiversity more socially intelligible by connecting diagnostic language to familiar

difficulties in work, school, family, and online life. That visibility should not be dismissed as misinformation, since many videos helped users separate neurodivergent experience from moral failure. The same communicative accessibility also weakened the distance between self-recognition and diagnostic certainty. Awareness was strongest when videos opened space for reflection while keeping assessment, impairment, and differential explanation in view. Where captions, hashtags, or comment threads pushed recognition toward belonging too quickly, the content began to prepare the conditions for diagnostic cueing, which became more explicit in the next pattern of analysis.

## 2. Symptom Generalisation and Diagnostic Cueing

The second pattern was coded through the relation between three elements, namely the explicitness of diagnostic wording, the presence or absence of clinical qualification, and the way the video invited viewers to apply the content to themselves. Diagnostic cueing did not always appear as a direct statement. More often, the cue was distributed across spoken narration, on-screen text, caption, hashtag, and comment interaction. A creator might speak cautiously about difficulty starting tasks or feeling depleted after social contact, while the on-screen wording translated that account into “missed signs” or “traits people ignore.” The spoken layer remained close to lived experience, but the textual layer pushed the video toward a broader diagnostic frame. This pattern explains why the analysis treated each video as a whole communicative unit rather than separating transcript, caption, and hashtag as independent fragments.

Symptom generalisation gained force through the platform’s capacity to make ordinary experience feel diagnostically meaningful. A delayed reply, an unfinished task, social exhaustion after a routine meeting, or discomfort with background noise can be part of neurodivergent life, yet such experiences can also arise from stress, poor sleep, anxiety, depression, grief, overwork, or temporary pressure. The difficulty was not that creators used ordinary language. Public psychological communication needs ordinary language to reach people outside clinical settings (Brennan et al., 2025). The problem appeared where short-form narration attached these experiences to ADHD or autism without making visible the clinical work that separates resemblance from diagnosis. Developmental history, persistence, impairment, differential explanation, and comorbidity rarely fit the rhythm of a video designed for quick recognition, so the absence of those elements often became less noticeable than it would be in a longer psychoeducational format (Verma & Sinha, 2025).

**Table 2. Diagnostic cueing and its coding basis in neurodiversity-related TikTok content**

| Level of diagnostic cueing | Coding basis                                                       | Dominant cue location                           | Audience-facing movement                               | Main analytical risk                                         |
|----------------------------|--------------------------------------------------------------------|-------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------|
| Reflective cueing          | Personal narration with cautious or open wording                   | Spoken narration and limited captioning         | Viewers are invited to reflect rather than identify    | Recognition remains unguided if further resources are absent |
| Suggestive cueing          | Viewer-directed wording such as “you might be” or “this could be”  | Caption and on-screen text                      | Personal experience becomes a possible identity prompt | Possibility begins to resemble evidence                      |
| Checklist cueing           | Several behaviours arranged as signs, traits, or missed indicators | On-screen text, caption, and hashtag clustering | Everyday difficulties are grouped under ADHD or autism | Clinical thresholds become less visible                      |
| Identity-confirming cueing | Caption, hashtag, and comments reinforce belonging                 | Hashtags and comment interaction                | Recognition moves toward self-identification           | Social validation can precede assessment                     |

The table indicates that diagnostic cueing was not coded only from the presence of psychological terms. A video mentioning ADHD or autism did not automatically count as diagnostically suggestive. The stronger cue emerged when viewer-facing language, compressed symptom framing, and weak clinical qualification appeared together. Reflective cueing left room for uncertainty because the creator narrated experience without pushing viewers toward a label. Suggestive cueing narrowed that distance by addressing the viewer more directly. Checklist cueing carried greater diagnostic pressure because separate behaviours were arranged as if their grouping already implied clinical coherence. Identity-confirming cueing was more unstable because comments and hashtags could turn resonance into belonging, even when the original video avoided direct instruction. These levels should not be read as a clean hierarchy inside every post, since individual videos often moved between them in a matter of seconds.

The most analytically significant cases were those in which the diagnostic claim was materially split across platform features. A creator could describe an experience in a modest tone, while the text overlay framed the same experience as a hidden sign of ADHD or autism. A hashtag then placed the video inside a wider neurodivergent discourse, and comments supplied recognition from viewers who felt that the video explained them. None of these elements alone proved misinformation (Kadir, 2025a). Taken together, however, they made self-diagnostic interpretation easier to reach. The platform form mattered here because TikTok does not require a diagnostic claim to be fully argued. A few coordinated cues can create the feeling of explanation before clinical qualification appears, and short videos often give that feeling enough emotional force to remain persuasive.

Clinical qualification was the main factor that separated careful awareness from premature certainty. Videos that referred to professional assessment, impairment, overlap between conditions, or the limits of short-form content kept diagnostic meaning more contained. Checklist-style content became more fragile because its persuasive force came from accumulation. Viewers were not asked to evaluate whether a single experience met a diagnostic threshold. They were invited to recognise a cluster of familiar difficulties and to treat that cluster as meaningful. Such framing can be emotionally relieving, especially for users who have spent years interpreting their difficulties as personal failure. Relief, however, can become epistemically stronger than the evidence available in the video. Once the content offers a name that reduces shame, the viewer may have little reason inside the platform encounter to slow down and ask what else could explain the same pattern.

Creator positioning complicated the coding of diagnostic cueing. Professional creators more often used cautionary language, yet professional status did not always prevent simplification once the content adopted attention-grabbing captions or quick checklist formats. Self-identified neurodivergent creators often offered more detailed accounts of embodied experience, particularly around masking, sensory strain, and executive difficulty, but autobiographical specificity could still become viewer-facing suggestion when captions widened the claim. Influencer-style content carried a different risk because psychological vocabulary was sometimes blended with personal branding and self-improvement language, making clinical terms appear as part of a broader identity script. The corpus therefore did not support a simple contrast between professional accuracy and lived-experience risk. Diagnostic pressure depended on how the claim was assembled across video form, textual framing, and audience invitation.

Audience response added another layer to diagnostic cueing. Public comments showed recognition, doubt, correction, peer confirmation, and requests for assessment advice. These comments cannot establish psychological effect, nor can they verify whether viewers later sought formal diagnosis. Their value lies in how they reveal uptake. Some comment threads widened uncertainty by reminding viewers that similar experiences can have different explanations or by encouraging professional consultation. Other threads narrowed uncertainty by turning recognition into collective confirmation. A viewer encountering repeated comments that echo “this explains my life” or “now I understand why I am like this” may experience the video as socially validated knowledge rather than as a preliminary interpretation. Diagnostic meaning was therefore shaped after publication, as comments and platform engagement extended the original video’s interpretive force (Hudon et al., 2025).

Symptom generalisation and diagnostic cueing clarify why the boundary between awareness and diagnostic contagion cannot be drawn around content accuracy alone. Some videos may describe real neurodivergent experiences while still allowing diagnostic meaning to travel beyond clinical limits (Kadir, 2025b). The more important issue is how TikTok’s communicative architecture joins relatable

narration, compressed textual cues, hashtag affiliation, and audience validation into a fast pathway from recognition to possible identity. Diagnostic contagion, in the restricted sense used here, refers to that pathway rather than to the social spread of ADHD or autism. The next layer of analysis turns more closely to audience uptake, where recognition, uncertainty, peer correction, and self-identification become visible as part of the platform’s public interpretive space.

### 3. Audience Uptake and the Unstable Boundary of Diagnosis

Within the coded comment subset, audience uptake was analysed in relation to the diagnostic cueing level of the original video, since comments often amplified or restrained the interpretive direction already established by captions, on-screen text, and hashtags. The comment space did not operate as a neutral reaction field beneath the video. It became a secondary interpretive layer where viewers tested whether a described difficulty should remain a personal resemblance, move toward diagnostic inquiry, or become part of a neurodivergent identity claim. Recognition responses were more visible beneath reflective or suggestive videos, while peer confirmation and identity uptake became more salient where checklist or identity-confirming cueing had already organised experience into signs, traits, or missed indicators. Comments cannot verify psychological effect, age, diagnosis, or later help-seeking. Their analytic value lies in how they make public the social handling of diagnostic meaning after a post begins circulating.

Audience uptake became stronger when personal resonance received immediate social confirmation. A viewer who saw part of their own life in a video could then encounter comments that repeated the same sense of explanation, asked whether assessment was needed, or framed the described experience as something many neurodivergent people had long failed to name. In such moments, the video’s diagnostic force no longer depended only on the creator’s wording. Collective validation added interpretive weight. This was most apparent under checklist-style content, where the comment thread often extended the logic of the video by treating recognition as cumulative. A single overlap might remain tentative, but several familiar difficulties, followed by many comments expressing similar recognition, could make the label feel increasingly plausible. The process remained social and discursive, not clinical (Samuel et al., 2024).

**Table 3. Audience uptake patterns and their relation to diagnostic cueing**

| Audience uptake pattern | Typical relation to video cueing                         | Comment cue                                                          | Diagnostic effect                                                        |
|-------------------------|----------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------|
| Recognition response    | More common under reflective and suggestive cueing       | Viewers state that the description feels personally familiar         | Keeps diagnosis open when uncertainty is still present                   |
| Diagnostic questioning  | Often follows suggestive or checklist cueing             | Viewers ask whether ADHD, autism, or AuDHD assessment is relevant    | Can support help-seeking while leaving room for premature interpretation |
| Peer confirmation       | Stronger under checklist and identity-confirming cueing  | Other users affirm that the experience fits the label                | Increases social confidence before clinical assessment                   |
| Corrective response     | Appears across cueing levels, especially contested posts | Commenters mention overlap, assessment, or alternative explanations  | Slows down diagnostic closure                                            |
| Identity uptake         | Closely tied to identity-confirming cueing               | Viewers use neurodivergent language as belonging or self-description | Makes the label socially meaningful beyond clinical criteria             |

The table clarifies why audience response cannot be reduced to an echo chamber. Some comments narrowed uncertainty, while others reopened it. Diagnostic questioning, for example, did not always indicate premature self-diagnosis. A viewer asking whether a pattern warrants assessment may be moving toward a responsible form of help-seeking, especially when other commenters recommend professional evaluation or point to overlap with anxiety, trauma, burnout, sleep problems, or depression.

Corrective responses performed a modest but important form of lay regulation. They did not turn TikTok into a clinical environment, yet they introduced friction into a space that otherwise rewards fast recognition. Such friction matters because diagnostic contagion, as used here, depends on the weakening of uncertainty. Where commenters kept alternative explanations visible, self-diagnostic closure became harder to sustain.

Identity uptake required more careful interpretation. Neurodivergent community language can reduce shame and help users articulate experiences that have been dismissed in family, school, or workplace settings. A comment thread where viewers describe feeling “finally named” or newly less alone should not be treated as evidence of false identity. The analytic concern begins when belonging replaces clinical reflection rather than supporting it. In identity-confirming threads, users sometimes moved from personal resonance to community membership without much attention to assessment, impairment, or differential explanation. That movement does not invalidate self-identification, particularly where formal diagnosis is inaccessible or historically biased against less stereotypical presentations. Still, the comment space can make a label feel settled because it has already provided explanation, relief, and social location.

Audience uptake also changed how video accuracy should be interpreted. A cautious video could become more diagnostically suggestive when comments repeatedly converted tentative recognition into label affirmation. Conversely, a strongly cueing video could be partially restrained when commenters questioned the generalisation or redirected viewers toward assessment. Meaning was assembled across interaction. The creator initiated a frame, platform features amplified the post, and viewers negotiated its relevance through public response. This finding complicates accuracy-based assessments that evaluate only the original video. Public neurodiversity content develops a social life after publication, and diagnostic meaning can shift as comments accumulate, repeat, contest, or soften the initial cue.

The audience layer brings the central tension of the analysis into sharper focus. TikTok neurodiversity content becomes powerful because psychological language arrives with visible traces of other people trying to interpret themselves. Shared recognition can reduce isolation and open a path toward help-seeking, but the same social visibility can make diagnostic language feel persuasive before clinical uncertainty has been examined. Diagnostic contagion, in the restricted discursive sense used here, emerges through the interaction of relatable narration, compressed textual cues, hashtag affiliation, and comment-based validation. The relevant object is not a single misleading post, but a platformed interpretive process in which recognition, doubt, correction, and belonging continually reshape the boundary between self-understanding and diagnosis.

The main contribution of the analysis lies in shifting attention from content accuracy to diagnostic usability. Neurodiversity-related TikTok content matters not only because some videos may be inaccurate, but because platform form can make psychological language easy to use as an explanation for the self. A lived account of masking, executive difficulty, or sensory strain may be valid as personal testimony and still be insufficient as diagnostic evidence. The difficulty begins when recognition becomes usable without the clinical work that should normally accompany diagnosis. Short-form narration supplies affective familiarity, captions compress that familiarity into a portable cue, hashtags attach it to a diagnostic community, and comments add public confirmation. Psychological knowledge is altered at the point where users can move from “this feels familiar” to “this may explain who I am” with very little friction (Kadir, 2024).

Diagnostic contagion becomes analytically useful only under that restricted meaning. The term does not refer to the social spread of ADHD or autism, and it should not be read as suspicion toward neurodivergent identity. A more precise use points to a pathway through which diagnostic cues circulate, intensify, and gain social confidence in platform interaction. The pathway begins with cue compression, where complex clinical categories are reduced into brief signs that can be recognised quickly. Viewer-directed framing then invites the audience to apply those signs to personal experience. Hashtag affiliation places the post within a larger diagnostic or identity discourse, while comment-based validation can make the interpretation feel socially supported. Contagion, in this sense, names the movement of diagnostic plausibility, not the production of neurodevelopmental conditions (Kadir, 2026).

The findings also refine debates on self-diagnosis. Online self-identification cannot be dismissed as gullibility, since formal systems often miss people whose symptoms do not match narrow stereotypes, especially adults, women, and users with limited access to assessment. TikTok can offer

language before institutions offer recognition. Yet the same process may harden into certainty too early when the platform supplies relief faster than it supplies clinical qualification. The critical psychological movement is a recognition-to-certainty pathway. Personal resonance becomes stronger when repeated videos, similar captions, and affirming comments make one diagnostic label feel more coherent than competing explanations such as anxiety, depression, burnout, sleep disruption, trauma, or ordinary situational strain. Self-diagnosis remains ambivalent because it can open a route toward assessment while also making assessment feel less necessary.

For digital mental health communication, the findings suggest that accuracy alone is too narrow as a professional standard. A psychologist, psychoeducator, or clinically trained creator may give technically correct information while still encouraging premature diagnostic closure through a checklist caption or a viewer-facing prompt. Relatable language should not be removed from public psychology, since accessibility is part of its value. Better communication would keep recognition available while slowing certainty. A short video can still mention persistence, impairment, developmental pattern, overlap across conditions, and professional assessment without becoming inaccessible. Even a modest phrase that frames the content as something worth exploring rather than something that confirms identity can preserve space for clinical reasoning (McCashin & Murphy, 2023).

The limits of the data clarify the level of the claim rather than weakening it. Public videos and comments cannot establish psychological effect, verify diagnosis, or reveal what viewers believe after leaving the platform. Engagement indicators mark visibility, not influence. Comments offer public traces of interpretation, not private mental states. Those limits are epistemically important because the relevant problem begins before measurable clinical outcome. TikTok matters as a site where diagnostic meaning becomes publicly available, emotionally persuasive, and socially negotiated before any formal assessment takes place. Neurodiversity awareness and diagnostic contagion share that space, and the boundary between them depends on how recognition is framed, qualified, repeated, and socially taken up.

## CONCLUSION

Neurodiversity-related TikTok content occupies an unstable position between public psychological education and premature diagnostic certainty. Across the analysed material, short-form videos made ADHD, autism, masking, sensory strain, and executive difficulty more socially intelligible, especially for users whose experiences had been dismissed, misnamed, or treated as personal failure in school, family, or clinical encounters. That accessibility should not be dismissed as a minor benefit. Public recognition can reduce shame, create language for help-seeking, and challenge narrow stereotypes about how neurodevelopmental difference appears in everyday life. The same communicative strength, however, can weaken the boundary between self-recognition and clinical assessment. Diagnostic meaning becomes persuasive through the combined work of spoken narration, captions, on-screen text, hashtags, and comment-based validation, rather than through the creator's statement alone.

Diagnostic contagion is better understood as a discursive pathway than as a claim about the social spread of ADHD or autism. The problem lies in how simplified cues travel through platform interaction and make a label increasingly usable as an explanation for the self. Relatable psychological language remains necessary because public mental health communication cannot rely only on technical vocabulary. Greater care is needed in how that language is framed, qualified, and socially reinforced. A more responsible standard would preserve recognition while delaying certainty, allowing neurodivergent identity to remain accessible without letting platform resonance replace diagnostic reasoning.

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