



**PSYCHOLOGICAL DYNAMICS IN A PATIENT WITH COMPLEX PARTIAL
EPILEPSY AND ORGANIC MENTAL DISORDER: CASE STUDY**

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ABSTRAK

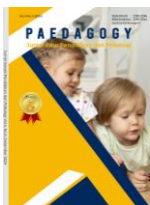
Epilepsi merupakan kondisi neurologis kronis yang dapat disertai berbagai manifestasi psikologis, tetapi interaksi antara pengalaman psikopatologis, kondisi psikososial, respons koping, dan pengalaman pengobatan masih belum banyak dideskripsikan pada tingkat kasus individual. Penelitian ini bertujuan mengeksplorasi dinamika psikologis pada pasien dengan epilepsi parsial kompleks dan gangguan mental lain akibat kerusakan dan disfungsi otak serta penyakit fisik (F06.8). Penelitian menggunakan pendekatan kualitatif dengan desain studi kasus tunggal dan teknik *purposive sampling* pada seorang perempuan berusia 50 tahun yang diidentifikasi dengan inisial RH. Data diperoleh melalui observasi klinis, wawancara dengan pasien, caregiver, dan perawat psikiatri, serta telaah rekam medis, kemudian dianalisis secara tematik melalui triangulasi sumber. Hasil penelitian menunjukkan adanya pengalaman perseptual auditorik dan visual, keyakinan berkaitan dengan kebesaran dan persekusi, isolasi sosial, keterlibatan keluarga, koping religius, aktivitas sehari-hari, ketidakpatuhan pengobatan, kelelahan, dan kondisi emosi intens sebagai dimensi penting kasus. Temuan tersebut menunjukkan bahwa dinamika psikologis pasien perlu dipahami sebagai pengalaman klinis dan psikososial yang saling berkaitan, bukan sebagai bukti mekanisme kausal tunggal. Penelitian menyimpulkan bahwa pemahaman dinamika psikologis pada pasien dengan komorbiditas neurologis dan psikiatri memerlukan perspektif terintegrasi dan berpusat pada pasien yang mempertimbangkan manifestasi klinis, pengalaman subjektif, konteks sosial, sumber koping, serta pengalaman pengobatan.

Kata kunci: *Dinamika Psikologis, Epilepsi, Faktor Psikososial, Gangguan Mental Organik, Koping*

ABSTRACT

Epilepsy is a chronic neurological condition that may be accompanied by various psychological manifestations, yet the interaction among psychopathological experiences, psychosocial circumstances, coping responses, and treatment experiences remains insufficiently described at the individual case level. This study aimed to explore the psychological dynamics of a patient with complex partial epilepsy and other mental disorders due to brain damage and dysfunction and physical disease (F06.8). A qualitative approach with a single-case study design was employed using *purposive sampling* to select a 50-year-old woman identified by the initials RH. Data were collected through clinical observation, in-depth interviews with the patient, caregiver, and psychiatric nurses, and medical record review, followed by thematic analysis and source triangulation. The findings identified auditory and visual perceptual experiences, grandiose-related and persecutory-related beliefs, social isolation, family involvement, religious coping, daily activities, treatment nonadherence, fatigue, and intense emotional states as important dimensions of the case. These findings indicate that the patient's psychological





dynamics comprised interconnected clinical and psychosocial experiences rather than a single causal mechanism. The study concludes that understanding psychological dynamics in patients with neurological and psychiatric comorbidity requires an integrated, person-centered perspective that considers clinical manifestations, subjective experiences, social context, coping resources, and treatment experiences.

Keywords: *Coping, Epilepsy, Organic Mental Disorder, Psychological Dynamics, Psychosocial Factors*

INTRODUCTION

Epilepsy is a chronic neurological disorder characterized by a persistent predisposition to generate epileptic seizures and may be accompanied by cognitive and psychological difficulties that influence patients' daily functioning. Cognitive problems are relevant in the long-term experience of epilepsy because the duration of illness and clinical characteristics of seizures may be associated with memory performance (Agustina et al., 2024). In addition, the duration of epilepsy and the number of antiepileptic drugs have been associated with cognitive functioning among patients with epilepsy, indicating that the clinical experience of the disorder extends beyond seizure manifestations alone (Haliza et al., 2024). Therefore, understanding epilepsy requires attention to both neurological manifestations and the psychological and cognitive experiences that accompany the condition.

In addition to cognitive difficulties, people with epilepsy may experience emotional and psychiatric problems that can affect quality of life. An Indonesian cohort study demonstrated that depression and anxiety are relevant psychological dimensions in patients with temporal lobe epilepsy, emphasizing the importance of psychological assessment within epilepsy care (Bakhtiar et al., 2021). Epilepsy has also been described as a condition that may have emotional and psychological consequences, including mental-health difficulties that can coexist with neurological symptoms (Grant & Collier, 2024). These findings indicate that psychological manifestations should be considered as an important component of the overall clinical experience of people with epilepsy.

Among the psychiatric manifestations associated with epilepsy, psychotic symptoms represent an important but heterogeneous clinical phenomenon. A narrative review of children and adolescents with temporal lobe epilepsy indicates that psychiatric disorders may occur alongside epilepsy and require attention to individual clinical characteristics (Cappelletto et al., 2024). Recent literature further describes psychosis in epilepsy as a heterogeneous condition involving different clinical presentations and possible mechanisms rather than a single uniform disorder (Qiu et al., 2025). A multicenter cohort study has likewise examined the prevalence, clinical characteristics, and risk factors of psychosis among people with epilepsy, highlighting the importance of careful clinical characterization of these manifestations (Shen et al., 2025). Consequently, perceptual disturbances and unusual beliefs in a patient with epilepsy should be interpreted according to their clinical context rather than automatically classified as one specific psychiatric disorder.

The psychological experience of epilepsy is also influenced by psychosocial circumstances surrounding chronic illness. Perceived stigma and discrimination have been associated with psychological problems among people with epilepsy, suggesting that social responses to the illness may form an important part of patients' psychological experiences (Malik et al., 2022). In the Indonesian cultural context, epilepsy has also been associated with persistent myths and culturally shaped perceptions that may influence how the condition is



understood by patients and their communities (Valencia & Yuwanto, 2022). Thus, psychological dynamics in epilepsy need to be understood within the interaction between clinical manifestations and the patient's social and cultural environment.

Stress and coping may constitute additional dimensions of the psychological experience of epilepsy. Recent research has examined the relationship between stressful experiences and seizures, while emphasizing the need to consider the individual clinical context when interpreting such associations (Doron et al., 2025). Religious or spiritual coping may also become an important resource for people living with chronic illness, particularly in Asian cultural contexts where religious practices may be integrated into everyday responses to illness and distress (Undariningsih et al., 2025). Accordingly, psychological assessment should consider emotional experiences and coping responses alongside neurological and psychosocial circumstances.

Treatment experiences represent another important dimension in understanding psychological dynamics in chronic epilepsy. Treatment adherence has been associated with quality of life and continued engagement with therapy among people with epilepsy, making adherence an important contextual factor in long-term clinical management (Lusnikova, 2022). Psychiatric management in epilepsy likewise requires consideration of both neurological and psychological dimensions because psychiatric symptoms may coexist with the underlying neurological condition (Kedare & Baliga, 2022). Recent literature has also emphasized that epilepsy-related psychosis should be understood according to its clinical presentation and relationship with the neurological condition rather than being assumed to represent a single psychopathological process (Yousaf & Baldwin, 2024). However, existing studies predominantly describe prevalence, clinical characteristics, psychiatric comorbidities, or treatment-related outcomes, leaving less detailed understanding of how psychopathological experiences, social circumstances, treatment experiences, and coping responses are experienced simultaneously within an individual case. Therefore, this study aims to explore the psychological dynamics of a patient diagnosed with other mental disorders due to brain damage and dysfunction and physical disease (F06.8) with a history of complex partial epilepsy (G40.2), focusing on psychopathological manifestations, psychosocial circumstances, treatment experiences, and coping mechanisms.

METHOD

This study employed a qualitative approach with a *single case study* design to explore the psychological dynamics of a patient with other mental disorders due to brain damage and dysfunction and physical disease (F06.8) accompanied by a clinical history of complex partial epilepsy (G40.2). The participant was selected using *purposive sampling* based on predetermined case characteristics, namely a documented psychiatric diagnosis of F06.8, a history of complex partial epilepsy, and availability for qualitative data collection. The participant was a 50-year-old woman identified by the initials RH. Data were collected through direct clinical observation, in-depth interviews with the participant, interviews with her older sibling as the primary caregiver and psychiatric ward nurses, and review of relevant medical records. The research instruments consisted of an observation guide and semi-structured interview guides developed by the researchers based on the research objectives, relevant literature, and the clinical context of the case. The observation guide focused on observable psychological and behavioral responses, emotional expressions, interpersonal interactions, daily activities, and responses during clinical observation, while the interview guides explored





subjective psychological experiences, perceptual experiences, beliefs, emotional responses, coping strategies, social relationships, family involvement, treatment experiences, and changes in daily functioning. The instruments were developed specifically for this case study and were not directly adopted from a single previous research instrument. Before data collection, the guides were reviewed by the researchers for clarity, relevance to the research objectives, appropriateness to the clinical context, and ethical considerations.

Data from observations, interviews, informants, and medical records were integrated to construct a comprehensive clinical narrative. The medical records were used to document the patient's diagnostic history, neurological and psychiatric course, treatment history, and reported episodes, whereas interview and observation data provided qualitative evidence concerning subjective experiences, behavior, coping responses, and psychosocial circumstances. Data credibility was strengthened through source triangulation by comparing information from the participant, caregiver, psychiatric nurses, clinical observations, and medical records, with discrepancies considered during interpretation. Data were analyzed thematically through repeated review of the data, transcription, identification of meaningful units, initial coding, grouping of related codes, development of themes, and examination of relationships among themes in relation to the research objective and clinical context. The study did not independently establish a new neurological diagnosis or infer a specific neurobiological mechanism; F06.8 and the history of complex partial epilepsy were treated as diagnoses documented in the medical record. Ethical procedures included explanation of the study, voluntary participation, informed consent, confidentiality through the use of initials, minimization of potential risks, and the participant's right to withdraw without consequences. Because the participant had a psychiatric condition, capacity to provide consent was considered in accordance with applicable institutional ethical procedures, with family involvement used as appropriate without automatically replacing the participant's own consent.

RESULT AND DISCUSSION

Results

The clinical data indicated that RH, a 50-year-old woman with a documented history of complex partial epilepsy and a psychiatric diagnosis of F06.8, presented with several psychological and behavioral manifestations during the observation period. Interview and observation data indicated perceptual disturbances, including auditory experiences described as whispers or voices and visual experiences involving shadowy figures. RH also expressed beliefs involving prominent political or state-related figures and reported experiences in which she felt watched, threatened, or pursued by others. These experiences were accompanied by observable behavioral changes, including responses to perceived voices, figures, or threatening situations. The frequency and intensity of these experiences appeared to vary during the observation period, based on information obtained from RH and supporting reports from the caregiver and psychiatric nurses. The different data sources generally indicated changes in RH's psychological and behavioral functioning, although the specific pattern and timing of these experiences varied across reports. These manifestations were documented as reported experiences and observed clinical phenomena and were not interpreted as evidence of a specific psychotic disorder or interictal psychosis because a clear temporal relationship between the symptoms and seizure episodes was not established. The clinical and psychopathological manifestations identified in RH are summarized in Table 1, based on patient interviews, clinical observations, caregiver and nurse reports, and medical records.



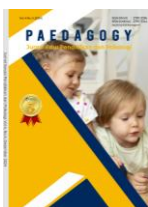


Table 1. Psychopathological Manifestations Identified in RH

Domain	Finding	Evidence from Case Data
Auditory perceptual experiences	Hearing whispers or voices	RH reported experiencing voices or whispers that were not attributable to an identifiable external source.
Visual perceptual experiences	Seeing shadowy figures	RH described seeing shadow-like figures during episodes of psychological disturbance.
Grandiose-related beliefs	Beliefs involving prominent political/state figures	RH expressed statements and beliefs involving political or state-related figures that were not corroborated by the available clinical information.
Persecutory-related beliefs	Feeling watched, threatened, or pursued	RH reported experiences suggesting that other people were monitoring, threatening, or pursuing her.
Behavioral response	Changes in behavior in response to perceived experiences	Observations and informant reports indicated behavioral responses corresponding to the psychological experiences reported by RH.

Table 1 summarizes the principal psychopathological manifestations identified from interviews, clinical observations, and informant reports. The findings included auditory and visual perceptual experiences as well as beliefs characterized by grandiose-related and persecutory-related content. The table also indicates that these experiences were accompanied by behavioral responses observable in the clinical context. The classification presented in the table is descriptive and reflects the available case evidence rather than establishing an independent psychiatric diagnosis beyond the diagnosis documented in the medical record.

Psychosocial Experiences and Coping Responses

The interviews further identified social and emotional circumstances that formed an important part of RH's psychological experience. RH described reduced social interaction and periods of being alone, while the caregiver reported changes in her social relationships and increased dependence on family members during periods of psychological difficulty. Family involvement was evident through the older sibling's participation in daily care, monitoring, and providing support when RH experienced psychological difficulties. These social circumstances were accompanied by several coping activities, including *wiridan*, Qur'anic recitation or *murottal*, prayer, and simple household activities. RH reported engaging in these religious practices during periods of distress, while household activities were maintained as part of her daily routine and provided opportunities for continued activity. The available data also indicated that fatigue and intense emotional states were reported alongside changes in RH's psychological experiences and daily functioning during certain periods. However, the qualitative data did not establish these factors as direct causes of changes in symptoms or behavior. The psychosocial experiences and coping responses identified from the case data are presented in Table 2, summarizing social circumstances, family involvement, religious and activity-based coping, daily activities, and contextual experiences of fatigue and emotional intensity.

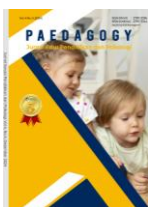


Table 2. Psychosocial Factors and Coping Responses

Theme	Finding	Evidence from Case Data
Social isolation	Reduced social interaction and periods of being alone	RH and caregiver described limited social engagement and experiences of being alone.
Family involvement	Dependence on family/caregiver support	The older sibling participated in care and provided information concerning RH's condition and daily functioning.
Religious coping	<i>Wiridan</i> , prayer, Qur'anic recitation, and <i>murottal</i>	RH reported using religious practices during periods of psychological distress.
Activity-based coping	Simple household activities	RH engaged in simple daily household activities as part of her routine and coping efforts.
Fatigue	Fatigue reported in relation to symptom changes	Information from the case indicated that fatigue accompanied changes in psychological experiences.
Emotional intensity	Intense emotions reported in relation to symptom changes	Episodes of strong emotional states were described in connection with changes in RH's psychological experiences.

Table 2 describes the psychosocial circumstances and coping responses identified across the different data sources. Social isolation and family involvement represented important contextual aspects of RH's daily experience, while religious practices and simple activities were reported as coping responses. Fatigue and intense emotional states were also identified as contextual factors associated with variations in the reported psychological experiences. These findings describe the circumstances reported by RH and other informants without establishing a direct causal relationship between any particular psychosocial factor and the emergence or reduction of symptoms.

Clinical History and Course of the Case

The clinical history showed that RH had experienced epilepsy since adolescence, with subsequent psychological difficulties documented in the course of her illness. The available medical and interview data indicated that psychological symptoms had been experienced over an extended period, while the current psychiatric admission provided an opportunity to document the manifestations and psychosocial context more systematically. The case history also documented periods of treatment nonadherence, particularly in relation to prescribed medication, although the available data did not establish nonadherence as the primary cause of symptom exacerbation. Information from the caregiver and medical records was used to clarify the chronology and course of the condition, while patient reports were used to describe her subjective experiences. The clinical history and course of RH's condition are presented in Table 3. The table summarizes the documented history of epilepsy, psychiatric difficulties, current diagnosis, treatment experiences, symptom course, contextual changes, and the clinical setting in which the data were collected.



Table 3. Clinical History and Course of RH's Condition

Aspect	Case Finding	Source
Epilepsy history	History of epilepsy beginning during adolescence	Medical records and interview
Psychiatric history	Psychological and behavioral disturbances documented during the subsequent course of illness	Medical records, interview, and informant report
Current psychiatric diagnosis	F06.8 documented in the psychiatric clinical record	Medical record
Treatment history	History of psychiatric/medical treatment and periods of nonadherence	Medical records and caregiver report
Symptom course	Psychological experiences fluctuated across the clinical course	Interview, caregiver report, and clinical observation
Contextual changes	Fatigue and intense emotional states were reported alongside changes in psychological experiences	Interview and informant report
Current clinical setting	Psychiatric inpatient treatment provided the setting for observation and data collection	Medical record and clinical observation

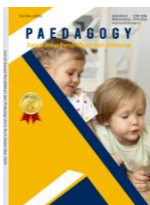
Table 3 presents the chronological and clinical information used to understand RH's case. The documented history included epilepsy beginning in adolescence, subsequent psychological difficulties, psychiatric treatment, and periods of treatment nonadherence. The table also shows that symptom changes were described in relation to several contextual circumstances, including fatigue and intense emotional states. Because the study relied on retrospective reports and clinical records, the chronology of some psychological experiences was interpreted by comparing information from multiple sources rather than assuming a single definitive temporal sequence.

Integrated Description of the Case Findings

Across the three thematic domains, the findings showed that RH's psychological experience consisted of interconnected perceptual, cognitive, emotional, behavioral, and psychosocial features. The most prominent clinical manifestations involved auditory and visual perceptual experiences together with grandiose-related and persecutory-related beliefs, while the psychosocial data highlighted loneliness, reduced social interaction, and dependence on family support. At the same time, RH reported several coping strategies, particularly religious practices and simple daily activities, which formed part of her efforts to manage distress and maintain daily functioning. The clinical history additionally showed periods of treatment nonadherence and contextual reports of fatigue and intense emotional states occurring alongside changes in psychological experiences.

Overall, the case findings indicate that the psychological dynamics of RH cannot be represented solely through the presence of psychiatric symptoms, because the case also involved subjective experiences, social circumstances, coping responses, treatment





experiences, and changes across the clinical course. The integration of patient reports, caregiver information, nursing observations, and medical records provided a multidimensional description of these phenomena. Importantly, the results establish associations and descriptions derived from the case data rather than causal mechanisms linking epilepsy, psychosocial factors, treatment adherence, and psychopathological manifestations. The findings therefore provide the empirical basis for the subsequent discussion of how the observed psychological and psychosocial patterns can be understood in relation to relevant clinical and psychological literature.

Discussion

The findings of this case study indicate that RH experienced a combination of auditory and visual perceptual experiences, unusual beliefs, emotional responses, and behavioral changes within the context of documented epilepsy and F06.8. Similar psychiatric and perceptual manifestations have been reported in case-based literature involving patients with epilepsy. Alfarossi and Hutasoit (2020) described psychotic manifestations in a patient with uncontrolled epilepsy, while Anisa Wahyuni and Cahyaningsih Fibri R. (2021) reported an organic mental disorder in a young patient with epilepsy. These previous case reports provide a clinical context for understanding the manifestations observed in RH, although the specific symptoms and clinical circumstances differ between cases. In addition, a case series and review of literature emphasized that psychosis associated with epilepsy may involve complex clinical presentations and requires careful clinical evaluation (Synmon et al., 2023). Therefore, the perceptual experiences and unusual beliefs observed in RH can be understood as clinically relevant manifestations within her documented neurological and psychiatric context, without automatically establishing a specific psychotic classification.

The interpretation of RH's psychological experiences also needs to consider the methodological characteristics of a single-case study. The present research integrates information from the patient, caregiver, psychiatric nurses, clinical observations, and medical records, allowing the psychological dynamics to be examined within the patient's clinical context. This approach is consistent with the purpose of qualitative case study methodology, which enables an intensive examination of a phenomenon within its real-life context and through multiple sources of evidence (Baxter & Jack, 2008). The integration of multiple sources is particularly important in RH's case because some experiences were based on subjective reports, while other information was obtained from caregivers, nurses, observations, and medical documentation. Accordingly, the findings should be interpreted as a contextualized description of the case rather than as evidence of a general mechanism applicable to all patients with epilepsy.

The cognitive and clinical dimensions of epilepsy also provide an important background for interpreting RH's psychological condition. Previous research has demonstrated that epilepsy may be associated with cognitive difficulties, while broader cognitive disorders can involve disturbances in memory and other higher-order functions (Haiga et al., 2024). In addition, technological developments in seizure detection using EEG signals illustrate the importance of objective neurological assessment when characterizing seizure-related phenomena (Mallick & Baths, 2024). In the present case, however, the study did not independently perform neurological or EEG assessment to establish a specific neurophysiological mechanism for the psychological experiences. Therefore, the reported hallucination-like experiences and unusual beliefs should remain interpreted within the documented clinical diagnosis and qualitative

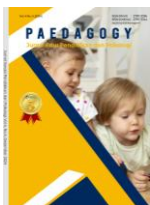


evidence rather than being attributed to a specific neurological mechanism that was not directly examined.

The psychosocial findings further showed that RH experienced reduced social interaction, periods of being alone, and dependence on family support. These experiences are relevant because the social and clinical circumstances of people with epilepsy can influence their everyday functioning and overall experience of illness. Research examining patients with epilepsy in several regions of Indonesia has documented variation in patient characteristics and clinical profiles, demonstrating the importance of considering the broader context in which epilepsy is experienced (Nugraha et al., 2023). The presence of social and family dimensions in RH's case is also consistent with the broader need to distinguish psychological symptoms from other forms of problematic behavior. Literature concerning psychiatric and behavioral disorders emphasizes that psychological symptoms should be interpreted according to their clinical context rather than being used as a basis for assumptions about criminal or harmful behavior (Nurmala et al., 2024). Thus, RH's social isolation and unusual psychological experiences are more appropriately understood as components of her individual clinical and psychosocial context.

The case also identified treatment experiences, including periods of medication nonadherence, as part of RH's clinical history. Although nonadherence was documented, the available qualitative evidence does not establish it as the primary cause of changes in psychological symptoms. Previous research has shown that sleep quality and medication compliance are relevant considerations in the management of epilepsy, indicating that treatment behavior may be interconnected with patients' broader everyday experiences (Bahar et al., 2021). Pharmacist-assisted counselling has also been examined as an approach to supporting medication adherence and quality of life among patients with epilepsy (T., Menon, Vijayan, Pradosh, & Thomas, 2022). These findings support the importance of considering treatment adherence as part of a multidimensional clinical assessment. In RH's case, however, adherence should be interpreted as one contextual dimension among several rather than as a demonstrated trigger of psychopathological symptoms.

Finally, the findings indicate that RH used religious practices and simple daily activities as coping responses during periods of psychological distress. These included *wiridan*, prayer, Qur'anic recitation or *murottal*, and household activities. The meaning of these practices is consistent with the broader understanding that coping strategies may be used to manage distress and maintain everyday functioning during chronic illness. At the same time, psychiatric comorbidities in epilepsy have been associated with quality of life and stigmatization, indicating that psychological symptoms, social experiences, and coping should be considered together rather than independently (Talibov et al., 2024). Research on epilepsy in children has also described organic amnesic syndromes associated with epilepsy, demonstrating the importance of recognizing the diversity of psychological and cognitive manifestations that may accompany the condition (Tulus et al., 2025). Furthermore, assessment of depression, anxiety, and stress among people with epilepsy indicates that emotional distress represents an important dimension of the patient experience (Vishwakarma et al., 2025). Taken together, these findings support the interpretation that RH's psychological dynamics involved interconnected psychopathological, psychosocial, emotional, and coping dimensions, while the present case does not establish direct causal relationships among these factors.



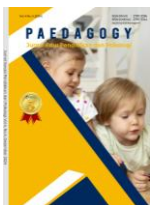
CONCLUSION

This case study demonstrates that the psychological dynamics of a patient with a documented history of complex partial epilepsy and F06.8 are multidimensional and cannot be understood solely from the presence of psychopathological symptoms. The findings indicate that subjective psychological experiences are embedded within broader psychosocial conditions, including social isolation, family involvement, coping practices, treatment experiences, fatigue, and emotional states. This perspective answers the study objective by showing that understanding the psychological dynamics of the case requires integration of clinical manifestations with the patient's lived experiences and psychosocial context. The findings also emphasize the importance of maintaining a clear distinction between documented clinical diagnoses and interpretations of individual psychological experiences, particularly when the temporal relationship between seizure activity and psychiatric symptoms has not been established. Accordingly, a comprehensive psychological assessment can provide a more contextualized understanding of patients with neurological and psychiatric comorbidity.

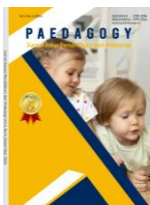
The findings have implications for clinical practice by supporting a multidisciplinary and person-centered approach that considers psychological symptoms, social functioning, coping resources, family support, and treatment experiences as interconnected components of care. Clinicians and caregivers may use this perspective to develop individualized monitoring and psychosocial support while avoiding assumptions about causal relationships that have not been clinically established. For future research, longitudinal case studies and multi-case qualitative investigations are needed to examine changes in psychological experiences over time and to clarify their temporal relationship with seizure activity, treatment adherence, and psychosocial conditions. Future studies may also explore how religious coping, social connectedness, and family involvement can be incorporated into psychosocial interventions for patients experiencing neurological and psychiatric comorbidity. Such research can strengthen evidence-based clinical formulations and contribute to the development of more comprehensive psychological and psychosocial care strategies for similar patients.

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