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Features of YouTube™ videos produced by individuals who self-identify with borderline personality disorder

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Abstract

Objectives: Many individuals use YouTube™ to seek out information and share first-hand experiences about mental illnesses, as well as to gain a sense of community. YouTube™ use may be especially appealing when offline supports are lacking or difficult to access, and when there is a fear of stigmatisation. Borderline personality disorder (BPD), also referred to as emotionally unstable personality disorder (EUPD), is a complex and often stigmatised mental-health disorder. The primary objective of this study was to describe the dominant messages that individuals who self-identify with the diagnosis of BPD present through YouTube™ videos.

Methods: The content analysis method was used to review 349 first-person YouTube™ uploads. Videos were coded for information regarding video and vlogger characteristics, video type, vlogger motivation and video content. Associations between video features including upload date and style and vlogger experience and motivation were examined.

Results: Findings indicate that more people who self-identify as being diagnosed with BPD are creating YouTube™ videos about their experiences, and these videos have shifted over time from being mostly anonymous multimedia productions to being monologues where the vlogger speaks directly to their audience. Discussions related to DSM-5 symptoms, treatment, effective coping and hope for the future are elements found in the uploads.

Conclusion: The nature and content of BPD first-person YouTube™ uploads has increased and changed over time. Increased awareness of these changes may assist mental-health practitioners to support clients and direct them to explore uploads that offer hope and promote engagement in help-seeking and effective coping behaviours.

Keywords

Borderline personality disorder, YouTube™, first-person vlogs, mental health, coping strategies

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Introduction

Recently, there has been increased global recognition of the prevalence and potentially disruptive impact of complex and severe mental illnesses, such as borderline personality disorder (BPD), on individuals' lives.[1] While mental-health professionals globally have long been familiar with individuals who present with various characteristics of BPD, the use of the diagnostic label is relatively recent. For instance, BPD was first officially recognised in North America in the third edition of the Diagnostic and Statistical Manual of Mental Disorders.[2] Almost a decade later, and following substantive validation of the BPD construct, emotionally unstable personality disorder (EUPD) was included in the International Classification of Diseases (ICD-10) which is used in more than 100 countries.[3] Sharing many of the same diagnostic criteria, evidence

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supports a common demographic profile across individuals with either the BPD or EUPD diagnoses, suggesting that the terms refer to the same group of individuals.[4]. For these reasons, the term 'BPD' is used in this study to refer to individuals who self-identify with either the BPD or EUPD diagnostic.

Approximately 1.6% of the North American population meet the clinical criteria for BPD, with similar statistics reported in the UK, Europe and Australia.[1,5,6] Individuals with BPD represent approximately 10% of those receiving outpatient mental-health treatment and about 20% of those admitted to psychiatric hospitals.[7] BPD is characterised by extreme and pervasive instability with respect to interpersonal relationships, emotional regulation, behaviour and perceptions of self.[7] Individuals with BPD experience challenges developing and maintaining interpersonal relationships. They often are distrusting of others and are consumed by fears of abandonment. These fears can be so intense that they often engage in extreme behaviours in order to avoid abandonment or being alone. Emotion and emotional regulation are also frequently challenging, with individuals frequently experiencing extremely intense and unstable emotional responses as well as sudden shifts in mood. Many individuals also experience extreme feelings of emptiness and boredom. They tend to hold dichotomous beliefs about others that shift between extremes of idealisation and devaluation (e.g. all good vs. all bad, worthy vs. worthless), as well as low self-esteem and an unstable sense of self. At times, these individuals may experience psychosis (e.g. hallucinations, delusions) and dissociative symptoms, especially in response to stressful events. Individuals with BPD tend to demonstrate poor impulse control and act impulsively. They often engage in risky behaviours such as alcohol and substance use, binge eating, overspending, unsafe sexual practices and self-harm (e.g. cutting, burning). Suicide ideation is also common, with almost 75% of individuals with BPD attempting suicide at least once in their lives. Individuals with BPD often experience co-occurring mental-health disorders, including mood disorders, substance use disorders, eating disorders, post-traumatic stress disorder (PTSD), attention-deficient/hyperactivity disorder and other personality disorders.[7,8]

Another diagnosis which has been associated with BPD is complex PTSD, sometimes also referred to as complex trauma. There has been debate concerning whether BPD and complex PTSD are essentially the same disorder, as there is some overlap of symptoms, particularly the presence of childhood trauma, notably sexual abuse.[9] Latent class analyses and network analytical studies have demonstrated, however, that they are distinct entities, with frantic efforts to avoid real or imagined abandonment, unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation, markedly and persistently unstable self-image or sense of self and impulsiveness being present in BPD but not in complex PTSD.[10,11] As a result, complex PTSD and/or complex trauma was not included as part of the BPD term.

BPD is one of the most stigmatised mental-health disorders in the general population and among mental-health professionals.[12–14] Too often, stigma has a negative impact on individuals' treatment outcomes, employment and social acceptance.[15,16] Many individuals with BPD come to accept the societal prejudices against them (self-stigmatisation), integrating these negative messages into their self-concept. High levels of self-stigma are in turn positively associated with maladaptive behaviours, including social isolation, thus reinforcing promoting a vicious cycle of isolation and stigmatisation.[17]

Arendt[18] advances that everyone has the right to appear as a singular, embodied individual. Through individuals' speech and actions, they materialise in the public domain, which Arendt argues is the space where one appears to others and others appear to the individual. Over time, the loss of the right to appear may prompt individuals to disappear or become invisible from public discourse and society. Many individuals with BPD indicate that they feel removed from public discourse as a result of social and self-stigmatisation processes or need to hide their mental-health diagnosis when they enter the public domain.[15]

Internet-based social-networking sites provide relatively anonymous and readily accessible venues for individuals to share information about self and lived experiences, as well as to seek out information about areas of interest and concern. YouTube™ is one such video-sharing platform that allows vloggers to express themselves through a combination of audio, visual and print modalities. Viewers in turn may view, upload, rate and respond to videos, as well as subscribe to vloggers. Created just over a decade ago, YouTube™ is the largest video-sharing site on the Internet and the third most frequently visited website in the world. YouTube™ hosts an estimated 180 million unique viewers per month, and 100 video hours are uploaded per minute,[19,20] with young adults being especially active on these sites.[21,22]

Engagement in such social-media sites is especially prevalent among young adults and consistent with the time when many individuals first receive a mental-health diagnosis.[23,24] There is increasing evidence that YouTube™ users include those who experience mental-health challenges such as depression, anxiety, eating disorders, psychosis and PTSD,[25–27] with

first-person uploads being the most frequently visited type of YouTube™ upload.[28–30] YouTube™ users report valuing opportunities to share first-hand experiences and coping mechanisms, as well as opportunities to gain access to supportive communities.[25,26,31] Accessing YouTube™ uploads may be especially appealing when offline supports are lacking or difficult to access, and when there is a fear of stigmatisation.[28]

The right to appear[18] can be readily used to explain the attraction of YouTube™ to those from socially marginalised populations, including individuals who experience mental-health disorders and challenges. YouTube™ is the only form of mass media that provides individuals who self-identify with stigmatised conditions, such as BPD, their right to appear without the interpretation of intermediaries.[31,32] There is a gap in research exploring how individuals from stigmatised groups, including those who self-identify as having BPD, choose to appear. First-person vlogging may promote self-reflection that supports increased insight, understanding and awareness of self, others and the world.[33] Through their representation of authentic lives and experiences of ordinary individuals, first-person uploads may be especially impactful to others who experience BPD or BPD symptoms, especially if they are reluctant or unable to access offline supports and services and/or seek to use social media to gain a sense of community.[31,34,35]

Social identity theory (SIT) posits that individuals make sense of who they are by classifying themselves into actual or symbolic social groups.[36] Tajfel[37] defines social identity as 'that part of the individual's self-concept which derives from their knowledge of their membership in a social group (or groups) together with the value and emotional significance of that membership' (p. 255). Individuals are motivated by their needs to safeguard and promote their self-esteem and create a sense of emotional connection to others. Being a member of a social group fulfils both these needs.[36] According to SIT, individuals with BPD, who often struggle with self-esteem, sense of identity and interpersonal relationships,[7] may find belonging to a social group particularly attractive and desirable. For many of these individuals, membership of the social group may be associated with an increased sense of loyalty to the BPD community and a need to advocate on behalf of it. The sense of emotional connectivity can, in turn, influence their relationship with the diagnosis and the broader mental-health community. For these reasons, professionals within the helping profession may be better able to support individuals with BPD if they possess an awareness of the types of narratives, messages and counter-narratives that their clients are likely to encounter on YouTube™.

The purpose of this study was to describe the dominant messages that individuals who self-identify with the diagnosis of BPD present through YouTube™ videos. Specifically, we address a series of questions about the structure and content of YouTube™ videos posted by these individuals who self-identify as BPD or EUPD: (1) What are the general features of vloggers and their YouTube™ videos? (2) What motivations and contexts do vloggers cite for posting YouTube™ videos? (3) What type of life experiences do vloggers present in their YouTube™ videos?

Method

The search terms 'borderline personality disorder', 'BPD', 'emotionally unstable personality disorder' and 'EUPD' were entered individually into the YouTube™ search feature and then in combination with the additional terms 'my story', 'my experience' and 'my life' on 10 July 2018. Search results yielded a total of 504,600 uploads. Of these, the majority (92.01%) used either 'borderline personality disorder' and/or 'BPD' in their titles, while the remaining uploads used the terms 'emotionally unstable personality disorder' and/or 'EUPD' (7.99%). Inclusion criteria for the study included publicly available English-language first-person accounts of individuals who self-identified with the diagnosis of BPD. There were no restrictions with respect to the date of posting. Exclusion criteria included lectures and/or presentations by credentialed professionals, second-hand accounts (e.g. family members, partners), posts by the government, institutional or para-professional presentations, online chats/call ins, academic assignments, role plays and dramatisations (professional, amateur), advertisements and restricted access postings (registration, password or login requirements). Duplicates were also removed within and across search terms. In total, 362 YouTube™ videos met the eligibility criteria. Thirteen videos were subsequently excluded, as they were either no longer available or incomprehensible (production quality), resulting in a total of 349 videos being analysed here. Information pertaining to these video URLs, date of upload, length and view count was recorded on the same day.

Coding protocol

The content analysis method was used in order to provide a systematic, non-invasive analysis of text, images and audio data for the identification of trends, patterns, commonalities and discrepancies as presented in the YouTube™ artifacts.[38] A coding protocol was developed to include four broad areas: (a) YouTube™ video and vlogger characteristics, (b) video type, (c)

vlogger motivation and (d) video content. Video content was the largest and most exhaustive category and included items such as DSM-5 diagnostic criteria, treatment, attitude towards treatment, self-care and future orientation (see Appendix A for the coding sheet).

All 349 videos were reviewed and coded by the authors, both of whom are licensed mental-health professionals who have clinical experience working with individuals with BPD. Initially, the authors met to review the six most frequently viewed videos to develop the coding sheet (Appendix A) and discuss scoring protocols. The next 15 most frequently and the 15 least frequently viewed videos were independently reviewed next. After this, the authors met to confirm adherence to the scoring protocol, achieving a total inter-rater agreement of 88% across all the categories for the 30 videos. All disagreements were resolved through discussion, with these resolutions extended to subsequent scoring. The remaining videos were divided and independently reviewed by the authors over a four-week interval.

Ethical considerations

The Research Ethics Board at Brock University considered the study exempt from review, as YouTube™ postings are publicly available data. Data-collection and data-analyses procedures used in this study were consistent with the ethical guidelines for Internet-mediated research and designed to respect individuals' rights to privacy and dignity.[39,40] Specifically, there were no interactions with vloggers or respondents in this study. Potentially identifying information was excluded from data analyses, and excerpts of quotations taken from the YouTube™ videos were minimised.

Results

Descriptive statistics were used to analyse continuous video-posting features, with dichotomous coding used to indicate the presence or absence of video motivation and content. Table 1 shows the distributions of continuous variables, and Table 2 shows the frequencies of discrete variables.

Due to the significant skew of all the continuous variable distributions, Spearman's rho was used to analyse relationships between continuous and discrete variable pairings. Relationships between discrete variable pairings were analysed using phi coefficients.

Video demographics

The YouTube™ videos analysed here were posted for a mean of three years, with videos being available online between one day and 11.6 years (as of 10 July 2018). The increased number of uploads in recent years resulted in a skewed distribution. Videos uploaded for longer had more views ($r_s = 0.478$, $p < 0.001$) and more comments ($r_s = 0.143$, $p < 0.01$). Uploads were also analysed for their inclusion of trigger warnings intended to pre-emptively notify viewers of potentially emotionally distressing content, typically related to either suicidality and/or self-harm in the videos, thus enabling viewers to prepare mentally for this content or to forego viewing it.[41] Relatively few videos contained trigger warnings in either the videos or video descriptions, but those that did were associated with more views ($r_s = 0.164$, $p < 0.01$), more likes ($r_s = 0.192$, $p < 0.01$), more dislikes ($r_s = 0.175$, $p < 0.01$) and more comments ($r_s = 0.167$, $p < 0.01$).

Monologues or personal testimonials where individuals appeared on video and spoke directly to their audience represented the majority of uploads. Two videos represented dyadic discussion, and the remaining videos represented mixed-media presentations where vloggers used assorted compilations of music, images, text, notecards or voice-overs. Monologues tended to be associated with fewer views ($r_s = -0.215$, $p < 0.01$) and longer productions ($r_s = 0.448$, $p < 0.001$), while mixed-media presentations were positively associated with number of views ($r_s = 0.206$, $p < 0.01$) and

Table 1. Psychometric properties of the study's continuous variables ($N = 349$).

Variable	*M*	*SD*	Range	Skew
Number of days posted	1102.8	970.8	0–4239	0.958
Video length (minutes)	11.1	9.4	0.3–61.5	5.435
Number of views	10,791.1	55,171.1	1–855,388	11.555
Number of likes	147.4	554.7	0–5380	6.307
Number of dislikes	6.1	21.3	0–203	5.800
Number of comments	43.3	141.6	0–1179	5.395

Table 2. Frequencies of the study's dichotomous variables ($N = 349$).

Variable	Yes (%)	No (%)
Trigger warning	38 (10.9)	311 (88.9)
Video type		
Monologue	246 (70.5)	103 (29.5)
Mixed media	101 (28.9)	248 (71.1)
Interview/dyad	2 (0.6)	347 (99.4)
Motivation		
Understand me	309 (88.5)	40 (11.5)
Educate others	182 (52.1)	167 (47.9)
Support others	104 (29.8)	245 (70.2)
DSM-5 criteria		
Fear of abandonment	198 (56.7)	151 (43.3)
Unstable relationships	232 (66.5)	117 (33.5)
Identity disturbance	146 (41.8)	203 (58.2)
Impulsivity	120 (34.4)	229 (65.6)
Suicidal ideation/behaviour	164 (47.0)	185 (53.0)
Self-harm	171 (49.0)	178 (51.0)
Affective instability	167 (47.9)	182 (52.1)
Chronic feelings of emptiness	121 (34.7)	228 (65.3)
Intense anger	163 (46.7)	186 (53.3)
Dissociation or paranoid ideation	98 (28.1)	251 (71.9)
Treatment		
Received some form of treatment	214 (61.3)	135 (38.7)
Attitude towards treatment		
Positive	97 (27.8)	252 (72.2)
Negative	30 (8.6)	319 (91.4)
Mixed (positive and negative)	35 (10.0)	314 (90.0)
Not stated	187 (53.6)	162 (46.4)
Self-care		
Engaged in some form of self-care	130 (37.2)	219 (62.8)
Future orientation		
Hopeful	191 (54.7)	158 (45.3)
Hopeless	75 (21.5)	274 (78.5)
Not stated	83 (23.8)	266 (76.2)

negatively associated with video length ($r_s = -0.465$, $p < 0.001$). Mixed-media presentations, however, were positively associated with upload date ($r_s = 0.530$, $p < 0.001$), while monologues were negatively associated with upload date ($r_s = -0.521$, $p < 0.001$), indicating more individuals were creating monologues more recently.

Motivation for vlogging and video creation

Vloggers provided at least one, and sometimes several, motivations for creating and uploading their videos. As presented in Table 2, the most commonly cited motivation was to document the experience of being an individual with BPD in order to promote understanding of self (i.e. understand me). For instance, some vloggers indicated that they were responding to specific requests from others ('People ask, what's it like to have BPD?', 'What does BPD feel like?') while others indicated they were self-compelled to disclose their experiences ('Maybe if [people] understood what it was like I wouldn't be so alone'). The second most frequent motivation vloggers cited was to educate others about the disorder ('Need to talk openly and educate people', 'People need to learn that people with BPD are still people') and to reduce the stigma surrounding mental illness, especially BPD ('I was passed over by 15–20 therapists and doctors because of the stigma and I want to change that'). The third motivation most frequently cited was to support others with BPD. Vloggers stated, 'You are not alone', 'I'm here for you' and 'I am here to support you, especially when you face challenges'. Videos intended to educate others or support others tended to be longer (educate others $r_s = 0.343$, $p < 0.01$; support others $r_s = 0.202$, $p < 0.01$), with videos intended to support others also presenting more trigger warnings ($\Phi = 0.147$, $p < 0.01$).

DSM-5 criteria

All vloggers referred to and shared personal experiences related to one or more of the DSM-5 criteria for

BPD. Many referred explicitly to the DSM-5 and outlined how their own personal experiences related to the criteria. As shown in Table 2, two-thirds of the vloggers discussed having unstable relationships, and more than half detailed their fears of being abandoned by significant others, making these symptoms the most frequently discussed throughout the YouTube™ videos.

Close to half of all the vloggers discussed engaging in self-harm, as well as suicidality, affective instability and/or being prone to periods of intense and inappropriate anger. Approximately 40% of vloggers discussed having an identity disturbance which was frequently expressed through statements such as 'I do not know who I am', 'I imitate others because I do not know how to be myself' or 'I am always wearing a mask'. Just over a third of vloggers discussed being impulsive and experiencing chronic feelings of emptiness. The BPD symptoms which vloggers discussed the least were dissociation and/or paranoid ideation, with just under one third of vloggers detailing experiences related to this criterion (Table 2).

Treatment, coping strategies and hope for the future

More than 60% of all the vloggers described engaging in some form of treatment for BPD (Table 2). Treatments that were discussed typically involved medication, hospitalisation, counselling through mental-health professionals and specific interventions (e.g. dialectical behaviour therapy). The majority of vloggers expressed no sentiment towards treatment, while just over a quarter described their treatment experiences positively. Less than 10% of vloggers expressed a negative attitude towards treatment or expressed having a mixed attitude, where they perceived certain treatments or components of treatments as helpful and others as not helpful. More than a third of all vloggers described using effective coping strategies. These strategies included using specific dialectical behavioural distress tolerance and emotional regulation skills, engaging in mindfulness-based practices or seeking support from friends and family.

Creating a monologue was positively associated with having engaged in some form of treatment ($\Phi = 0.250$, $p < 0.01$), with having a positive attitude towards treatment ($\Phi = 0.178$, $p < 0.01$) and with having used coping skills that the vlogger found were helpful ($\Phi = 0.201$, $p < 0.01$). Conversely, creating a mixed-media presentation was negatively associated with having engaged in some form of treatment ($\Phi = -0.226$, $p < 0.01$), with having a positive attitude towards treatment ($\Phi = -0.186$, $p < 0.01$) and with having used coping skills that the vlogger found were helpful ($\Phi = -0.193$, $p < 0.01$). Videos in which vloggers were motivated to educate others were positively associated with having engaged in some form of treatment ($\Phi = 0.166$, $p < 0.01$) and were positively associated with having a positive attitude towards treatment ($\Phi = 0.132$, $p < 0.01$).

More than half of all the vloggers expressed being hopeful about the future. Videos in which vloggers discussed being engaged in treatment were positively associated with expressions of hope for the future ($\Phi = 0.220$, $p < 0.01$). In the same way, videos that presented a positive or mixed response to treatment were also positively associated with expressions of hope for the future ($\Phi = 0.306$, $p < 0.01$; $\Phi = 0.127$, $p < 0.01$, respectively). Just over a fifth of all vloggers expressed feeling hopeless. Feelings of hopelessness were positively associated with negative orientation towards treatment ($\Phi = 0.113$, $p < 0.01$). Videos that used mixed-media expressions were more likely to present a sense of hopelessness ($\Phi = 0.327$, $p < 0.01$). Vloggers who discussed receiving treatment were also more likely to discuss utilising effective coping strategies ($\Phi = 0.233$, $p < 0.01$), regardless of their orientation towards treatment.

Discussion

Individuals are increasingly turning to Internet-based social-media platforms such as YouTube™ to share life experiences, gather information and form social networks and communities. The process of vlogging is potentially empowering, providing individuals who post first-person uploads with the opportunity to exercise their right to appear as their authentic selves.[42] These first-person uploads in turn tend to be highly sought out by viewers, making them potentially very powerful and influential vehicles for knowledge dissemination, identity formation and socialisation processes.[28,29] For these reasons, we explored how individuals who self-identify with a BPD diagnosis represent themselves and the disorder on YouTube™.

The results of this study suggest that the nature and content of BPD first-person YouTube™ uploads have changed over time. Specifically, there has been a steady increase in the number of first-person vlogs, with the number of posts increasing by almost eightfold over the last decade. While it is possible that some older posts have been deleted over time, these numbers suggest that more individuals who self-identify as having BPD are electing to post on YouTube™. Increased numbers of uploads are consistent with individuals' growing preferences and comfort levels using YouTube™ to access and share information,[43] particularly with respect to mental health.[29,34]

Recent uploads were also more likely to include visual self-identifying information (non-anonymous), with vloggers electing to upload monologues more

often than more anonymous mixed-media productions. There are several possible reasons for this shift in video presentation style. While we could not formally track age or post country demographics, we noted that vloggers who did provide such demographic information tended to identify as young adults from the UK, Europe, Australia and North America – an age group that tends to be technologically savvy and who demonstrate an affinity with digital media.[43] Younger individuals, especially those from Western countries, are also more likely to disclose potentially identifying information than older individuals and those from collectivist cultures who tend to be reluctant to discuss mental-health challenges in public forums.[44,45]

There are potential risks associated with vlogging, especially when posting first-person accounts. Vloggers may be subject to discriminatory, hostile or destructive comments that may further their sense of marginalisation and isolation, decrease engagement in help-seeking behaviours, diminish their self-esteem and increase symptomology.[34] Alternatively, they develop a dependency on online relationships which may work to deter or impede engagement in offline environments and further promote a sense of isolation beyond the online community.[34,46] Vloggers and responders may also interact in ways that serve to trigger, or even promote, engagement in harmful behaviour urges (e.g. self-harm, suicidality, substance misuse/abuse) and/or propagate unreliable or inaccurate information.[46] In the same way, creating and consuming YouTube™ uploads may create fear, anxiety, false or unrealistic expectations and/or a sense of inadequacy related to condition prognosis and/or management.[34,47] It is probable that the nature of BPD symptomology (e.g. challenging interpersonal relationships, fears of rejection and abandonment, emotional intensity, sensitivity to negative appraisal and impulsive behaviour) may intensify these risks for individuals who identify with the disorder. Thus, the nature and quality of responder–vlogger interaction and associated impact on vlogger activity are areas that warrant further exploration and study.

All vloggers in this study referred to at least one of the DSM-5 diagnostic criteria when describing their daily lives and BPD experiences, with the majority of vloggers referring to compromised relationships, fear of abandonment, extreme and unstable mood shifts, intense and inappropriate anger and a poor sense of self. Almost half of vloggers described suicide ideation, suicide behaviour and self-harm. Collectively, vloggers' descriptions confirm the complex nature of BPD. Vloggers references to specific DSM-5 symptoms as well as evidence-based treatment approaches also suggest that they tended to situate and make meaning of their experiences within a biomedical model. These findings are consistent with those of other researchers who have documented similar discourse patterns among individuals who self-identify with BPD and engage in social media.[48] The complex nature of BPD, including identity challenges, may warrant some concern for the referencing of diagnostic criteria. While diagnostic criteria can provide valuable insights into the self, a narrowing sense of identity to these criteria can be potentially maladaptive and can support negative self-fulfilling processes.[49]

Irrespective of these considerations, vloggers who elect to include self-identifying information are actively exercising their right to appear.[18] Enacting the right to appear requires that individuals identify themselves in meaningful ways that allow them to be seen and recognised by others. As Arendt qualifies, to hold agency requires the identification of self, 'Action without a name, a "who" attached to it, is meaningless' (pp. 180–181).[18] The increase in monologue uploads over time may suggest that current vloggers are more willing to self-identify, despite potential risks associated with stigma towards the diagnosis and mental illness than their peers in the past.

The nature of vlogging and some BPD symptoms may also work to promote self-disclosure. For instance, vlogging creates increased opportunities for self-reflection and self-awareness, with processes positively associated with online disclosures.[50,51] At the same time, individuals who experience states of loneliness, interpersonal distress, shyness and unfulfilled psychological needs are more likely to disclose identifying information than their peers.[51,52] Engaging in online disclosures may appear less challenging and risky than face-to-face and other synchronous, interactive communications, as video monologues are unidirectional communications directed to largely unknown and dispersed audiences.

When vlogging, social interactions are secondary and can only occur after uploading.[50] Some of the vloggers in this study seemed sensitive to potential negative viewer responses requesting that readers refrain from judgemental and negative comments. Other vloggers qualified that their continued engagement was dependent on receiving likes and comments. Consistent with self-identity theory,[36] self-identification and disclosure may also promote a sense of vlogger trustworthiness and authenticity, potentially promoting empathetic responses and community building.[50,51] While analysis of responder comments were beyond the parameters of this study, analysis of vlogger–responder interactions amongst those who self-identify as having a severe mental-health disorder suggests that these interactions have the potential to serve as a dynamic and responsive system of peer support.[31,34,35] In these previous studies, responders and vloggers worked to validate and normalise shared experiences, minimise a sense of isolation

and hopelessness, strategise and problem solve challenges associated with daily living and form a united front to shut down disparaging, judgemental or critical commentary.

Finally, vloggers are more likely to upload monologues when they are motivated to share information.[53] Many vloggers in this study commented about being inspired by other first-person vloggers. These vloggers in turn indicated their intentions to create communities that are supportive of all its members.[36] Mental-health stigma can be reduced when individuals provide subjective and contextualised accounts of their lived experiences.[54] As stigma decreases, treatment engagement and publicly identifying with a mental-health disorder increases.[55] Globally, there has been increased implementation of anti-stigma campaigns, with these efforts being somewhat successful in promoting mental-health literacy and decreasing stigma.[56] Many vloggers in this study indicated awareness of evidence-based treatment approaches and supported mental health and BPD anti-stigma movements (e.g. Project Semicolon, Project 375, Mental-Health Awareness Month, BPD Awareness Month).

Educating others and eliminating stigma were primary motivations cited by vloggers in this study. Evidence suggests that personal disclosure of mental-health status promotes positive self-esteem and self-efficacy while minimising self-stigmatisation, including feelings of self-loathing and shame.[57,58] An enhanced sense of self in turn may promote consumer activation where individuals acquire critical knowledge about their disorders and use this information to seek out relevant supports and services.[34] For individuals who identify with BPD, consumer activation may also involve challenging negative stereotypes and misinformation within the mental-health community as well as within broader society. Unlike the case with other mental-health disorders, there is substantive evidence that stigma towards BPD still exists within society and health-care professions and that this stigma substantially interferes with individuals' access to mental-health services and how they are treated while receiving services.[59–61] Many vloggers in this study identified their intentions of challenging stigma in order to gain greater access to respectful mental-health services and care as a rationale for self-identifying as an individual with BPD at this time. It appears that the relationship between stigma and publicly identifying as an individual with BPD is complex and that more research in this area is required.

Discussions related to treatment, coping and hope for the future differed by type and purpose of video. In general, monologues and videos intended to educate others tended to reference treatment and present a positive attitude towards it. They also tended to present coping strategies, with the reverse largely holding for older, mixed-media productions. These findings may reflect greater access to evidence-based treatment approaches for BPD, which in turn may minimise feelings of shame and self-hatred while enhancing individuals' positive sense of self, coping capacities and hope for the future.[62,63] Such discussions also run counter to long-held misconceptions of individuals with BPD being unmanageable, difficult, manipulative, bad, attention seeking and generally beyond treatment and care.[64–66] Presumably, when individuals exercise their right to appear by sharing positive treatment experiences and recovery outcomes, they promote positive self-identity, inspire hope and motivate engagement in consumer activation and help-seeking behaviours.[18,36]

Mental-health practitioners are well advised to be aware of the nature of YouTube™ uploads. Rather than deterring clients from this platform, practitioners may wish to work with clients to access, explore and deconstruct critically their perceptions and understanding of these uploads. Borrowing from recommended practices from work with other groups including youth who engage in non-suicidal self-injury, practitioners may work with clients to monitor the nature and frequency of YouTube™ usage, including posting and viewing first-person uploads. Exploring of the impacts of YouTube™ experiences in the context of knowledge acquisition, belief systems (self, other, world), behaviours and mood are also important areas for deconstructing and processing.[67]

YouTube™-related discussions may include the provision of psychoeducation related to media and mental-health literacy and would be consistent with social-emotional learning and evidence-based interventions that promote personal understanding, effective communication, positive interpersonal interactions, efficacy and adaptive coping.[68,69] For instance, practitioners and clients may explore criteria associated with vlogger credibility and/or trustworthiness, healthy versus maladaptive coping strategies and compatibility with treatment objectives. They may also wish to explore external and internal factors that work to trigger, reinforce and/or dissuade posting and/or viewing behaviours, working to differentiate beneficial interactions factors from harmful ones. Practitioners can further support clients' healthy identity formation by assisting them in negotiating tensions associated with needs of increased understanding of BPD and self and potential harms associated with exclusive affiliation with a diagnostic label and community that promotes positioning as the misunderstood other.[49] In these ways, practitioners may support clients' self-care practices by encouraging them to seek out uploads that offer hope, encourage help-seeking and promote adaptive coping behaviours. Finally, practitioners are

encouraged to reflect on their own biases and assumptions related to BPD. They then can work to challenge directly YouTube™ messaging related to professional discrimination, stigmatisation and marginalisation of individuals with BPD. In these ways, practitioners can support clients' right to appear, sense of empowerment and personal agency.

Several limitations are associated with this study. Despite the use of multiple search terms, we cannot guarantee that this is an exhaustive review of all first-person vloggers who self-identify with the diagnosis of BPD nor can we confirm the authenticity of this diagnosis. Furthermore, we cannot guarantee that our search results can be replicated due to the dynamic nature of YouTube™ uploads. Vlogger demographic information, including age, self-identified gender and geographic location, were largely unavailable, making it impossible to create accurate vlogger profiles and/or to explore video-production differences as a function of individual differences. We also made no attempt to assess the accuracy of video content or how information presented in these videos may differ from content presented in professionally produced productions. Instead, we outlined the nature, purpose and content of first-person BPD uploads, arguing that the insights gained here have implications for individuals who identify with BPD and for mental-health professionals.

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