When the Diagnosis Becomes the Self: How Years in the Mental Health System Reshape Identity in Borderline Personality Disorder

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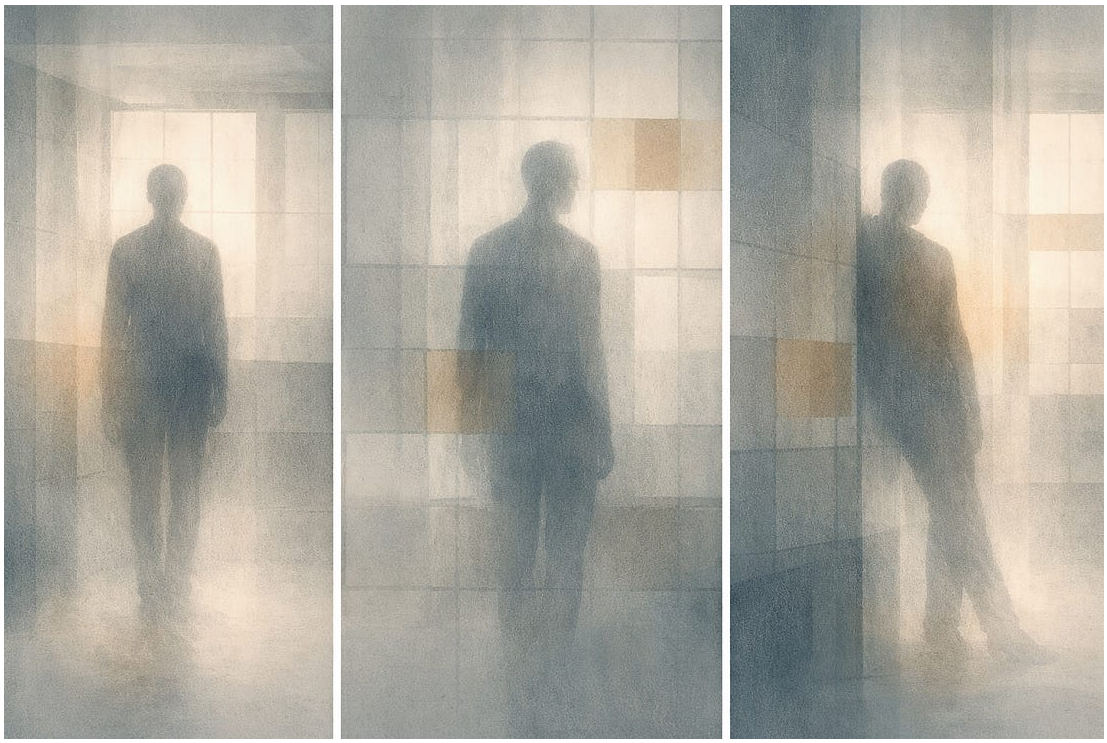


There's a question that haunts anyone who's spent enough time cycling through psychiatric care: *Does being in here mean there is something wrong with me?*

That line, the title of a 1989 study by Stephen Lally on psychiatric patients' self-concept, captures something that clinical research is only now beginning to take seriously. Not the question of whether someone

has a disorder, but what happens to a person's sense of who they are after years of being told they do.

For people with borderline personality disorder (BPD), this question cuts deeper than it does for almost anyone else. BPD is, at its core, already a disorder *of* identity. The DSM-5's Alternative Model for Personality Disorders places identity disturbance at the very foundation of all personality pathology, and both network analyses and factor analytic work confirm that identity pathology is particularly pronounced in BPD (Kaufman & Meddaoui, 2021; Leichsenring et al., 2024).

The system designed to help often becomes another force reshaping that identity, not always for the better.

The Starting Point: Identity Was Already Fractured

Before the first hospitalization, before the first therapist or crisis line or psychiatric evaluation, there was already a fracture. Research on identity disturbance consistently shows that people with BPD struggle to form a stable, integrated sense of self (Bogaerts, de Moor, & Lind, 2024; Kaufman & Meddaoui, 2021). They report feeling empty, shifting rapidly between different versions of who they are depending on who they're with, and having no clear sense of what they value or where they're headed.

But recent research has complicated the picture in important ways. Historically, identity pathology in BPD has been defined primarily by instability: frequent and rapid changes to goals, values, career plans, and relationships. Kaufman and Meddaoui (2021) argued that this conceptualization is incomplete.

Identity pathology also manifests as excessive rigidity, including unrelenting negative self-evaluations and overidentification with a restricted role or group membership, like defining yourself entirely as “the sick one” or “the borderline.” And it manifests as incongruence: simultaneously holding discordant beliefs, or acting in ways grossly contradictory to one’s stated values.

A landmark study by Wilkinson-Ryan and Westen (2000, as cited in Kaufman & Meddaoui, 2021) identified four factors of identity disturbance in BPD, including “role absorption,” where a single label or group membership comes to define the person’s entire identity. This finding becomes especially important when we consider what the mental health system offers as a role.

Bogaerts and colleagues (2024) found, using both self-report measures and personal narratives, that people with higher levels of personality pathology tend to tell stories about their lives marked by low agency (feeling passive, victimized, without control) and low communion (feeling disconnected, betrayed, abandoned). Their sense of self, when they can locate it at all, often reflects what that same research described as “persistent and pervasively negative self-evaluations,” with individuals scoring three to four times higher than comparison groups on items measuring feelings of worthlessness and feeling like a complete failure.

In plain terms: before the system ever gets involved, the person with BPD is already missing the internal scaffolding that would help them resist being defined by a single role or label. They are already prone to absorbing whatever identity is most available. And the mental health system has a very specific identity to offer.

First Contact: The Hospital as Identity Threat

Imagine being nineteen, twenty-two, twenty-five. You've been struggling with relationships that keep imploding, with self-harm that you can't explain to the people who love you, with emotions so intense they feel like they'll tear you apart. And then you end up in an emergency room. A crisis unit. An inpatient ward.

Erving Goffman (1961), in his landmark study of psychiatric institutions, described what happens next as the "moral career of the mental patient," a term he used not in the everyday sense of career success or failure, but to describe the regular sequence of changes that institutional processing entails in a person's self-concept and in the framework they use to judge themselves.

Goffman observed that on entering a psychiatric hospital, the new inpatient finds themselves “cleanly stripped of many of his accustomed affirmations, satisfactions, and defenses, and is subjected to a rather full set of mortifying experiences.” This is where, he wrote, “one begins to learn about the limited extent to which a conception of oneself can be sustained when the usual setting of supports for it are suddenly removed.”

Lally (1989), building on Goffman’s framework, found that patients almost universally arrive with deeply negative views of psychiatric institutions and the people in them. There is an immediate, visceral conflict: *I always looked down on places like this. And now I’m here.*

In the beginning, most people resist. They distance themselves from other patients. They explain their admission away: *I’m just here for a medication adjustment. I’m not like the others. I’m too smart to be really sick.* Lally described this not as clinical denial, but as a person desperately trying to hold onto a sense of competence, a self-concept that predates the hospital doors.

Goffman (1961) documented these same patterns with striking precision. He described how new patients may avoid talking to anyone, stay by themselves, even appear “out of contact” or “manic” so as to avoid any interaction that would force them to acknowledge what they have become in the eyes of others. He called this phase “not-hereness,” a taxing effort at anonymity that patients eventually give up as they “settle down” and begin to present themselves for conventional social interaction within the hospital community.

For someone with BPD, this stage is both more painful and more precarious. The self they’re trying to protect was never quite solid to begin with. The person without BPD who gets hospitalized after a psychotic break has a “before” to return to, a self that existed prior to illness. The person with BPD may not have that anchor. The question

isn't just *Will I get back to who I was?* It's *Was there ever a stable "me" to get back to?*

The Revolving Door: When Each Return Chips Away a Little More

BPD is associated with some of the highest rates of emergency department presentations and rehospitalizations of any psychiatric condition (Leichsenring et al., 2024). Crisis after crisis. ER visit after ER visit. And each one does something to the self-concept that the last one didn't quite finish.

Lally's (1989) quantitative findings showed that both the frequency and duration of psychiatric hospitalizations are significantly correlated with the adoption of a patient identity. Each return reinforces the message: *This is who I am. This is where I belong.*

At some point, it stops feeling like something that's happening to you and starts feeling like who you are.

One patient in his study put it plainly: each time they went back to the hospital, it made them accept the fact of their mental illness a little more, where before they had always wanted to deny it.

What Goffman (1961) described at the institutional level, Lally documented at the psychological level. Goffman showed how the physical structure of the hospital itself communicates identity. The ward system, with its graded levels of restriction and privilege, doesn't just organize care. It presents each patient's placement as "not as a reward or punishment, but as an expression of his general level of social functioning, his status as a person." The more "medical" and "progressive" a hospital, the more the patient may be confronted by staff arguing "that his past has been a failure, that the cause of this has

been within himself, that his attitude to life is wrong, and that if he wants to be a person he will have to change his way of dealing with people and his conceptions of himself."

For someone with BPD, the revolving door does something additional. It doesn't just say *you are sick.* It says *you are the kind of sick that doesn't get better.* And here, clinicians themselves become part of the problem. Leichsenring and colleagues (2024) noted that it often takes many years before individuals with BPD seek help, and that when they do, they are "unfortunately often still met with stigma with regard to the nature and treatability of their problems in many health care settings."

The message, spoken or unspoken, is that the person is somehow responsible for being back, that their suffering is manipulative, attention-seeking, a waste of resources. For patients who are already exquisitely sensitive to rejection, perceiving that distancing from clinical staff reinforces exactly the beliefs the treatment is supposed to address.

This experience gets woven into the person's narrative identity. Bogaerts and colleagues (2024) found that individuals with high levels of personality pathology recount events marked by helplessness, disconnection, and a sense of being acted upon rather than acting. Each hospitalization becomes another chapter in a story that says: *I am broken. I am beyond repair. I am not the kind of person who gets to have a normal life.*

The Middle Ground: Accepting the Problem, Mourning the Possibilities

There's a stage in the engulfment process that Lally (1989) described as the "middle stage," where the person has accepted that they have psychiatric problems but hasn't yet decided whether those problems are permanent. Patients in this stage often say things like *I'll get over this in a few years.* There's a sense of a parallel life still running alongside the current one, a normal trajectory that they've temporarily stepped off of and can return to if they just get well enough.

Picture someone in a partial hospitalization program, twenty-six years old, scrolling through social media during a break between group sessions. An old college roommate just got engaged. A high school friend posted about a promotion. The person puts the phone away. They've been in some form of treatment since they were twenty. They've done inpatient, outpatient, residential, day programs. They still believe, on good days, that this is temporary. On bad days, they are not sure there's a version of life where they're the one posting milestones instead of watching them scroll by.

Goffman (1961) observed something closely related. He described how patients construct what he called a "sad tale," a narrative account of their life designed to show that they are not responsible for what has

become of them. In the mental hospital, the setting and the house rules "press home to the patient that he is, after all, a mental case who has suffered some kind of social collapse on the outside, having failed in some over-all way." The patient responds by attempting to assert a story proving they are not really sick, that whatever trouble they got into was someone else's fault, that their past life had some honor and rectitude. These stories are shared with other patients and accepted without open question, a mutual courtesy that protects everyone's fragile self-concept.

Bogaerts and colleagues (2024) noted that identity disturbance is especially pronounced during the transition from adolescence to adulthood, a developmental stage focused on questions like "Who am I?" and "How do I fit into the social world?" When that stage is spent in treatment settings rather than in the ordinary crucible of early adult life, the loss is not just personal. It is developmental.

Something else happens in this middle stage. The person begins to feel more comfortable with other patients than with people outside the system. Lally (1989) described an "insider/outsider split": a growing sense that only people who've been through similar experiences can truly understand. Family and old friends become "outsiders" whose reactions must be carefully managed. Fellow patients become the people you can actually be honest with.

This shift is understandable. It's also a trap. Because as the person's social world narrows to the mental health system (therapists, case managers, group members, other patients), the system itself becomes the scaffolding of identity. The patient role is the only role that remains.

Estroff (1989, as cited in Yanos, Roe, & Lysaker, 2010) described this as the progressive restriction of roles until only the patient role is left. And for someone already prone to what Kaufman and Meddaoui (2021) called "overidentification with a restricted role or group membership," the pull is especially strong.

The Diagnosis as Identity: When BPD Becomes Who You Are

Here's where the research on illness identity becomes most relevant, and most troubling.

Yanos, Roe, and Lysaker (2010) proposed a model in which the meanings a person attaches to their diagnosis directly shape their hope, self-esteem, and ultimately their recovery. The key finding is this: it's not just *whether* you accept a psychiatric label that matters. It's *what you believe that label means about you.*

For someone with BPD, the label often comes loaded with meanings that are uniquely destructive to self-concept. Unlike depression or anxiety, which are widely understood as things that can happen to anyone, BPD is a *personality* disorder. The diagnosis doesn't say *something is wrong with your mood.* It says *something is wrong with you.* With your personality. With the core of who you are.

Picture the moment someone reads their discharge paperwork and sees the diagnosis for the first time. Or the moment a therapist explains what BPD means, and the person goes home and searches for it online, finding forums full of people calling borderlines manipulative, untreatable, toxic. That search becomes a defining experience, because the person was already looking for a framework to explain their own suffering. The disorder gave them one: *You are the problem.*

Leichsenring and colleagues (2024) documented that BPD is associated with considerable functional impairment, intensive treatment utilization, and high societal costs, yet the stigma surrounding it remains deeply entrenched in clinical settings.

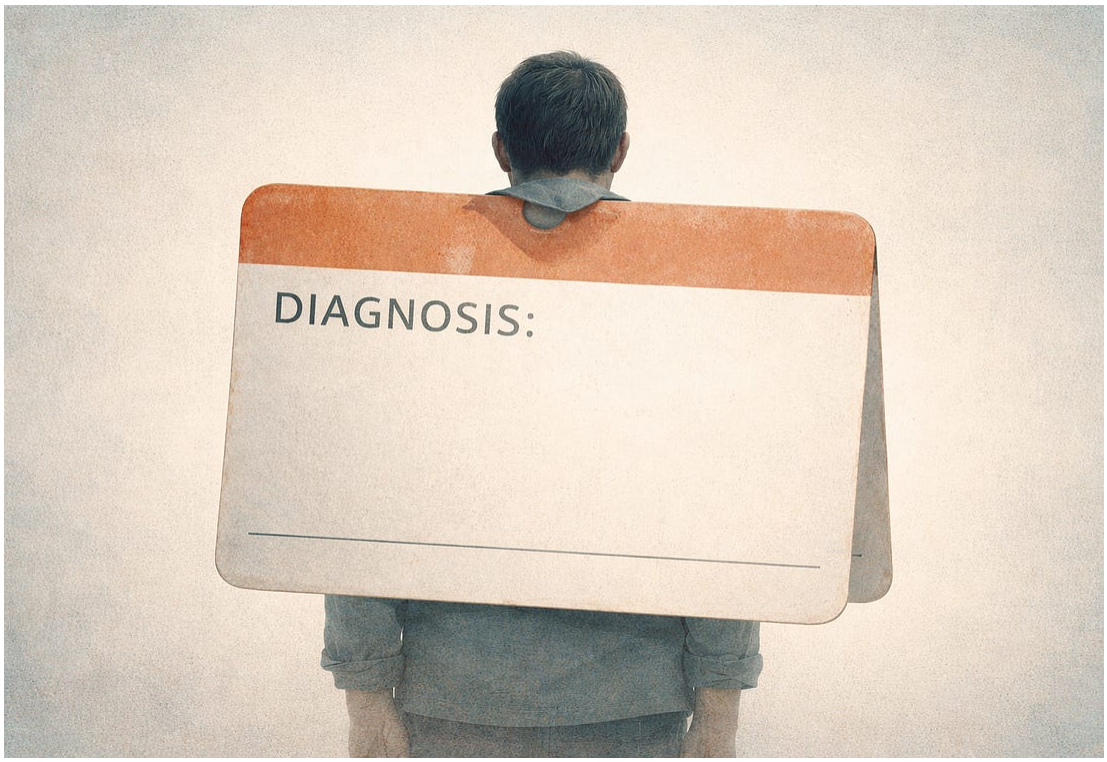
It is worth noting that much of the empirical research on illness engulfment and identity has been conducted with people diagnosed

with schizophrenia, not BPD (Lally, 1989; Konsztowicz & Lepage, 2019; Yanos et al., 2010). The inferential bridge to BPD rests on a specific connection: Kaufman and Meddaoui's (2021) finding that identity pathology in BPD includes "role absorption," the overidentification with a restricted role or group membership that is functionally equivalent to what Lally called engulfment and Yanos called illness identity. The mechanism is the same: a person becomes defined by their diagnosis. The difference is that in BPD, the person was already vulnerable to exactly that process. The identity was already fragile. The label doesn't have to fight its way in.

Konsztowicz and Lepage (2019) found that illness engulfment mediates and moderates the relationship between clinical insight and depressive symptoms in schizophrenia. When people are more aware of their illness *and* have become engulfed in a patient identity, they experience more depression than people who are equally aware but haven't been engulfed. Lysaker, Roe, and Yanos (2007, as cited in Yanos et al., 2010) demonstrated the same pattern with internalized stigma: individuals with high insight who had also internalized stigmatizing beliefs showed lower self-esteem and less hope than those with equivalent insight who had rejected those beliefs.

The person stops being someone who *has* BPD and becomes someone who *is* borderline. The diagnosis swallows every other possible identity: friend, artist, worker, parent, partner.

That same body of research hypothesized that extreme instability may actually reinforce negative self-evaluations, as individuals struggle to make sense of their own contradictory feelings and actions ("I must be broken"). Once entrenched, these negative self-appraisals color the interpretation of all social and contextual information, with attentional biases toward negative feedback that is personally relevant becoming particularly pronounced (Kaufman & Meddaoui, 2021).



The Mourning No One Talks About

In the late stages of engulfment, Lally (1989) described something that deserves more attention than it gets: the mourning of a lost self.

Patients in his study spoke about this with a rawness that's hard to read without feeling it. One woman said: *The real me wouldn't let me be on account of the way I was. I want to weep because that was me. You can't think about things like that. Got to change.*

Another put it this way: *Before I used to see myself as very able, able to handle things, very strong person. Now I see myself as just the opposite. Just have to accept it.*

Goffman (1961) described the structural conditions that produce this mourning. He wrote that the mental hospital is an "extreme instance" of how the physical facts of an establishment can be "explicitly employed

to frame the conception a person takes of himself." When a patient's ward placement, daily restrictions, and every interaction with staff all communicate the same message, namely that they are a person who has failed and whose condition justifies their current degraded status, the self-concept eventually buckles under the weight of that message.

For people with BPD who have been through years of treatment, this mourning takes a specific shape. It's not just mourning the loss of what they were. It's mourning the loss of what they might have been. The version of themselves that might have existed without the disorder, without the hospitalizations, without the years lost to crisis and treatment and trying to hold the pieces together.

It's a grief for a self that may never have fully existed, which makes it harder to name and harder to resolve.

What Clinicians Can Do: Identity as a Treatment Target

The research isn't all grim. There's growing evidence that the process of engulfment can be interrupted, and that people can construct identities that include but are not consumed by their experiences with mental illness. But this requires clinicians to think about identity as a treatment target, not a background feature.

The major evidence-based treatments for BPD each address identity, though they approach it through different lenses (Leichsenring et al., 2024). Some focus on building skills and stabilizing the sense of self: DBT teaches mindfulness and distress tolerance as ways of grounding a self that otherwise fragments under emotional pressure. Others work through understanding: MBT helps patients restore the capacity to make sense of their own and others' mental states, addressing the mentalizing imbalances identified as central to BPD. Still others target identity integration directly: TFP explicitly aims at "normalization of personal identity" through working with the split-off, contradictory aspects of self-experience, while schema therapy develops the "healthy adult" mode, countering the punitive and abandoned child modes that fuel negative self-definition, with a final phase that focuses specifically on "the sense of identity."

Beyond these specific modalities, Yanos and colleagues (2010) described how narrative approaches can help people challenge internalized stigma and reconstruct a sense of self that includes themes of agency and strength, building richer self-narratives that emphasize connection and meaning alongside the challenges of illness.

But perhaps the most important clinical implication cuts across all modalities: how the diagnosis itself is communicated and held.

Leichsenring and colleagues (2024) recommended that BPD patients be informed about their diagnosis, expected course, risk factors, and

treatment options as a first step. How that conversation happens matters enormously. Consider the difference between two approaches. A clinician says: *You have borderline personality disorder. It's a serious condition that affects your personality and your relationships. Treatment is long-term.* The patient hears: *Something is fundamentally wrong with who I am, and it's probably not going to change.* Now consider: *What we're seeing is a pattern of intense emotional responses and relationship difficulties that have a name, and that name is BPD. It's one of the most researched and treatable conditions in personality psychology. People recover from this. The patterns you've developed make sense given what you've been through, and they can change.* The patient hears something different: *There's a framework for understanding this, and it doesn't mean I'm broken.*

In Goffman's (1961) terms, the question is whether the institution offers the patient only a degraded identity, or whether it also offers materials from which a more complex and livable self can be constructed.

But here is where the engulfment framework demands something that existing treatments don't fully provide. DBT, MBT, TFP, and schema therapy each address aspects of identity, but none of them were designed around the specific process this post has described: the progressive narrowing of a person's self-concept to the patient role through repeated institutional contact, stigma, and role absorption.

An intervention designed from the engulfment framework would need to do something different. It would need to explicitly monitor whether treatment itself is reinforcing the patient identity it's trying to dissolve. It would need to actively build and protect non-clinical roles and identities throughout the course of care, not as an afterthought once symptoms stabilize, but as a primary treatment target from the beginning.

It would need to attend to how each element of the treatment structure (the frequency of appointments, the language on intake forms, the physical environment of the waiting room, the way progress is measured) communicates something to the patient about who they are.

And it would need to treat the moment a patient begins to define themselves primarily through their diagnosis not as insight, but as a clinical warning sign.

We do not yet have a manualized intervention that does all of this. The closest approximations are NECT (Yanos et al., 2010) and the engulfment-focused group work tested by McCay and colleagues (2007, as cited in Konsztowicz & Lepage, 2019), but both were developed for psychosis populations, and neither has been adapted or tested for BPD. This is perhaps the most actionable gap the engulfment literature points to.

The key finding from the engulfment research is surprisingly hopeful. Konsztowicz and Lepage (2019) found that at low levels of engulfment, greater awareness of illness was actually associated with *lower* depression scores. It's possible to have good insight into your mental health challenges without experiencing depression or loss of identity, if illness engulfment is minimized.

The awareness itself isn't the problem. The problem is when that awareness exists in the absence of any other framework for understanding who you are.

Kaufman and Meddaoui (2021) noted that identity pathology appears amenable to treatment, but that we currently lack a clear understanding of the mechanisms of change producing improvement. Closing that gap may require building interventions around the engulfment process itself, not retrofitting identity work onto frameworks designed for other purposes.

For someone with BPD, recovery isn't just about symptom reduction. It's about the slower, harder work of building an identity that can hold the experience of illness without being defined by it. As Bogaerts and colleagues (2024) noted, narratives can be modified through intervention, and narrative therapy focused on reconstructing life

stories emerges as a promising approach to promote identity integration.

Recovery means learning to tell a story about your life in which you are not just a patient, not just a diagnosis, not just a collection of crises, but a person who has been through something extraordinary and who is still, against considerable odds, becoming.

The self is not a fixed thing. It is a story we are always in the process of telling. And the most important part of recovery may be reclaiming the right to be the one who tells it.

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