Neuroendocrinology Letters Volume 47 No. 1 2026
ISSN: 0172-780X; ISSN-L: 0172-780X; Electronic/Online ISSN: 2354-4716
Web of Knowledge / Web of Science: Neuroendocrinol Lett
Pub Med / Medline: Neuro Endocrinol Lett

CASE REPORT

"I am Borderline": Psychiatric Diagnosis, Identity, Self-Presentation, and Digital Culture in Borderline Personality Disorder

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Submitted: 2026-01-11 Accepted: 2026-03-03 Published online: 2026-03-12

Key words: **Borderline personality disorder; psychiatrization; diagnostic identity; identity diffusion; schema therapy; mentalization; digital self-presentation; social media; identity - focused psychotherapy; case vignettes**

Neuroendocrinol Lett 2026; **47**(1):37–52 **PMID:** 41915927 470107

Abstract

BACKGROUND: The psychiatrization of borderline personality disorder (BPD) has expanded beyond clinical contexts into identity formation, interpersonal regulation, and digital self-presentation. For individuals with BPD—whose psychopathology centrally involves identity diffusion—the diagnostic label may function not only as an explanatory framework but also as a stabilizing, defensive, or performative identity resource, particularly within online environments.
OBJECTIVES: This article aims to examine how individuals with BPD integrate psychiatric diagnosis into their self-concept, to identify the psychological and relational functions of diagnostic identity in offline and digital contexts, and to explore clinical implications for psychotherapy, with a focus on schema therapy.
METHODS: A narrative review of international literature on psychiatrization, identity diffusion, stigma, and digital self-presentation in BPD was conducted and integrated with four analytically constructed clinical case vignettes. There are composite, theory-driven models derived from extensive clinical experience and are used to illustrate recurring patterns rather than individual patient trajectories. The analysis is grounded primarily in schema therapy, complemented by

psychodynamic and mentalization-based perspectives.
RESULTS: Across the reviewed literature and case material, psychiatrization in BPD emerged as a dynamic and context-dependent process. Four prototypical patterns were identified: (1) diagnosis as a public or performative identity, (2) diagnosis as a protective shield against guilt and responsibility, (3) diagnosis as an idealized marker of sensitivity and moral value, and (4) diagnosis as a community-based identity providing belonging. While diagnostic identification often provides relief, coherence, and a shared language for emotional experience, rigid identification may constrain agency, reinforce maladaptive relational strategies, and become amplified by digital environments that reward emotional intensity and visibility. This article introduces a clinically grounded typology of psychiatrization in BPD, linking diagnostic identity to specific relational and regulatory functions across offline and digital contexts
CONCLUSIONS: Psychiatric diagnosis in BPD functions as a double-edged tool: it may support understanding and self-compassion, yet also risk becoming an identity substitute that limits psychological growth. Effective psychotherapy should therefore address not only symptoms but also the meaning and function of the diagnosis within the patient's identity system. Identity-focused work, strengthening of mentalization and emotion regulation, and reflective engagement with social media use are central clinical tasks. Further qualitative and longitudinal research is needed to examine how relationships to diagnosis evolve over the course of psychotherapy and across sociocultural contexts.

INTRODUCTION

Over the past two decades, psychiatric language has increasingly permeated everyday communication, popular media, and digital environments. Diagnostic terms once confined to clinical settings are now widely used in self-descriptions, online profiles, and community narratives. This broader process, commonly referred to as psychiatrization, denotes not only the expansion of psychiatric categories into social life, but also the increasing use of diagnostic language as a framework for interpreting the self, relationships, and moral responsibility (Rose 2007). While psychiatrization may contribute to greater awareness and destigmatization of mental disorders, it also raises critical questions about how diagnoses shape self-concept, interpersonal behavior, and expectations of change.

Borderline personality disorder (BPD) occupies a particularly sensitive position within this process. Clinically, BPD is characterized by instability of emotions, relationships, and identity, alongside chronic feelings of emptiness and a heightened dependence on external validation (Lieb *et al.* 2004; Rivnyák *et al.* 2021). These features make individuals with BPD especially vulnerable to incorporating diagnostic labels into their self-definition. For many patients, receiving a diagnosis provides relief and coherence by offering a language to describe previously confusing emotional states. At the same time, however, the diagnosis may become rigidly internalized, functioning not merely as an explanatory framework but as a central component of identity. Rather than remaining a descriptive tool, the diagnosis may become a defining reference point for understanding oneself and one's relationships. The contemporary digital environment appears to function not merely as a background context but as an active amplifier of psychiatrization processes, particularly in individuals with identity vulnerability.

The digital environment appears to intensify these dynamics. Social media platforms tend to privilege emotionally salient and highly personal content, which may resonate particularly strongly with individuals who experience intense emotional reactivity and heightened sensitivity to interpersonal feedback, as commonly observed in borderline personality disorder (Ooi *et al.* 2020; Yang & Crespi, 2025). Online spaces enable individuals with BPD to find community, validation, and shared narratives; however, they may also foster performative self-presentation, the romanticization of suffering, and the reinforcement of maladaptive behavioral patterns (King & McCashin, 2022; Beckmann, 2024).

Although existing research has addressed stigma and self-stigma in BPD (Rüsch *et al.* 2006; Quenneville *et al.* 2020; Ociskova *et al.* 2023), less attention has been paid to how individuals actively use the diagnosis in everyday life, particularly in relation to identity construction, interpersonal regulation, and online self-presentation. Specifically, the ways in which individuals with BPD strategically, defensively, or idealizingly integrate the diagnosis into their self-concept remain underexplored. Even fewer studies have examined these processes from an integrative clinical perspective that combines empirical literature with in-depth therapeutic experience.

The present article aims to address this gap by offering a narrative review of international literature on psychiatrization, identity, and digital self-presentation in BPD, complemented by analytically constructed clinical case vignettes. Rather than treating the diagnosis as a static label, the article explores how the BPD diagnosis functions dynamically within patients' self-concepts and relationships, and how these functions shape therapeutic challenges and opportunities.

Research Questions

The article is guided by the following research questions:
(1) How do individuals with BPD integrate the psychiatric diagnosis into their self-concept and identity narratives?
(2) What psychological and relational functions does the BPD diagnosis serve in offline and online contexts (e.g., explanation, protection, self-presentation, belonging)?

(3) How can different forms of psychiatrization be identified and therapeutically addressed within identity-focused psychotherapy, particularly schema therapy?

METHODOLOGY

This article is based on a narrative, conceptually oriented review of the literature combined with analytically constructed clinical case vignettes.

The aim of the narrative review is not to provide an exhaustive synthesis of the literature, but to integrate key theoretical, empirical, and clinical perspectives into a coherent conceptual understanding of psychiatric diagnosis as a potentially identity-shaping phenomenon in individuals with BPD. The reviewed literature was selected purposively from psychiatry, clinical psychology, psychotherapy, and related disciplines. Searches were conducted in PubMed, PsycINFO, and Google Scholar using combinations of the terms 'borderline personality disorder,' 'psychiatric diagnosis,' 'identity,' 'psychiatrization,' 'self-stigma,' 'social media,' and 'schema therapy,' with emphasis on publications from 2000 onward. Inclusion was guided by theoretical and clinical relevance rather than methodological criteria.

In addition to the narrative review, the article includes four clinical case vignettes illustrating distinct modes of psychiatrization in BPD. The vignettes are composite, theory-driven constructions based on the authors' long-term clinical experience rather than descriptions of individual patients. They are designed to capture recurring developmental and relational patterns observed across multiple cases rather than unique life histories.

The case vignettes serve an illustrative and theory-building function rather than an empirical one, aiming to make abstract clinical and sociocultural processes more tangible for conceptual understanding and clinical reflection. Each vignette represents a specific way in which psychiatric diagnosis may be internalized, communicated, or used in interpersonal and identity-related contexts (e.g., as a public identity, a defensive strategy, or a source of belonging). The clinical material is analytically linked to the narrative review by translating abstract concepts into concrete therapeutic situations, without claims of empirical generalizability.

All clinical interpretations and interventions are grounded primarily in schema therapy, complemented by psychodynamic and mentalization-based perspectives. Described interventions include work with schema modes, imagery rescripting, chairwork, emotion regulation strategies, and reflective work with transference and countertransference. Brief therapeutic dialogues are included to illustrate clinically relevant processes related to psychiatrization and identity work. The credibility of the vignettes lies not in representativeness but in their internal coherence, theoretical saturation, and consistency with established empirical findings cited in the narrative review.

The therapeutic processes in the vignettes are intentionally condensed for illustrative purposes. While homework engagement and change are depicted as relatively accessible, clinical work with BPD is typically non-linear and marked by fluctuating engagement and ruptures; these complexities are backgrounded to preserve conceptual clarity rather than to suggest typical treatment trajectories. The four-type psychiatrization typology was developed iteratively: initial prototypes emerged from recurring clinical observations, were refined against the reviewed literature on identity diffusion (Rivnyák *et al.* 2021), self-stigma (Quenneville *et al.* 2020), secondary gain (Kernberg, 1984), and online self-presentation (Ooi *et al.* 2020), and were subsequently operationalized through the construction of one case vignette per type. The typology is intended as a heuristic clinical framework, not a validated taxonomy

This methodological approach aligns with prior conceptual and clinically oriented work in personality disorder research, where analytically constructed vignettes are used to examine processes that are difficult to capture through standardized quantitative designs.

RESULTS

Psychiatrization in the context of BPD

The psychiatrization of BPD is described in the current literature as a complex process that can have both stabilizing and maladaptive effects. For many patients, receiving a diagnosis represents the first moment of understanding long-standing disorganized emotional experiences, chaotic relational reactions, and a pervasive sense of emptiness (Moltu *et al.* 2023). The diagnostic category provides a comprehensible framework, language, and narrative through which previously confusing experiences can be made sense of. Patients often describe the diagnosis as a source of relief ("I finally know why I am like this"), a finding consistent with qualitative studies examining internalized stigma and the meaning of identity in BPD (Aviram *et al.* 2006; Quenneville *et al.* 2020). At the same time, the literature cautions that the same diagnosis may function as a limitation if it comes to be interpreted as an unchangeable aspect of personality. Some individuals may gradually begin to interpret not only their symptoms, but also everyday emotional reactions predominantly through diagnostic language (Naslund *et al.* 2016; Stiles *et al.* 2023). Such a process may, in certain cases, contribute to a more rigid identification with distress patterns that are no longer experienced as readily modifiable, but rather as "natural" or even "typical of individuals with BPD." This mechanism closely resembles the classic psychodynamic concept of secondary gain (Kernberg, 1984), in which symptoms provide not only emotional

relief but also an identity-related advantage, such as an escape from guilt, responsibility, or disappointment.

The phenomenon of positive reinterpretation of a diagnosis is the subject of several studies focusing on self-identification on the Internet. Here, a diagnosis can be understood as a sign of authenticity, sensitivity or artistic depth. For example, this occurs in communities that romanticize emotional intensity, self-disclosure or instability as signs of a "sensitive nature" (Cervantes *et al.* 2023). Beckmann (2024) describes how some online creators use a diagnosis as part of a personal brand, which can also bring economic and community benefits. In such cases, a diagnosis can grow beyond its clinical function and become part of both public and private self-image, creating a tension between useful understanding and maladaptive identification.

The literature thus shows that the psychiatrization of BPD is not a unidirectional phenomenon, but moves between two poles: explanation and imprisonment, destigmatization and idealization, understanding and rigid labelling. Taken together, the literature suggests that psychiatrization in BPD oscillates between meaning-making and identity foreclosure, with clinical consequences depending on how flexibly the diagnosis is integrated.

The role of social media

The digital environment is an important factor that shapes identity, emotion regulation, and interpersonal functioning for people with BPD. Research shows that people with BPD traits publish more impulsive content, which is then accompanied by feelings of shame or regret; a cycle that closely matches the emotional dysregulation known to occur in BPD (Martinez-Aguirre *et al.* 2025).

The study by Ooi *et al.* (2020) shows that individuals with higher BPD scores exhibit higher interpersonal reactivity on social media, greater sensitivity to comments, and a greater need for validation. In such cases, social media acts as a "social mirror" that provides immediate but unstable and highly variable validation. This can lead some patients to become dependent on online positive feedback and to dramatize content to elicit stronger reactions from their audience.

Online platforms can actively shape the expression of pre-existing psychological tendencies by reinforcing emotionally salient content, encouraging performative self-presentation and reducing social inhibition (Hudon *et al.* 2025). While naming emotions is often considered a therapeutic tool, experimental research suggests a paradoxical effect. Labelling helps to downregulate high-intensity distress, but it can actually amplify distress when the emotional intensity is low or ambiguous (Levy-Gigi & Shamay-Tsoory 2022).

YouTube and TikTok have also become prominent spaces in which individuals with BPD share publicly accessible content that is often framed in quasi-therapeutic terms. Cervantes *et al.* (2023) note that these creators experience the online environment as a safe space for authenticity, largely because they are embedded within audiences that recognize and validate their lived experiences. At the same time, the authors caution against the risks associated with heightened emotional vulnerability: overly intense self-disclosure may contribute to re-traumatization or generate a perceived obligation to maintain a particular online persona. Similar concerns are echoed in systematic reviews examining the relationship between psychopathology and social media use (Yang & Crespi 2025; Paris 2020).

The digital environment thus functions as a structurally enabling context for psychiatrization in BPD — amplifying identity vulnerabilities while providing substitutive validation and belonging. The clinical implications of these dynamics are examined in Section 5.2.

Identity and the phenomenon of identity diffusion

Identity is one of the most important concepts in research on BPD (Faggioli *et al.* 2024). The concept of identity diffusion, as defined in the literature, refers to a state in which an individual is unable to integrate different parts of themselves into a stable and coherent self-concept (Rivnyák *et al.* 2021). People with BPD often describe the paradoxical experience of "many selves" or, conversely, "no self", a phenomenon that makes the diagnosis attractive as a structure that provides order where chaos reigned. In the online environment, identity diffusion becomes even more pronounced. Digital platforms allow for a selective and aestheticized presentation of identity, sometimes emphasizing vulnerability, sometimes strength or exceptionality. Some authors point out that online identities of people with BPD can be hyperbolized, dramatized, and at odds with their real-life experiences (Martinez-Aguirre *et al.* 2025). This creates a split between the "online self" and the "offline self," which can further disrupt the stability of the self-concept.

Patients often say things like "I'm braver online" or "I feel like someone there." These statements confirm that identities shared on social media act as compensatory mechanisms, but they can make therapeutic work more difficult if the patient begins to see their "digital self" as more authentic than reality (Faggioli *et al.* 2024).

Therapy: clinical challenges, risks and dilemmas

Working with patients who identify significantly with a diagnosis presents a specific clinical challenge. The therapist must delicately balance validating the experience with supporting change (Masterson *et al.* 1992; Linehan 1993). The diagnosis often has a dual function for the patient. It provides explanation and relief, but it can also serve as a protective shield against responsibility, frustration, or failure. Therefore, it is important in therapy to always examine what the diagnosis means to the patient at a given moment: is it a name for

Tab. 1. Summary of main themes of the narrative review

PART	KEY FINDINGS (SYNTHESIS OF LITERATURE AND CLINICAL OBSERVATIONS))
Psychiatrization and BPD	Diagnosis functions as a tool of understanding and as an identity label; it can stabilize but also limit. Risk of rigid identification, positive idealization or surrogate identity (Quenneville *et al.* 2020; Kernberg 1984).
Social networks	Emotionally charged content is algorithmically favoured; individuals with BPD publish more impulsively and react sensitively to feedback (Ooi *et al.* 2020). The online environment allows for support, but also for the creation of idealized identities and maladaptive patterns (Martinez-Aguirre *et al.* 2025; Cervantes *et al.* 2023).
Identity and diffusion	Identity diffusion leads to a feeling of emptiness and to the need to stabilize the self through diagnosis (Rivnyák *et al.* 2021). Online identities could be are selective, dramatized, and aestheticized; the split between the "offline self" and the "online self" increases instability (Paris 2020).
Therapy	The diagnosis can serve as a regulator of relationships, a defence, a tool of self-presentation, and a secondary gain. Therapeutic challenges include validation without reinforcing rigid schemas, working with mood states, mentalization, emotion regulation, and the gradual construction of an identity outside the diagnosis (Kernberg 1984; Young *et al.* 2003).

Note: Findings synthesize reviewed literature and clinically derived observations. This table is intended as an illustrative overview, not an exhaustive systematic summary.
BPD = Borderline Personality Disorder. Schema therapy.

a problem or an identity symbol? Is it a tool for regulating relationships? Is it a form of self-defence?

Kernberg (1984) points out that secondary gains can significantly influence treatment motivation and contribute to the rigidity of maladaptive patterns. Therapy must therefore address not only the symptoms themselves, but also the functions that the symptoms fulfil. For individuals who use the diagnosis to justify their reactions, mentalization and the ability to differentiate between emotion, impulse and behavior need to be encouraged (Fonagy & Luyten, 2009). For those who idealize the diagnosis, it is important to separate real personality resources from pathological interpretations. For those who engage problematically with online communities, it is necessary to create a bridge between the digital and real worlds – for example, through gradual behavioral experiments.

The review shows that psychiatrization is thus becoming not only a social phenomenon, but also a clinical problem that requires specific therapeutic tools.

CASE VIGNETTES

The case studies presented in this section are not descriptions of specific patients, but composite model stories created on the basis of clinical experiences. The individual stories combine recurring motifs from childhood, adolescence and adulthood, especially experiences with parental emotional unavailability, abandonment, relationship instability, self-harm, the search for identity and specific ways of handling the diagnosis in the offline and online worlds. In their creation, the emphasis was placed on protecting anonymity, maintaining clinical credibility and illustrating broader phenomena, not on documenting a unique individual. Each case study shows a specific way in which the diagnosis of BPD becomes part of the self-image; sometimes as a mark of authenticity, at other times as a protective shield, and at other times as a positively reinterpreted "gift" or a community identity. These patterns are not universal and represent one possible pathway.

The therapeutic parts of the stories describe what specifically happened in therapy: what situations were discussed, what sentences were said, and what exercises and homework were used. Theoretical commentary is then left until the mini-analysis at the end of each case study. These vignettes illustrate specific modes of psychiatrization rather than a typical clinical trajectory

Case vignette 1: "Thousands Are Following My Story"

Clinical narrative

Klára is a twenty-eight-year-old freelance graphic designer living alone who has gained a large social media following by sharing short videos about living with BPD. In these clips, she openly describes emotional instability, crises, self-harm, and relationship conflicts, receiving feedback that evokes pride, relief, and a sense of belonging. She enters therapy when she begins to feel that her life has become a performance for an audience and that, without online validation, she no longer knows who she is.

In childhood, Klára lived with a mother suffering from chronic depression and mood instability, who often withdrew emotionally and physically. Klára learned to be quiet, to wait, and to attune herself to brief moments of maternal availability. Her father worked abroad for most of the year and, despite sporadic attempts at closeness, remained emotionally distant. Klára recalls waiting for his attention and recognition, usually in silence and disappointment.

During early adolescence, Klára increasingly felt responsible for her emotionally unstable mother, who spoke about not coping and hinted at disappearance. Klára took on caregiving roles while experiencing that there was no space for her own emotions. At school, she alternated between invisibility and attention-seeking behaviors. After being told she was "too sensitive and dramatic" at age fifteen, she engaged in self-harm for the first time, later describing it as a way to feel something that belonged only to her.

In the following years, Klára moved through a series of shifting identities and intense but unstable relationships. At around twenty, after suicidal ideation following a breakup, she was psychiatrically hospitalized and first diagnosed with BPD. Reading the diagnostic terms, she felt that the description defined her more clearly than she could herself.

After discharge, she began consuming and later creating mental health–related content online. What started anonymously gradually became public and closely tied to her identity. As her audience grew, she experienced a sense of being fully seen and valued. A period of increased online attention marked a turning point, after which her daily life increasingly revolved around producing content and maintaining audience engagement.

Currently, Klára reports feeling that without recording videos she "does not exist." Periods of online silence trigger anxiety and fears of being forgotten. Offline relationships deteriorate as content creation takes priority, and even intimate crises are mentally framed as potential videos. This growing split between lived experience and performed self ultimately leads her to seek therapy.

Therapeutic process and interventions

In therapy, themes from childhood repeatedly resurface: the long silence in the apartment, the closed door of her mother's bedroom, the waiting to be noticed. The therapist does not judge Klára's behavior in social media, but shows interest in the specific emotions associated with these situations. Klára describes a mixture of fear, shame, and emptiness. When the therapist once asks, "When you see thousands of hearts under a video today, who does that remind you of?" Klára responds after a pause: "It's as if I finally knocked on that door and someone answered." In this moment, her childhood experience of invisibility becomes linked to her adult dependence on online attention.

The therapeutic process gradually shifts from sharing toward a gentle exploration of what happens immediately before and after publishing a video. Klára notices, for example, that before recording she often feels tense, frequently argues with her partner, or cancels plans in order to have "something to say." After publishing a video, a brief sense of relief and satisfaction follows, but within hours this is replaced by tension: she constantly checks view counts, reads comments, and responds to messages. The therapist asks her to begin documenting these cycles in a diary. Klára records the situation, emotion and video content she posts. After several weeks, she can see clearly that emotional downturns are not smaller after videos but often more pronounced.

In one session, she brings up a situation in which someone commented under a video: "This is just attention-seeking." Klára admits that she felt an urge to delete the video and simultaneously record another, even more emotional one. The therapist invites her to imagine how "little Klára," sitting alone behind the bedroom door, might respond to such a comment. After several minutes of silence, Klára quietly says: "She would say she'd rather not cry, so it wouldn't be her fault." The therapist then asks her to imagine a second scene: someone comes to the door, sits beside her, and says, "I see you, even when you don't cry, even when you're not recording anything." This imagery is repeated in various forms and gradually becomes one of the key stabilizing moments in therapy.

Practically oriented interventions include several types of homework assignments. One of them is an "offline day": one day per week during which Klára deliberately does not post or check social media. Initial attempts are extremely challenging; she describes physical restlessness, uncertainty, and the feeling that "something will happen if she is not online." Gradually, however, she learns to fill these days differently: she paints for herself rather than for her feed, goes for walks without her phone, and engages in face-to-face contact with others. Another task involves recording videos solely for a personal archive—videos that will never be published. Klára finds it surprisingly difficult to speak to the camera when "no one will be on the other side." The therapist understands this as a step toward learning to be a witness to herself, without an audience.

One session focuses on the question: "Who would you be if all profiles and accounts disappeared?" Klára initially remains silent and then says: "I don't know. Maybe nobody." The therapist does not offer superficial reassurance but instead searches with her, for concrete answers: "I am someone who is creative since childhood," "I am someone who hurts when others feel lonely," "I am someone who managed to survive so many silent days." Klára writes these sentences into a notebook that she carries with her as a counterbalance to the "numbers" on social media.

After several months, her online content also begins to change. Klára reduces the frequency of posting, stops sharing her most intimate crises in real time, and speaks more about learning to live beyond the screen. She loses part of her audience but gains a different type of follower—those who appreciate a calmer, more reflective tone. Toward the end of therapy, she says: "I have a smaller audience, but a stronger sense that I'm living my own life. I no longer want to be defined by how many people are watching me."

Brief Conceptual Analysis of the Case

This case vignette illustrates how Klára's childhood experience of invisibility and abandonment leads in adulthood to a desperate attempt to be seen at any cost. From a schema therapy perspective, persistent patterns rooted in an emotionally unavailable mother and an absent father are evident—particularly a deep fear of abandonment, a sense of emotional emptiness, and the belief that her needs are "too much" or "a burden." During adolescence, these experiences manifest in self-harm and shifting identities; in adulthood, they transform into performative emotional openness on social media. The online audience becomes a substitute source of validation that was missing in childhood, with view counts and comments replacing parental attention and recognition.

From a psychodynamic perspective, Klára's social media activity can be understood as an attempt to externalize and process an internalized maternal object that was emotionally distant and unstable. The audience functions as a "parent" who is constantly present, evaluating and affirming. The problem, however, is that this parent is inconsistent, fluctuating, and impersonal. Any decline in attention may unconsciously be experienced as a repetition of childhood abandonment. Therapy therefore aims to help Klára gradually build an internal representation of a "good enough" relationship, independent of online feedback, through

the therapist and through the strengthening of her own emerging "Healthy Adult" self.

The case vignette demonstrates how easily a diagnosis of BPD can become part of a personal brand in the digital environment and how thin the line is between destigmatization and performative self-presentation. At the same time, it shows that through concrete steps– mapping the publication cycle, using imagery-based interventions, conducting "offline" experiments, and searching for answers to the question *"Who am I without the diagnosis and without an audience?",* it is possible to gradually restore contact with authentic experience and strengthen an identity that is not solely based on the fact that *"thousands are following my story."*

Case vignette 2: "When the Diagnosis Becomes a Protective Shield"

Clinical narrative

Marek is a forty-year-old IT analyst who presents as calm and rational but enters therapy at his partner's insistence due to recurrent conflicts, anger outbursts, and emotional withdrawal. He describes himself as "simply borderline," a diagnosis he received three years earlier after the breakdown of another intense relationship that followed a familiar pattern of idealization, criticism, and an explosive ending.

Marek grew up with an unpredictable father who was abusing alcohol and a fearful, emotionally unavailable mother. As a child, he learned to stay quiet, avoid attention, and suppress fear. During episodes of paternal aggression, he recalls dissociative "shutting down," feeling detached from his body and surroundings. At school, he was bullied and responded by withdrawing internally and cultivating a sense of superiority, though this occasionally gave way to sudden, disproportionate rage, after which he felt ashamed and self-blaming.

In adolescence, Marek's coping strategies solidified into alternating withdrawal and explosive anger. He appeared emotionally detached but inwardly longed for protection and understanding. In adulthood, he succeeded professionally, finding safety in logic and structure, while intimate relationships replayed earlier dynamics. Initial idealization of partners quickly shifted to perceived attacks, followed by either prolonged silence or verbal aggression, then remorse.

Receiving the diagnosis of BPD brought relief and clarity, but it gradually became both an explanatory framework and a defensive shield. Marek began justifying his behavior as inevitable and unchangeable, using the diagnosis to deflect responsibility and to test whether his partner would stay. Only when she threatened to leave, stating she no longer wanted to live with someone hiding behind a diagnosis, Marek sought more intensive therapy.

Therapeutic process and interventions

The initial sessions were marked by ambivalence. Marek repeatedly emphasized that he "knows how borderline works," that he had "read a lot of articles," and that his problem is "given by the disorder." The therapist did not refute this; instead, he asked what the diagnosis had concretely taken from Marek and what it had given him. After several sessions, Marek said: "It gave me that I don't have to keep explaining why I'm so hypersensitive. And it also gave me the right to be treated considerately." When the therapist asked what it had taken from him, Marek was silent for a long time and then said: "Maybe… the possibility to say that some things are done by me, not by the disorder."

In a key session, Marek brings in a situation from the previous week: his partner was late from work and did not respond to a message for two hours. In his mind, a scenario in which 'she doesn't care anymore whether she comes home' and that she will "leave him anyway." When she arrived, he launched into a barrage of reproaches; she began to cry - he shouted: "We're not talking until you realize what this does to me!" The next day he texted her: "Sorry, you know I'm borderline, I just can't handle this."

The therapist asks:

Therapist: "When you say 'I'm borderline,' what exactly do you mean by that? What does it mean for you in that moment?"

Marek: "That my reactions are stronger, that I can't control it like others. That I can't help how everything floods over me."

Therapist: "But is there also something like, 'I can't help it at all'?"

Marek (after a pause): "Maybe. If I could help it, I would blame myself for hurting her. This way it sort of… falls on the diagnosis."

In this point, the therapist does not confront him directly, but broadens the perspective. In the next part of the session, they analyze what Marek felt in his body, what thoughts ran through his mind, and what he imagined would happen if his partner had not responded for even longer. Marek begins to recognize the core fear is not "an unanswered message," but a familiar childhood experience: someone close disappears, no one protects him, and he is alone in it.

In one session, the therapist spontaneously introduces the metaphor of an "Inner Child". In schema therapy terms, the therapist was addressing the activation of the Vulnerable Child mode beneath Marek's Angry Child reactions:

Therapist: "Let's replay that situation. Imagine ten-year-old Marek. Dad is gone, Mom is absorbed in fear. That boy is waiting to see whether someone will come. How does he feel?"

Marek: "He feels sick. His stomach is churning, he's afraid of every step in the hallway."

Therapist: "And what does he have to do for someone to notice him?"

Marek: "Either be completely quiet… or explode."

This moment opens a link between childhood experience and present functioning. The therapist invites Marek to describe both poles—the withdrawal and the explosion—in detail, and then returns to the situation with his partner:

Therapist: "When she didn't reply, which of those two ways was closer?"

Marek: "First I froze. And then I exploded."

Therapist: "It sounds as if that ten-year-old boy was left alone in the apartment again. And the diagnosis only comes second, as an explanation. But what's happening inside looks the same."

They gradually begin practicing a different response. Marek receives a concrete homework assignment: in a similar situation (a delayed message, the feeling of being ignored), he should do three things before responding at all: name out loud what he is afraid of ("I'm afraid she will leave me"), exhale deeply three times, and write a sentence in his diary: "The boy who was alone at home is waking up in me right now."

Only then should he consider whether to respond immediately or wait. At the next session, he reports that once he managed it—he wrote the sentence in his diary, walked through the kitchen, drank a glass of water, and responded only after twenty minutes. Instead of an outburst, he wrote: "I feel anxious when you don't reply, but I'll wait until you have time." His partner told him that evening that she noticed the change and that it felt "very different" to her.

In another phase of therapy, the topic of using the diagnosis as an excuse emerges. The therapist reflects Marek's phrases back to him: "I can't help it, I'm borderline."

Therapist: "When you tell her this, what do you hope will happen?"

Marek: "That she won't be so disappointed. That she'll understand I'm not just an asshole."

Therapist: "So one part of you wants to protect her from feeling you are bad. And one part of you protects you from guilt?"

Marek: "Yes. If I said 'I made a mistake,' I'd have to face that guilt. This way I split it, between me and the disorder."

A shared therapeutic task becomes helping Marek gradually say: "My past made this harder for me, but I am responsible for this reaction." The therapist asks him to write this sentence on a small note and carry it in his wallet. Another homework assignment involves writing a brief reflection after each conflict in three sentences: "What I felt," "What I did," and "What I want to try differently next time."

By the end of the first year of therapy, Marek reports fewer outbursts, and when they occur, he is able to apologize more quickly without referencing the diagnosis. In one session he says: "It's easier to say 'I'm sorry, I was cruel' than 'I'm sorry, that's my disorder.' Even though it's also harder." His partner reflects that she feels more seen as a person, rather than as a "caretaker of someone with borderline." For the first time, Marek mentions that he is beginning to experience the diagnosis as a description of a set of difficulties, not as an alibi.

Brief Conceptual Analysis of the Case

Marek represents a characteristic example of psychiatrization, in which a diagnosis shifts from a legitimate explanation of suffering into a protective shield that covers both inner vulnerability and responsibility for behavior. From a schema therapy perspective, his story reflects chronically unmet needs for safety, predictability, and protection. Growing up in an environment shaped by alcohol dependence and fear fosters deep patterns of expecting danger and abandonment. Marek learned that the world is unsafe, that others will not stand on his side, and that emotions must either be shut down completely or released explosively.

In his adult functioning, these experiences translate into two pronounced poles: withdrawal ("shutting down") and aggressive outbursts. Both are destructive for relationships, yet subjectively familiar and paradoxically "safe," because they resemble the known chaos of his home environment. The diagnosis of BPD enters this pattern as a framework that makes his experience more understandable, but also as a means of avoiding shame and guilt ("it's not entirely me, it's the disorder").

From a schema therapy standpoint, Marek's recurring phrase, "I can't help it, I'm borderline", reflect an attempt to preserve a fragile self-concept. Full acknowledgment of responsibility would collide with an old defectiveness schema ("I am a bad person"). Therapy therefore does not aim at simply "tightening the screws" or pressuring performance, but at gradual differentiation: his past made things harder, and at the same time he carries responsibility for how he responds today. This subtle distinction makes it possible for Marek to relinquish secondary gains from the diagnosis without denying his pain.

Psychodynamically, Marek's narrative reveals an inner conflict between an internalized aggressive object (the father) and a submissive, anxious object (the mother). In relationships, Marek oscillates between these poles, sometimes adopting the role of a dominating, shouting aggressor, and other times the role of a powerless victim who needs protection. Within his inner world, the diagnosis of BPD can become a third element, an "authority" that decides what is and is not possible, thereby relieving him of a sense of agency. In therapy, a corrective emotional experience is crucial: a therapist who remains present even when Marek's fear of abandonment is activated becomes a new, steadier internal object. Gradually, this creates the possibility for Marek to experience conflict, frustration, and guilt without having to hide behind the shield of the diagnosis or collapse into old childhood positions.

This case vignette illustrates that the goal of working with the diagnosis is not to remove it or invalidate it, but to transform its function: from a protective shield and alibi into a realistic description of difficulties with which the client can—step by step—work consciously and responsibly.

Case vignette 3: "A Sensitivity That Both Saves and Exhausts"

Clinical narrative

Martina is a thirty-year-old lower secondary school teacher who is widely perceived as exceptionally kind, empathic, and reliable. She consistently puts others' needs first—at work, in volunteer activities, and through a blog on sensitivity and mental health. She enters therapy feeling emotionally exhausted, dissociated, and increasingly unable to function, alternating between presenting herself as a "sensitive guide" and experiencing intense self-disgust. She describes herself as extremely sensitive and frames her BPD, diagnosed six years earlier after a crisis with self-harm and hospitalization, as both a gift and a burden.

Martina grew up in a high-functioning family where emotional expression was discouraged and personal worth was linked to performance. Praise was conditional, emotions were minimized, and she learned to earn acceptance by being capable, helpful, and undemanding. Her own fears and needs remained largely unspoken.

In adolescence, Martina developed a persistent sense of emptiness and instability, cycling through interests and relationships. Episodes of self-harm emerged in response to perceived failure or criticism. Although outwardly well-adapted, she felt invisible unless she excelled or helped others.

After receiving a diagnosis of BPD in early adulthood, Martina encountered narratives that positively reinterpreted sensitivity. She adopted this framework to counter feelings of weakness, integrating the diagnosis into a morally valued identity: someone who feels more, understands more, and therefore must

help more. This led to chronic overinvolvement, difficulty setting boundaries, and self-neglect, justified as the "price" of sensitivity. In intimate relationships, initial idealization gave way to strain as Martina demanded the same emotional availability she offered. A partner's need for space was experienced as personal rejection, reinforcing oscillations between grandiosity ("my sensitivity makes me exceptional") and worthlessness ("without helping others, I am nothing").

Therapeutic process and interventions

At the beginning of therapy, Martina speaks fluently, structurally, and with considerable insight, but most often about other people. She talks about her students, about a colleague going through a divorce, about a friend with depression. When the therapist asks, "And you?" she often answers: "I'm fine, I'm just tired." Only after several sessions does she admit that sometimes she finishes a blog post about how important it is to "listen to yourself," and then collapses into bed unable to comfort herself.

The therapist first decides to explore what Martina means by "sensitivity." In one session he invites her: "Try to tell me when you feel truly proud of being sensitive." Martina describes noticing a boy sitting rigidly at his desk, eyes red, trying to hide his notebook. After class she approached him, learned that his parents were divorcing, and offered individual support. When she talks about it, a spark appears in her eyes: "This is what I can do—see when someone is suffering."

Then the therapist asks her to describe a situation in which her sensitivity harmed her. Martina recalls a day when she stayed at school three extra hours after teaching, helping a colleague who was crying about her partner, then speaking with a parent of a "difficult" child, and finally writing a blog article about "how important it is to be there for others." When she came home, she was not even able to make dinner; she sat on the kitchen floor and felt an urge to hurt herself. In her mind she told herself: "I am completely empty. My sensitivity is killing me."

The therapist reflects this polarity: "It seems your sensitivity has two forms: in one you are a rescuer, in the other you are exhausted and empty." Martina nods and adds: "As if that's the price. Either I'll be useful, or I'll be nothing."

In the next phase of therapy, they focus on where this pattern came from. The therapist asks her to recall a childhood scene in which she tried to be a "good daughter." Martina describes an image: she stands in the living room holding a report card full of top grades; her parents sit in armchairs; she hands it to them. Her father says: "Good work, that's how it should be," and returns to his laptop. Her mother nods that she is glad Martina "didn't disappoint." No one says anything about how Martina feels. The therapist invites her, in imagery, to come closer to little Martina and ask what she longs for. After a silence, Martina says: "She wants someone to ask how she is. She wants someone to stroke her hair."

In imagery, the therapist enters as "another adult" and says to little Martina: "You don't have to be only high-performing. You can be sad; you can be tired. You matter even when you're not helping anyone." They return to this scene in subsequent sessions; Martina describes feeling pain "in her chest" when she imagines being worthy simply as herself, without performance.

Gradually, they introduce concrete interventions. The therapist suggests keeping an "energy diary": during the week Martina records situations that give her energy and those that drain it. After two weeks, they review the notes together. It becomes clear that the most exhausting experiences are long evening "therapeutic" calls with colleagues who repeatedly phone her with their problems, and weekend events where she takes on more tasks than had been agreed. In contrast, deeply nourishing moments are short, genuine contacts, such as when a student draws her a picture and brings it "just because," or moments when she reads, paints, or goes for a walk alone.

The therapist invites an experiment: "Next week, try saying 'no' once to a request that is not your obligation, and write down what happens." Martina initially responds with anxiety: "I can't, I would disappoint them." Still, she takes a tiny step: when a colleague suggests going for a drink after work "to talk through problems," Martina replies that she has another plan today. In her diary she notes intense tension, guilt, and fear that the colleague will like her less. At the same time, she records that after an evening spent quietly at home, she fell asleep without tears for the first time in a long time. Although Martina did not engage in self-harm following this boundary-setting experiment, she reported transient urges and self-critical thoughts, which were processed in subsequent sessions.

A significant moment in therapy involves working with her "heroic" part. The therapist uses a two-chair technique: on one chair sits the "sensitive rescuer," on the other "exhausted Martina." As the rescuer, Martina says: "I have to be there for others. If I'm not useful, I have no value. If I don't feel their pain, who will help them?" When she moves to the exhausted chair, she is silent for a long time and then quietly says: "I can't go on like this. Sometimes I feel sick just hearing the phone ring."

In the dialogue between these two parts, a new sentence gradually emerges: "I can be sensitive and still have boundaries." The therapist encourages her to use this sentence as an anchor in difficult situations. As homework, Martina writes it on small notes and places them where she is most often, her desk, the kitchen, and the bedroom.

Another set of interventions focuses on her relationship to the diagnosis. The therapist asks: "What would happen if someone told you your sensitivity is not a gift of BPD, but simply one of your traits?" Martina responds at first with mild defensiveness: "But I know I have BPD. That's not just a trait." The therapist assures her that he is not questioning the diagnosis, but exploring whether part of her idealization of sensitivity might be covering something else. After several sessions, Martina admits: "If it weren't a gift, but just a trait… I would have to find out more about myself. And maybe I would find out that I am… ordinary." This sentence opens a deeper theme: fear of ordinariness as a synonym for worthlessness.

In the concluding phase of therapy, they focus on helping Martina be "ordinary" also in relationships. She begins practicing conversations in which she does not analytically care for the other person, but shares small joys and worries of her own. In one session she says: "Yesterday I told my friend I was tired and didn't feel like talking about anything deep. We just watched a movie. And it was nice. I didn't have to be a therapist." The therapist highlights this as a moment in which Martina allowed

the relationship to be symmetrical rather than one-sidedly caretaking.

At the end of therapy, Martina says: "Before, I told myself my borderline sensitivity was a gift I had to sacrifice for others. Now I tell myself: I am sensitive. But first I need to use that sensitivity on myself, too."

Brief Conceptual Analysis of the Case

Martina's story illustrates a specific form of psychiatrization in which the diagnosis of BPD becomes an idealized source of identity. Instead of openly acknowledging vulnerability and emptiness, Martina defined herself through "sensitivity as a gift." Here, "borderline" is not primarily experienced as a cluster of difficulties, but as an explanation for exceptional empathy, thus, the diagnosis becomes a moral and identity label ("I am the one who feels more than others").

From a schema therapy perspective, a combination of emotional deprivation, conditional acceptance ("I am worthy when I perform"), self-sacrifice, and an underdeveloped self is evident. In childhood, Martina learned that love comes through achievement and emotional restraint. In adulthood, this pattern shifts into hyper-empathy and chronic caretaking of others: when she feels their pain, she experiences herself as "existing correctly." Her "sensitive rescuer" is, in fact, a compensatory mode that protects a small, exhausted, and neglected child inside.

In this case, the diagnosis of BPD strengthens an idealized self: it gives her sensitivity a name, a framework, and a kind of claim to moral status. Yet this also carries the risk that deeper experiences of emptiness, exhaustion, and anger toward her parents, who never saw her as an emotional being but as a well-functioning project, remain covered. Therapy therefore moves toward "disenchanting" the diagnosis as an exclusive identity source: sensitivity is not only a borderline "gift," but also a vulnerability when it lacks boundaries—and it is not her only characteristic.

Psychodynamically, Martina's pattern can be understood as a defence against a depressive experience of the self. Rather than meeting the feeling "I am tired; I'm not sure who I am," she identifies with the role of the one who rescues. A superego shaped by parental demands for performance and "reasonableness" is reflected in an inner voice that tells her she must be useful in order to have the right to exist. The idealization of sensitivity as a "borderline gift" function as a substitute form of grandiosity—grandiose not through power, but through empathy.

Therapeutically, a key turning point is making Martina's "ordinariness" tolerable. Imagery work (the report-card scene), the energy diary, experiments with refusal, and the two-chair dialogue help separate innate sensitivity from learned self-sacrifice. Over time, a "Healthy Adult" mode develops that can say: "Yes, I am sensitive. But I have the right to rest, set boundaries, and not always be in the rescuer role."

Martina's case thus shows how a diagnosis of BPD can be used to positively reinterpret one's functioning, and at the same time how thin the line can be between empowering acceptance and a risky idealization that leads to burnout and denial of one's own needs.

Case vignette 4: "I'm Not Just a Diagnosis—But I'm Afraid That Without It, I'm Nothing"

Clinical narrative

Tomáš is a twenty-four-year-old man diagnosed with BPD at nineteen during his first psychiatric hospitalization following self-harm and suicidal online postings. He lives with his mother, studies computer science remotely, and spends most of his time online, where he feels more real and coherent than in face-to-face interactions. He describes himself as a "digital person" and enters therapy as he becomes aware that his life has narrowed to the screen, while the idea of leaving online communities feels like a threat to his very existence.

Tomáš grew up as an only child with an absent father and a chronically exhausted but non-rejecting mother. Emotional contact was brief and practical rather than sustained. From early childhood, the computer became his main source of safety and continuity. During adolescence, repeated peer ridicule reinforced withdrawal into online spaces, where anonymity and shared interests reduced shame.

In online mental health communities, Tomáš experienced his first sense of being seen and mirrored. He adopted diagnostic language that gave structure to previously nameless states and felt deeply recognized in descriptions of BPD. Following a romantic rejection and escalating online distress, he engaged in self-harm and was hospitalized, where the diagnosis was formally confirmed.

Afterward, identification with BPD intensified. Tomáš became highly active in online BPD communities, eventually taking on a moderator role. The diagnosis functioned both as an explanation for his inner chaos and as a gateway to belonging and purpose. While his online identity expanded, his offline life stagnated: his studies remained isolated, relationships were almost exclusively virtual, and in-person contact provoked anxiety and identity confusion.

In therapy, Tomáš articulates a core fear: "When I'm not writing in the chat, it's like I stop being." Silence online triggers feelings of disappearance and worthlessness, while offline encounters are avoided because he "doesn't know who he is supposed to be." The diagnosis, once stabilizing, has become tightly bound to an online-dependent sense of self.

Therapeutic process and interventions

At the beginning of therapy, Tomáš speaks slowly and cautiously. He often looks down; occasionally he checks his phone. When the therapist asks what would happen if Tomáš had no internet access for one day, Tomáš instinctively laughs, then becomes serious: "I can't imagine it. I'd probably just lie there and stare at the ceiling." The therapist does not push. First, she tries to understand what the online world provides for Tomáš.

In an early session, the therapist asks Tomáš to recall specific moments when he felt truly "alive" or "connected" recently. Tomáš describes a late-night conversation with a small group of friends, in which they shared their worst memories and he felt as if they were "looking into the same hell." The second moment is when one member wrote to him privately: "Thanks for being here. If you hadn't messaged me, I honestly don't know what I would have done."

The therapist uses these experiences as a starting point. She does not judge them; instead, she asks: "What is most important in these situations, the platform, the diagnosis, or the fact that you are in contact?" After a pause, Tomáš admits that it is not so much the diagnosis, but the fact that "someone responds, that I'm not in a vacuum." At the same time, he adds: "If I didn't have BPD, I probably wouldn't belong there."

Gradually, the work centres on a sentence Tomáš repeats: "Outside the community, I'm nobody." In one session, the therapist asks him to imagine that the Discord server ends tomorrow for good, the admin deletes it, everyone scatters. What would remain? Tomáš falls silent and then says: "Me, my mom, my room, school… and a huge emptiness." The therapist takes this sentence as the core of their inquiry, highlighting how both the diagnosis and the community can cover a deeper identity vacuum.

In imagery work, Tomáš pictures himself as a twelve-year-old boy sitting in a dark room in front of a flickering monitor. His mother is at work; the apartment is quiet. The boy keeps pressing F5, waiting for a new message to appear on the forum. The therapist invites him to describe what is happening inside the boy. Tomáš says: "He's cold. He's scared that if he disappeared, no one would notice. But when a new post appears and someone replies to his comment, he feels that for a moment he exists."

In rescripting, the therapist enters the scene as an adult who sits down next to the boy without looking at the monitor. She says: "I see you, even when no one is writing. You don't have to wait for a ping to count." Tomáš cries during this image, and afterward says: "It never occurred to me that someone could be interested in me even without those messages." This experience becomes one of the pillars of subsequent work—building an inner relationship that is not dependent on immediate external feedback.

Another central theme is mentalization. Tomáš tends to interpret other people's silence as rejection. The therapist walks with him step by step through a concrete situation: Tomáš shared something personal in the chat; three people responded, two did not. In his mind, an automatic scenario appeared: "Those two don't care, maybe I annoy them." The therapist asks him to list at least three alternative possibilities for why the two did not respond. After a moment, Tomáš says: "Maybe they were tired. Maybe they were dealing with their own stuff. Maybe they'll read it later." Through shared exploration, he notices how quickly he moves from a fact ("they didn't write back") to an interpretation ("I'm useless to them").

A concrete homework assignment is the so-called "pause card": Tomáš writes on a small card the sentence: "I don't know why they aren't responding. My mind offers the worst explanation, but there are other possibilities." Whenever panic arises because reactions are absent, he is to take out the card and read it aloud. In later sessions he reports that sometimes it helps only slightly, but at other times it is enough to prevent him from impulsively deleting his account or posting dramatic statuses.

At the same time, the therapist and Tomáš plan small "offline experiments." These are not radical disconnections, but brief, manageable steps. The first is a ten-minute walk without his phone. Tomáš reports pounding heartbeats and the feeling that he is "missing something important," but he also notices that when he returns, nothing catastrophic has happened. Further experiments follow: sitting in a café and simply observing people for a while; attending a lecture at school and staying in the space for five minutes afterward instead of immediately fleeing home to his computer.

The therapist helps him process these situations by asking which parts of him are activated (an Impulsive Child that wants to return to the comfort of the community; a Detached Protector that would rather numb everything), and by strengthening a Healthy Adult part that can say: "It's unpleasant, but manageable. Even if I have no one in the chat right now, I still exist."

The topic of diagnosis is also important. At one-point Tomáš asks: "If I'm not in those borderline communities, am I still borderline?" Hidden in this question is the fear that without community and shared language his self-image will collapse. The therapist responds: "A diagnosis describes your difficulties, not your identity. What remains is you—with all your pain and also your strengths—regardless of whether you're in a chat right now." Together they then explore other features that characterize Tomáš: his sense of humour, his ability to write, his interest in programming, his sensitivity to injustice. In this way, they gradually expand his "self" beyond the borderline label.

After several months of therapy, Tomáš reduces the number of servers on which he is active and stops moderating the largest community, because he notices how draining it is. He begins attending consultations at school, and once a week spends time with a classmate with whom he shares interests in gaming and programming. When the therapist summarizes at the end of one session that Tomáš now lives "on two continents, online and offline," Tomáš smiles and says: "And it's not like I'm afraid to step onto the offline one anymore."

Brief Conceptual Analysis of the Case

Tomáš's story illustrates a community-based form of psychiatrization. Here, the diagnosis of BPD does not primarily function as a defensive label or as a source of personal exceptionality, but as a ticket into a world organized around "we borderlines." This communal identity provides what was missing in childhood: a sense of belonging, the ongoing presence of others, and a shared language for emotions that are difficult to tolerate. At the same time, it carries a risk of becoming a prison, without "we borderlines," the individual "I" may feel unable to stand on its own.

From a schema therapy perspective, schemas of abandonment, social isolation, emotional deprivation, and identity diffusion are prominent. A childhood of semi-solitude, without a stable second parent and with a chronically overworked mother, creates fertile ground for the feeling "if no one sees me, I stop existing." A Detached Protector in the form of retreat into the digital world and an "Impulsive Child" desperately seeking immediate feedback reinforce each other in the online environment. Within a community context, the BPD diagnosis provides a framework in which these modes feel "normal", in spaces where outbursts, emptiness, and self-harm are shared experiences, motivation for individual change can weaken.

Psychodynamically, Tomáš's reliance on online groups can be understood as an attempt to create a substitute "attachment family." The community functions like a woven network of internal objects, someone available at 3 a.m., someone who

Tab. 2. Comparison of four case vignettes of psychiatrization in individuals with BPD

Category	Case vignette 1 – "Thousands Are Following My Story" (Klára)	Case vignette 2 – "When the Diagnosis Becomes a Protective Shield" (Marek)	Case vignette 3 – "A Sensitivity That Both Saves and Exhausts" (Martina)	Case vignette 4 – "I'm Not Just a Diagnosis—But I'm Afraid That Without It, I'm Nothing" (Tomáš)
Main form of psychiatrization	Diagnosis as a public label and part of a personal "brand"; performative self-presentation	Diagnosis as an excuse and shield against guilt; a tool for regulating relationships	Diagnosis as an idealized "gift of sensitivity"; moralized identity	Diagnosis as a community identity ("we borderlines"); a source of belonging
Childhood / development	Emotionally unstable mother, often absent father; loneliness and longing to be seen; self-harm in adolescence	Aggressive alcohol-dependent father, submissive mother; fear and chaos at home; bullying; learned shutdown and explosive outbursts	Cold, performance-oriented family; little emotional contact; conditional acceptance based on achievement; emptiness and self-harm	Single mother chronically exhausted; much time alone at the computer; peer ridicule; escape into the online world
Dominant schemas	Emotional deprivation, abandonment, insufficient identity, dependence on validation	Abandonment, mistrust/abuse, emotional deprivation, insufficient self-control	Emotional deprivation, conditional love/approval, self-sacrifice, identity uncertainty	Abandonment, social isolation, emotional deprivation, identity diffusion
Dominant modes	Vulnerable Child; Overcompensation modes: "borderline influencer" (self-presentational mode); Perfectionist	Angry Child; Detached Protector; Critical/Punitive Parent	Idealized self – rescuer; Overachieving Child; Vulnerable Child	Detached Protector; Impulsive Child; Vulnerable Child
Key secondary gains	Attention, admiration, a sense of exceptionality and control over one's narrative	Reduced guilt ("I can't help it"), obtaining care, lowering others' expectations	Moral superiority through "sensitivity"; need to be indispensably useful	Belonging, continuous mirroring, confirmation of existence through the community
Typical relationship to the diagnosis	"I'm borderline and it defines me—my audience loves me for it."	"I'm borderline, that's why I react like this—you can't be mad at me."	"I'm sensitive because I'm borderline—it's my gift and my curse."	"I'm borderline like them—without them I'm nobody."
Interpersonal manifestations	Intense disclosure, dramatization, polarization between online and offline self; demands for attention	Cycle of idealization–devaluation, anger outbursts, manipulation via the diagnosis	Hyper-empathy, inability to refuse, burnout, inner oscillation between rescuer and worthlessness	Extreme dependence on online relationships, avoidance of offline contact, panic when the community goes quiet
Therapeutic focus	Exploring the boundary between authenticity and performativity; work with the Vulnerable Child; reducing dependence on the audience	Accepting shared responsibility for behavior; work with the Angry Child and transference; exposure to frustration	Separating innate sensitivity from learned self-sacrifice; working with burnout; building boundaries	Building identity beyond the community; mentalization; work with the "boy at the monitor"; gradual offline experiments
Typical interventions	Emotion diary before/after posting, imagery work, chairwork, digital "detox"	Imagery dialogue with the Angry Child, conflict diary, a crisis "anchor sentence," transference work	Imagery rescripting of parent-related scenes, energy diary, two-chair technique, practicing saying NO	Rescripting the lonely child at the computer, "pause card," mentalization dialogues, graded exposure to the offline world
Therapy outcome	Less frequent dramatic sharing, greater authenticity, expanded identity beyond the influencer role	Fewer outbursts, greater ability to apologize without using diagnosis as an alibi, more stable partnership	Reduced self-sacrifice, ability to say NO, shift from "borderline sensitivity" to "a self who has sensitivity"	Reduced dependence on communities, first more stable offline relationships, ability to experience himself as "Tomáš," not only "a borderline community member"
Psychodynamic perspective	Audience as a substitute parental object; longing for mirroring and confirmation of existence	Diagnosis as a defence against overwhelming shame and fear of abandonment; repetition of the relationship with an aggressive father	Idealization of the diagnosis as a defence against depressive emptiness; superego grounded in performance and "usefulness"	Community as a substitute attachment matrix; repetition of early loneliness and the need to be "held" by the group

Note: All four vignettes are composite, theory-driven constructions derived from clinical experience. They do not represent individual patients and are not intended to imply empirical generalizability.
Schema mode terminology (Vulnerable Child, Angry Child, Detached Protector, Impulsive Child, Healthy Adult, Critical/Punitive Parent) follows Young, Klosko, & Weishaar (2003). BPD = Borderline Personality Disorder

responds immediately when he writes "I feel awful." Yet this attachment matrix is unstable, fragmented, and impersonal: people disappear, servers shut down, conflicts escalate quickly without regulation. Tomáš thus repeatedly encounters micro-abandonments that reopen old wounds.

In this context, therapy becomes a space where Tomáš learns to tolerate emptiness and uncertainty in the presence of a stable other. Imagery rescripting ("the boy at the monitor") supports the development of an inner representation of an adult who stays with him even when no chat pings. Mentalization-based interventions help separate his own emotions from assumptions about others' motives. Gradual offline experiments are not only social-skills training, but also symbolic steps toward a self that exists outside the collective narrative about BPD.

Tomáš's case demonstrates that psychiatrization can occur on a collective level: the diagnosis is not only an individual experience, but also part of group identity. Therapeutic work then is not about "taking away the community," but about supporting gradual individuation, so that the patient can say: "I belong among people with similar struggles, but I am not only a member of that group. I am also Tomáš."

Brief synthetic commentary

The four presented case vignettes demonstrate that the psychiatrization of BPD is not a uniform phenomenon, but rather unfolds along four common pathways: as a public identity linked to performative self-disclosure (Klára), as a protective shield and substitute argument in interpersonal conflicts (Marek), as an idealized "sensitivity" providing moral status and meaning (Martina), and as a community-based identity that replaces a missing stable sense of self (Tomáš).

Across all cases, the diagnosis offers relief and a language for previously inexpressible experiences; at the same time, however, it may reinforce maladaptive patterns of emotional and relational regulation. The discussion therefore rests on the tension between these two poles: diagnosis as a helpful framework and diagnosis as an identity trap.

DISCUSSION

This discussion is structured around the study's guiding questions, focusing on (1) how individuals with BPD relate to the diagnosis in terms of identity and self-concept, (2) how digital environments shape and amplify these processes, and (3) what clinical implications arise for psychotherapy, particularly schema therapy and mentalization-based work.

The present narrative review and the four analytically constructed case vignettes provide converging evidence that psychiatrization in BPD can be deeply intertwined with processes of identity formation, interpersonal regulation, and digital self-presentation. In line with the guiding research questions, the discussion below synthesizes the findings with respect to (1) integration of the diagnosis into the self-concept, (2) the psychological and relational functions of the diagnosis across contexts, and (3) implications for psychotherapy and clinical practice.

Integration of diagnosis into self-concept (Research Question 1)

Across all four case vignettes, the diagnosis of BPD emerges as more than a descriptive clinical label; it becomes an organizing element of self-understanding. This finding is consistent with theoretical accounts suggesting that diagnostic categories increasingly function as identity resources in late modern societies (Rose 2007). In individuals with BPD, whose core psychopathology includes identity diffusion, chronic emptiness, and unstable self-representation, the diagnosis may provide a temporary sense of coherence and continuity (Rivnyák *et al.* 2021; Faggioli *et al.* 2024).

Patients' behavior can be understood as closely linked to their current self-concept, values, and identity narratives, rather than as a fixed or inevitable expression of identity. It is then natural for them to behave in accordance with this identity. Behavioral patterns associated with BPD may feel familiar and internally coherent to patients when they are aligned with an established self-narrative, even if they are experienced as distressing or maladaptive. Behavior that is not consistent with this identity is difficult because they have to put in a lot of effort - it is not something that comes naturally to them. Therefore, an essential part of change is the creation of a new identity based on their values and motivations. The change in behavior is then maintained because it has become congruent with an internalized sense of self — a process schema therapy addresses through consolidation of the Healthy Adult mode (Young, Klosko, & Weishaar, 2003).

Klára´s and Martina´s case illustrate how the diagnosis can be integrated into a positively framed self-narrative: as a marker of authenticity, sensitivity, or moral value. In contrast, Marek´s and Tomáš´s case demonstrate more defensive forms of integration, in which the diagnosis becomes a stabilizing explanation that protects against shame, guilt, or existential uncertainty. These patterns suggest that the incorporation of the diagnosis into the self-concept is not inherently maladaptive, but becomes problematic when the diagnostic label substitutes for the development of a differentiated and flexible sense of self.

Importantly, the case material indicates that rigid identification with the diagnosis often coincides with reduced perceived agency ("this is who I am, therefore I cannot change"), whereas a more reflective relationship to the diagnosis allows room for personal responsibility and growth. This distinction directly informs clinical work with identity in BPD.

What distinguishes contemporary psychiatrization from earlier identity processes is the algorithmic amplification of emotional expression, which not only reflects but actively shapes patients' self-narratives and interpersonal expectations.

Functions of diagnosis in offline and online contexts (Research Question 2)

Addressing the second research question, the findings highlight that the diagnosis of BPD serves multiple psychological and relational functions that vary across offline and online environments. These functions include the explanation of inner chaos, the regulation of relationships, the justification of behavior, the provision of belonging, and the construction of a public self.

The performative dimension of psychiatrization is most evident in Klára's case, where diagnostic identity becomes part of a public persona shaped by the logic of social media platforms. Consistent with prior research on YouTube and influencer culture (King & McCashin 2022; Beckmann 2024), emotionally intense self-disclosure is rewarded with attention and validation, reinforcing the dramatization and aestheticization of suffering. In this context, the diagnosis functions simultaneously as content, brand, and community signal.

Marek's case exemplifies diagnosis as a protective shield. Here, the label legitimizes emotional reactivity and deflects responsibility for relational harm, closely aligning with psychodynamic notions of secondary gain (Kernberg 1984). While the diagnosis reduces shame and self-blame, it also risks perpetuating cycles of idealization and devaluation by externalizing agency.

Martina's narrative reveals a subtler function: diagnosis as an idealized trait. Sensitivity is reframed as a "gift," enabling moral positioning and a sense of purpose through caregiving. This form of positive interpretation of symptoms resonates with findings that internalized stigma may oscillate between self-devaluation and compensatory exceptionality (Grambal *et al.* 2016; Quenneville *et al.* 2020).

Finally, Tomáš illustrates diagnosis as a communal anchor. Online communities organized around "we borderlines" provide belonging, mirroring, and a shared emotional language, compensating for early relational deprivation (Naslund *et al.* 2015; Gowen *et al.* 2012). At the same time, such communities may inadvertently reinforce dependence and impede individuation, particularly when identity becomes contingent on constant participation and feedback.

Taken together, these findings suggest that psychiatrization operates as a dynamic, context-dependent process rather than a uniform phenomenon. The diagnosis functions as a relational tool whose meaning and impact are shaped by personal history, social context, and digital environments.

Implications for psychotherapy and clinical practice (Research Question 3)

The third research question concerns how different forms of psychiatrization can be understood and addressed within psychotherapy. The present findings indicate that working with the diagnosis in BPD is not merely a matter of psychoeducation, but a central component of identity-focused therapeutic work.

Across cases, effective therapy involved neither rejecting nor uncritically affirming the diagnosis, but exploring its function for the patient at a given moment. This meta-reflective stance allows the therapist to validate genuine suffering while preventing the consolidation of a psychiatrized self-concept in which the diagnosis becomes a final explanation ("this is just how I am"). Therapeutic change appears more sustainable when patients gradually construct alternative identity narratives that are supported by consistent behavioral patterns.

Schema therapy provides a particularly useful framework for this task. By conceptualizing diagnostic identification as part of specific schema modes (e.g., Overcompensator, Detached Protector, Vulnerable Child), therapy can address the unmet needs that sustain rigid identification. Strengthening the Healthy Adult mode enables patients to acknowledge their diagnosis while reclaiming agency, responsibility, and flexibility.

The findings also underscore the importance of explicitly addressing social media use in therapy. Digital environments act as amplifiers of borderline dynamics by privileging emotional intensity, immediacy, and binary evaluations (Ooi *et al.* 2020; Yang & Crespi 2025). Therapeutic conversations about when online engagement supports connection and when it reinforces avoidance or performativity are increasingly essential.

Finally, conscious work with secondary gains emerges as a key clinical task. Across cases, diagnostic identification concealed basic relational needs, such as to be seen, held, not abandoned, or to feel useful. Addressing these needs directly reduces reliance on the diagnosis as a substitute identity and supports the development of a more authentic and resilient self.

Ethical and research implications

Beyond individual therapy, the findings raise broader ethical questions. As psychiatric diagnoses become embedded in popular culture and the digital attention economy, a tension arises between the destigmatization and the commodification of mental health (Bonnington & Rose 2014). While public sharing of lived experience can foster understanding and solidarity, it may also anchor identity primarily in disorder and transform suffering into consumable content.

From a research perspective, the psychiatrization of BPD remains insufficiently explored. Existing studies have focused predominantly on stigma and symptomatology, while the active use of diagnosis in identity construction, especially across digital contexts, has received limited attention. Longitudinal and qualitative research examining how relationships to diagnosis evolve during psychotherapy would significantly advance the field. Comparative studies across cultural

contexts, including Central and Eastern Europe, may further illuminate how sociocultural factors shape psychiatrization processes.

Although the present analysis focuses on borderline personality disorder, the described processes of psychiatrization may not be unique to BPD. Similar dynamics may emerge in other ego-syntonic personality disorders in which diagnostic categories can become closely intertwined with identity and self-regulation. For example, in obsessive–compulsive personality disorder, diagnostic concepts may be used to legitimize rigidity, overcontrol, or moral superiority, while in narcissistic personality disorder, diagnostic narratives may support grandiosity, exceptionalism, or defensive self-coherence. In these contexts, diagnosis may similarly function as an explanatory framework, a relational tool, or a protective identity structure. Future research is therefore warranted to examine how psychiatrization operates across different personality organizations, and to identify both shared and disorder-specific mechanisms through which diagnostic language shapes identity, interpersonal functioning, and engagement with digital or social environments.

Although the case material originates from a Central European clinical context, the identified patterns are conceptual rather than culture-bound and may be relevant across Western mental health systems.

Limitations

This study is limited by its narrative design and reliance on analytically constructed clinical material rather than systematically collected empirical data. While the case vignettes are grounded in extensive clinical experience and established theory, they do not allow for statistical generalization. In addition, the perspectives presented reflect primarily Western and Central European clinical contexts, which may shape the forms of psychiatrization observed. These limitations are inherent to the chosen methodology and underscore the need for complementary empirical and cross-cultural research. A further constraint is the circular relationship between the typology and the vignettes: both were developed by the same authors, with each informing the other. Additionally, all vignettes are narrated from the therapist's perspective; patient-centred qualitative approaches would provide an essential corrective lens.

CONCLUSION

The psychiatrization of BPD represents a multilayered phenomenon that extends beyond the boundaries of a clinical diagnosis and reaches deeply into the domains of identity, interpersonal relationships, and digital culture. The presented case vignettes have shown that a diagnosis can assume very different roles: for some, it is a source of relief and explanation; for others, a tool of social regulation or a form of self-presentation; and for still others, a compensatory identity offering an illusion of exceptionality or belonging. What all cases share, however, is that the diagnosis of BPD never exists in a vacuum. It always enters an already established relational and developmental context, which determines whether it becomes a supportive framework or an identity trap.

The findings indicate that the diagnosis of BPD is a double-edged tool. It can bring understanding and structure to the lives of individuals who have long struggled to make sense of their emotional states or intense relational reactions. It may function as a map that helps orient them within inner chaos and can serve as a first step toward deeper self-care. At the same time, the diagnosis carries the risk of rigid identification that constrains growth, reinforces maladaptive strategies, or becomes a means of avoiding responsibility. Diagnostic language that was originally intended to clarify certain behavioral patterns may transform into a language that maintains or even strengthens those very patterns.

For clinical practice, it is therefore essential to focus attention on work with identity, not solely on symptoms. Therapy for individuals with BPD must offer space for the gradual differentiation of the self from the diagnosis, while simultaneously supporting the development of a stable identity grounded in values, authenticity, and realism rather than in pathological patterns or community-based labels. Equally important is the cultivation of mentalization—the capacity to understand one's own emotions, thoughts, and motivations, as well as those of others. Mentalizing capacity reduces the tendency to interpret interactions through the filter of the diagnosis and decreases the risk of black-and-white thinking (Fonagy & Luyten 2009).

Another key therapeutic goal is emotion regulation, which enables patients to respond to frustration, criticism, or fear with greater coherence and less intensity. Emotion regulation creates space between impulse and response, thereby contributing to more sustainable relationships and to genuine change. Closely related to this is the need to address social media use, which can amplify borderline dynamics and undermine authenticity. Therapists should help patients discern the difference between sharing that is healing and sharing that is performative or exhausting.

Finally, it is necessary to highlight the lack of empirical studies directly focused on the psychiatrization of BPD. Existing research has largely concentrated on stigma, self-stigma, and online behavior, while targeted analyses of how individuals construct identity around a diagnosis, how this process evolves over time, and how it is influenced by psychotherapy remain scarce. Future research should therefore emphasize longitudinal designs, qualitative analyses of personal narratives, and the development of clinical approaches that help patients find a balance between accepting the diagnosis and cultivating personal autonomy.

Psychiatrization is neither solely a problem nor solely a benefit, but a relational and cultural process

shaped by personal history, social context, and available narratives of suffering and recovery. It is a process that reflects a human effort to understand oneself, to be seen, and to find a place in the world. An important task for clinicians and mental health professionals is therefore to support patients in using diagnosis as a framework for understanding rather than as a substitute for identity. In this sense, responsible clinical practice does not aim to strip patients of diagnostic language, but to ensure that such language remains open, revisable, and secondary to lived identity.

ACKNOWLEDGEMENTS

Language editing and translation assistance were supported by artificial intelligence tools, which were used to improve clarity, style, and consistency of the English text. The authors take full responsibility for the content of the manuscript.

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