

Gestalt psychotherapy in the outpatient treatment of borderline personality disorder: a case report

Borderline personality disorder (BPD) is the most frequent and the most severe of all personality disorders in clinical practice. Although BPD bears the reputation of being “untreatable”, psychotherapy for patients with BPD has been the treatment of choice.^{1,2} A number of papers show the use and effectiveness of various psychotherapeutic approaches.³⁻¹⁰ This article presents the use of Gestalt psychotherapy in the treatment of BPD patients. The authors obtained the **informed consent** of the client for publication of this content.

A 30 year old female sought therapy for the following reasons (in her own words): She experienced a sensation of walking on the border between life and death, and a feeling of emptiness and being unwell. Nothing made sense for her, she was sad and dissatisfied with all aspects of her life, and it seemed that nothing was good enough.

She had been unable to establish an intimate relationship for the last seven years. Her family of origin was complete but she described a chaotic family life, characterised by regular physical and psychological abuse despite the maintenance of a normal facade.

During initial diagnostic evaluation, the psychological tests showed difficulties in social communication and adjustment, as well as hypersensitivity, feelings of deprivation and adoption of the victim role, accompanied by difficulties in close emotional relations. Inhibitory capacities were reduced, maladaptive irritability was prominent, the behavior was unpredictable, impulsive, not constructive, and the risk of aggressive responses was present in addition to the elements of borderline personality structure. General defence activity was low. The predominantly used defence mechanism was intellectualization and affect was suppressed. Projective tests showed that early family relationships represented an important area of conflict. Although the deficit of basic trust and safety was clearly visible, the effort to idealize herself and other people was present.

On initial psychiatric interview, frequent changes of mood were noted in keeping with the personality structure, fragmented psychotic reactions as well as self-destructive behaviour could also be experienced. Consequently, a diagnosis of BPD was made.

The Gestalt psychotherapy was carried out through 75 individual sessions. The emphasis of this individual work was placed on building the client–therapist relationship; developing the patient’s sense of their own value, instituting personal boundaries and limitations; developing productive verbal expression and on the establishment of continuity of the therapy.

The therapy was carried out through dialogues and exercises during individual sessions: creation of a genogram, collages and drawings; therapy with associative cards and through *The Diary of Awareness* that the patient kept throughout the last year of therapy.

Initially, it was very hard to establish continuity of attendance at therapy; hence the 75 sessions were unevenly spaced over three and a half years. In the beginning, the patient displayed a significant need to control the relationship. When she felt the relationship was not developing “as it should have”, she was either retreating or attacking towards the process. This pattern of behaviour was mirrored by numerous problems in her social relationships.

During psychotherapy, special emphasis was given to her developing awareness of her feelings and to timely recognition of her feelings that could allow conscious selection of responses towards others.

At the beginning of the therapy the patient was able to establish relationships with ease, but those relationships remained shallow and cold due to her difficulties in allowing herself to become involved in deep and sincere relations. Strengthening and increasing capacity for self-acceptance created the prerequisites for the patient to become more open towards others and to stand up for herself.

The patient tried to cope with her emotional difficulties by rationalization and involvement in a series of professional tasks. Through the therapy she learned not to get involved in new activities before allowing herself to recognize how she felt about them. She also learned not to constantly act out her impulses, but to seek alternative perspectives and to foresee the consequences of her actions.

More often than not she blamed others for her failures and had great difficulty accepting personal responsibility. However, therapeutic work directed towards tolerating personal responsibilities helped to diminish her sense of being treated badly by the people in her environment.

During the last year of therapy, the patient was able to maintain continuity, mostly on a weekly basis. She also graduated from University after twelve years of attendance, entered a higher level graduate program, moved out of her parents’ home and bought her own apartment, established a deep emotional relationship with a male partner leading to marriage, kept her permanent job in a government firm, and started her own business.

The results of follow-up psychological testing showed improved functioning, significantly reduced problems of social adjustment and communication, as well as a tendency of engagement in close personal relationships and increased levels of trust. The feelings of deprivation and the role of

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victim that were pronounced in the first psychological testing diminished. The personality structure remained a prominent feature, but she developed better control, realistic insight and higher levels of social regulation. She anticipated a positive future; she stated satisfaction with the changes she had achieved, with herself, and her current life circumstances.

The therapist's impressions were that the patient had significantly increased her capacity for self-regulation of emotions, accepted responsibility for her choices in life, significantly stabilized her sense of self and improved the integration of the fragmented pieces of her personality.

Through this case report, we demonstrate how change achieved during Gestalt psychotherapy reveals not just a reduction of symptoms of the disease, but also the impact it has on fundamental aspects of personality functioning evidenced by success in developing and maintaining an intimate relationship and friendships and achieving a greater ability to function educationally, occupationally and socially.

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Dementia masquerading as mania – when should it be suspected?

Frontotemporal Dementia (FTD) is a degenerative disorder of the brain that affects the frontal and temporal cortices resulting in impairments in reasoning, personality, movement, speech, social graces, language and memory. The changes in personal and social conduct, which occur in the early stages of the disease, include loss of inhibition, apathy, social withdrawal, hyperorality and ritualistic compulsive behaviors. These changes can be dramatic and may be misdiagnosed as a psychiatric disorder.¹ We present a case wherein FTD was misdiagnosed and treated as mania and highlight the features of late-onset 'mania' that should raise clinical suspicion.

The patient's family **consented** to the reporting of this case. Mr. M, a 56 year old man with 10 years of formal education, working as an agriculturist was brought to our centre by his family who were greatly distressed by changes in his behaviour

and personality. These alterations developed gradually over 2 years. There was no past or family history of any affective or psychotic illness. He was oblivious to any inappropriateness in his behavior, however, complained of 'tension'. Initially the family noticed irritability followed by other changes - spending excessive time on the phone, taking extra measures for grooming and watching music and fashion television programs excessively. Also, he started talking of business plans that the sons thought of as preposterous and foolish. His facial expression was usually stiff with no play of emotions but, occasionally, he would suddenly weep. There was a decrease in sleep and increased demand and intake of specific food items (fruit juices and milk). In addition, he started demanding sexual activity more often from his wife and was frequently found staring at women in the neighbourhood. Also, he recommenced drinking alcohol and smoking after quitting for several years.

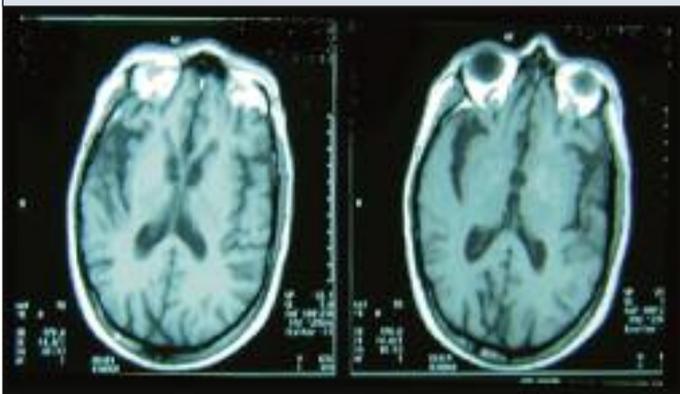
Mr. M was diagnosed with mania by private psychiatrists and prescribed antipsychotic drugs. When first seen at our centre, a diagnosis of mania versus psychosis was made and he was prescribed paliperidone and sodium valproate. However, a

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detailed mental status examination revealed blunted affect, monotonous speech, poorly sustained attention, and impaired immediate, recent and remote memory. Despite the family members initially denying any cognitive symptoms, a possibility of organic pathology was raised in view of certain atypical features of mania. On re-exploration of history, it appeared that over the preceding few months the patient would frequently forget events and conversations of few hours ago. Neurological examination revealed bradykinesia, slow and festinant gait, reduced arm swing, forward stoop, bilateral tremor of both hands, positive glabellar tap and palmomental reflex. On formal neurocognitive testing, his IQ was 52. There was significant impairment in remote and recent memory, delayed recall, poor retention for dissimilar pairs, reduced visual retention and recognition, poor perceptuo-motor function (BVMG test) and significant executive dysfunction (Wisconsin Card Sorting Test). The MMSE score was 21 out of 30. Serum vitamin B-12 levels were low (62 as compared to normal of 187- 1059 units). Magnetic resonance imaging (MRI) of the brain showed diffuse cerebral atrophy, principally in the frontal and temporal area and greater on the right side (See Figure 1).

Figure 1: MRI brain (sagittal section) shows diffuse cerebral atrophy, more in frontal and temporal areas (more on right side than left side)



With these findings, the patient was finally diagnosed as having fronto-temporal dementia (FTD) with the additional possibility of Vitamin B-12 deficiency related dementia. Paliperidone was replaced with olanzapine (12.5 mg) due to extra-pyramidal symptoms and it was continued for symptomatic management. Sodium valproate was stopped. Vitamin B-12 and donepezil was started after liaison with neurologists. The family was educated regarding the illness course, prognosis and principles of behavioral management. Despite initial improvement in behavioural symptoms, there has been gradual overall deterioration in cognitive and psychomotor features.

This case illustrates that misdiagnosis can occur with dementia presenting as psychiatric symptoms or a syndrome. Occurrence of 'manic' symptoms for the first time at the age of 54 years in a person with no past personal or family history of affective or psychotic symptoms is unusual. The insidious onset and progressive course, with non-infectious mood, blunted affect and non-concordant mood-thinking-activity raised suspicion and resulted in a meticulous search for evidence of an organic cause(s). FTD is a common cause of dementia in patients younger than 65 as in our case.² A review by Perry and Miller concluded that up to one-third of patients with FTD exhibit

euphoria in the form of elevated mood, inappropriate jocularity, and exaggerated self-esteem that can be indistinguishable from hypomania or mania.³ In addition, affective blunting, loss of insight and social awareness, lack of concern about the disease process and lack of empathy for others are common symptoms in the frontal lobe variant of FTD.⁴ Gluttonous overeating and exaggerated craving for carbohydrates (as in the case of Mr. M) are commonly reported in FTD.⁵ Furthermore, disinhibition, poor impulse control, and antisocial behavior are also seen.³

Neuroimaging studies show selective bilateral fronto-temporal atrophy and right sided frontal infarcts.⁶ Similarly, in the index case, the MRI brain revealed cerebral atrophy that was more marked in the frontal and temporal areas and on the right side. Patients with FTD and asymmetric atrophy of the nondominant frontal lobe, have been shown to exhibit dramatic alterations in their self as defined by changes in political, social, or religious values.⁷

One case series noted that the patients with FTD often presented initially to a psychiatrist rather than to a neurologist and received erroneous psychiatric diagnoses before FTD was correctly diagnosed at a later stage.⁸ The present case too illustrates the risk of misdiagnosis early in the course of FTD. Atypical clinical features and suboptimal treatment responses are considered as strong indicators of the need to reconsider the diagnosis.⁹ A detailed neurological examination, including evaluation of "soft" signs (primitive reflexes), is recommended in late-onset affective disorders.⁹ The index case emphasizes the need for a high index of suspicion for organicity based on history and thorough examination especially when dealing with late-onset psychiatric disorders such as mania.

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