Emotional anaesthesia: a cognitive-behavioural treatment of prolonged grief in a client with complex comorbidities – the importance of reintegrating attachment, memory, and self-identity

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Abstract: Objective: This case-report presents the formulation and treatment of a patient with a primary diagnosis of schizophrenia, and significant complex comorbidities. It was hypothesised that much of the presentation was secondary to unresolved grief. This raises issues regarding treatment and diagnosis of unresolved grief in psychiatric inpatient units, as the DSM-5 does not currently recognise Prolonged Grief Disorder (PGD). We argue that failing to recognise PGD as a distinct syndrome has implications for research into effective psychotherapeutic interventions for patients with unresolved, prolonged, or complicated grief. **Method:** A case-report of a patient diagnosed with schizophrenia and multiple co-morbidities who received 31 sessions of psychotherapy (i.e. integrative cognitive behaviour therapy for prolonged grief disorder) as part of a rehabilitation programme. The following measures were administered pre- and post-treatment: (i) The Depression Anxiety Stress Scale, to measure levels of depression, anxiety, and stress; (ii) The Beck Depression Inventory-II to assess more specifically levels of depression; and (iii) the Prolonged Grief Disorder (PG 13) to assess symptoms of prolonged grief disorder. **Results:** Upon completion of therapy, reductions were observed in PG-13 scores, stress on The Depression Anxiety Stress Scale, and depression on The Beck Depression Inventory-II. **Conclusions:** This case report demonstrates the utility of going beyond the DSM-5 when formulating complex patients. It also highlights the importance of identifying precursory and perpetuating factors driving complex presentations, and implementing a flexible and evidence-based treatment that sensitively addresses the presentation.

Keywords: Psychosis, inpatient, case-report, prolonged/complicated grief, cognitive behaviour therapy, bereavement

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Introduction

How one reacts to a death is a multifaceted and individual process. The intimate and individual nature of one's response to a death adds to the complexity of viewing grief as a universally experienced process. Although most people will experience some kind of loss within their lifetime, there is substantial variability in styles of coping among individuals and across cultures (Bonanno, 2004).

The course of one's grief is likely to be influenced by a combination of internal factors (i.e. style of thinking, affect adjustment, psychological resilience (Eisma *et al,* 2016; Bonanno, 2004) and external factors, (i.e. the nature of the relationship, circumstances surrounding the death, and the individual's culture and spirituality (Tal *et al,* 2016; Higson-Smith, 2014; Bonanno, 2004). Given the unique influence of a constellation of possible factors that contribute to one's expression and experience of grief, there has been no clear consensus in the bereavement literature as to what constitutes a 'normal' grief trajectory (Bonanno & Kaltman, 2001). Consequently, clinicians and researchers alike have exercised caution in pathologising bereavement for decades (Jordan & Litz, 2014; Boelen *et al,* 2010).

While by no means a psychological disorder, grief has been described as an extreme stressor that is both acutely distressing and disruptive of normal functioning (Mauro *et al,* 2016). Despite the powerful emotions, cognitive distortions, and psychosocial difficulties commonly experienced after the death of a close friend or relative, bereaved persons typically return to an adaptive level of functioning following the loss, with bereavement-related distress allaying substantially six months post-mortem (Rosner *et al,* 2011; Schaal *et al,* 2009; Bonanno & Kaltman, 2001). However, research has become increasingly interested in a small group of individuals whose grief follows a different trajectory: it is both complicated and prolonged (Prigerson *et al,* 2009; Horowitz *et al,* 1997). Estimated to have a prevalence of between 2 to 3 per cent worldwide (Kersting *et al,* 2011), such individuals fail to return to an adaptive level of functioning, continuing to suffer debilitating yearning for the deceased. This may culminate in a loss of self-identity, avoidance of reminders, emotional numbness, difficulty adjusting, and feeling angry, mistrusting, and hopeless (Prigerson *et al,* 2009). Such presentations are characteristic of Prolonged Grief Disorder (PGD) when not better explained by major depressive disorder, generalised anxiety disorder (GAD) or post-traumatic stress disorder (PTSD) (Prigerson *et al,* 2009; Prigerson *et al,* 2002).

Despite research interest, PGD remains a contentious diagnosis in the bereavement literature as well as within clinical practice (Boelen, 2016). One argument for the inclusion of PGD as a separate diagnostic consideration asserts that characteristics of PGD are distinct, and not captured by other disorders recognised by the DSM-5[1] (Boelen, 2016). Consistently, psychometric and factor-analytic research has demonstrated that PGD represents a psychometrically valid syndrome that is distinguishable from depression, anxiety and PTSD (Boelen *et al,* 2010; Prigerson *et al,* 2009; Boelen & Prigerson, 2007). Furthermore, concern exists in the literature that grief may become 'over-pathologised' (Wakefield, 2013). However, there is the equally worrying iatrogenic[2] process whereby misdiagnosing grief may undermine both treatment and recovery in individuals suffering PGD. Omitting PGD from the DSM-5 may also have implications for funding research into effective, evidence-based treatments, as well as access to treatment through insurance schemes (Boelen, 2016).

PGD is proposed to be included in the ICD-11[3] as a stress-related disorder. Currently, no such diagnosis is recognised by the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), although persistent complex bereavement disorder is classified as a 'condition for further study' (American Psychological Association, 2013). Whether PGD should be recognised as an independent diagnosis in the DSM remains controversial, with some critics asserting the current DSM-5 criteria for persistent complex bereavement disorder is too conservative, discounting approximately half of clinical cases (Cozza *et al,* 2016).

While there exists no empirically defensible consensus as to what constitutes normative bereavement, one prevailing theory called the 'dual processing model of coping' (Stroebe & Schut, 1999) posits that adaptive grieving entails the completion of loss-focused tasks. The bereaved confronts triggers of the loss (e.g. looking at photos and recounting memories involving the deceased) (Jordan & Litz, 2014). This process is emotionally demanding, and so many engage in a 'dual process', whereby they vacillate between engaging with loss-stressors and withdrawing to divert attention to future-focused activities (Stroebe & Schut, 1999). Thus, an integrative treatment for PGD aims to facilitate the bereaved to identify underlying factors prolonging grief (e.g. avoidance of loss-stressors, adopting a restoration-focus), and transform the grief through cognitive restructuring and exposure. This case report supports the clinical utility of a PGD diagnosis and treatment plan for improving patient outcomes and reducing symptoms of PGD.

Case report

BZ was a 50-year-old woman diagnosed with schizophrenia and hoarding disorder, whilst also meeting criteria for a major depressive episode. Concomitant with this, she had an eating/feeding disorder (Body Mass Index (BMI) was 15.5kg/

1 A manual used by mental health practitioners to classify various psychiatric and psychological disorders.
2 Relating to harm caused by a practitioner/clinician throughout the course of treatment.
3 An alternative classification system to the DSM-5.

m2, in the absence of body image concerns), attention deficit hyperactivity disorder (ADHD), personality sensitivities (i.e. schizoid personality disorder with narcissistic traits) and a history of benzodiazepine and amphetamine misuse. She had suffered a significant left middle cerebral artery (MCA) stroke in 1999 resulting in significant hypo-density, which likely occurred because of intranasal dexamphetamine use.

At the time of the psychological assessment, she was being treated for low weight/malnourishment, poor dental health, and stabilisation of her mental state with medication[4]. Her psychotic symptoms were in remission, and the core of BZ's difficulties appeared to lie with her unprocessed grief regarding the loss of several close family members. At assessment, her mother had died approximately 25 years prior (1990), and her father 15 years prior (2000). Both deaths occurred unexpectedly, and were associated with strong intellectual and emotional denial. BZ had also experienced the death of her stepfather by suicide in 1991, and both grandmothers in 1992. On clinical interview, BZ stated that these loses had resulted in '*total erasure of (herself), (her) history, and the closest people in the world to (her).*' She further stated that she was '*…just trying to get from one moment to the next.*'

Initially, BZ reported being unable to speak of her parents, or any associated memories. She felt unable to recall even pleasant memories due to a fear of becoming overwhelmed with emotion and not being able to cope due to the entrenched belief that if she was to experience grief, *'it (would) overwhelm (her) and (her) heart (would) stop.*' She ultimately described feeling '*emotionally anaesthetised.*' This had resulted in significant mental blocking, which she described as being '*Completely blocked. Not intellectually, but fundamentally.*' Consequently, she avoided any memories associated with her deceased family members, avoiding physical reminders (i.e. photographs), and locations/landmarks that triggered memories for her. She was prone to developing sentimental attachments to inanimate objects and feeling unable to throw them out, leading to a significant issue with hoarding. When she did speak about her parents in general terms, she spoke about them in the present tense, despite intellectual awareness that they were deceased.

History of presenting problems

Prior to admission, BZ was living independently in extremely squalid conditions due to hoarding. There was no power or water due to financial mismanagement. She had a history of poor social relations. She was estranged from her sister who was her only remaining relative.

BZ had a history of psychiatric admissions. The first was in 1990, due to an episode of adjustment disorder and depressed mood subsequent to her mother's death. She also had a one-month admission in 1999 due to longstanding chronic psychosis. BZ was allegedly under the care of a case manager in the community between 2004 and 2007, and hospitalised again in 2015 for one month due to paranoid ideas, formal thought disorder and auditory hallucinations.

The current admission (2015-2016) occurred in the context of a fire breaking out in a bedroom of her premises due to the use of candles as a light source in squalid conditions. Upon admission, BZ exhibited paranoid ideation regarding both the nature of the fire and the police. She was transferred to a psychiatric facility and admitted under the provisions of the New South Wales Government Mental Health Act of 2007.

Assessment measures

The Depression Anxiety Stress Scale-21 (DASS-21) (Lovibond & Lovibond, 1995) was administered to assess BZ's levels of anxiety, depression, and stress. Her ratings indicated moderate levels of depression, anxiety, and stress. The Beck Depression Inventory-II (BDI-II) (Beck *et al*, 1996) was administered to assess more specifically BZ's levels of depression. Her ratings indicated a moderate level of depression on this measure. The PG-13 (Prigerson *et al*, 2009) was used to diagnose and gauge symptoms of PGD.

The OMNI Personality Inventory (Loranger, 2001) was also administered to provide a description of BZ's personality traits. Based on BZ's responses, it was indicated that she exhibited personality traits characteristic of schizoid and schizotypal personality structures. She also scored above community norms on the impulsiveness and irritability subscales.

Formulation

BZ's presentation was best explained by PGD, and was thus conceptualised using an adapted model based on the 'Cognitive Attachment Model of prolonged grief', integrating attachments, memory, and identity, proposed by Maccallum and Bryant, (2013) (see Figure 1). There appeared to be a strong time-order relationship between her mother's death and subsequent onset of her complex presentation and psychotic symptoms. BZ was both dependent on and enmeshed with her mother, and appeared to suffer great identity loss after her death. She described extreme disbelief at this time, stating '*It couldn't possibly be true. How could the trains still be running?*' She was subsequently admitted for hospitalisation due to suicidal intent, and diagnosed with an adjustment disorder and strong emotional and intellectual denial of the death.

She did not attend her mother's funeral, and adopted poor coping mechanisms (i.e. prescription drug overuse, thought blocking, and avoidance). The subsequent deaths of her grandparents, stepfather, and father within a short timeframe appeared to act as perpetuating and exacerbating factors for her psychiatric difficulties, as her mental state and physical health deteriorated. As many of these deaths were unexpected, BZ likely felt unable to accept or process her grief. In her own words, she became *'emotionally*

4 Olanzapine, fluoxetine, and diazepam.

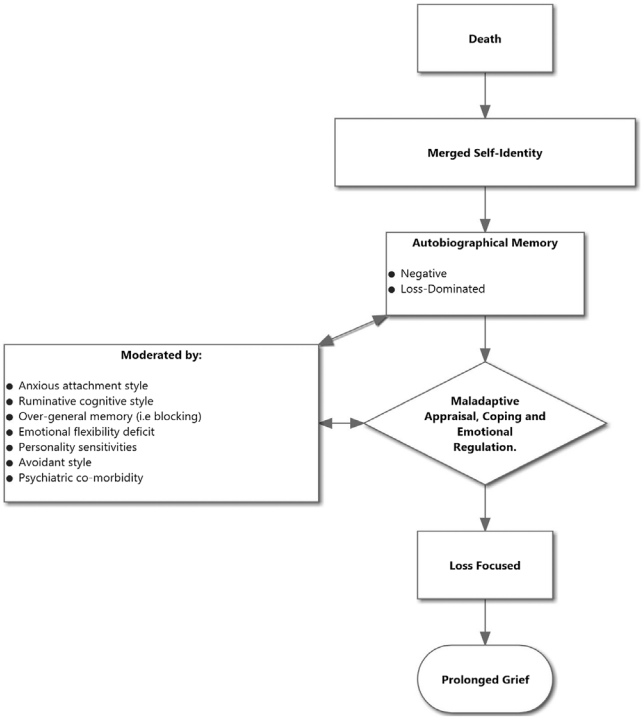

Figure 1: A cognitive model of PGD integrating attachments, memory, and identity, adapted from Maccallum and Bryant (2013)

anaesthetised.' She exhibited signs of 'over-general retrieval' memory, through being unable to recall specific details of the past, a common phenomenon observed in patients with complex bereavement or PGD (Sumner, 2012). However, delineating this from her pre-existing neuropsychological profile (i.e. ADHD, varied executive function post-stroke) is challenging.

Treatment

Treatment rationale

The treatment plan was derived from a manualised treatment of complicated grief using an integrative cognitive behavioural (PG-CBT) approach (Rosner *et al,* 2014). The treatment was delivered by a clinical psychology intern in a doctoral programme, under the supervision of a Principal Psychologist. BZ was referred for psychological therapy for grief by the consultant psychiatrist. Standard research ethics were followed. BZ was seen twice weekly for 31 sessions. As she was an inpatient in a psychiatric hospital, she was concurrently seen by other health professionals, including psychiatrists, mental health nurses, social workers, and occupational therapists.

The therapeutic intervention was adapted to account for BZ's inpatient status, mental state, and personality sensitivities (Table 1: Outline of session contents and treatment strategies). The treatment aimed to facilitate BZ to explore, confront and accept the most painful memories associated with her grief, with the ultimate aim of re-integrating her family history with her self-identity.

To date there have been four randomised controlled trials investigating the efficacy of PG-CBT (Rosner *et al,* 2014; Boelen *et al*, 2007; Wagner *et al* 2006; Shear *et al,* 2005). Importantly, efficacy has been demonstrated in inpatients with comorbidities (Rosner *et al,* 2011). Based on meta-analyses (Rosner & Hagl, 2007, Rosner *et al,* 2005) the most efficacious components of treatment appear to be: (i) psycho-education about normal and PG processes; (ii) exposure elements relating to the most painful aspects of the loss; and (iii) transformation of the loss to enable change. These components were thus central to BZ's psychological treatment.

Treatment components

Assessment

Due to BZ's fragile mental state and history of paranoia, several sessions were taken to build rapport, and conduct a sensitive and thorough assessment. This included accessing her previous medical records from archives, and getting collateral information from her estranged sister.

Despite clear enjoyment of social contact with the therapist, BZ was initially highly avoidant of discussing her grief due to her core beliefs that: *'If I think about it/let it spill out of me, I will die; 'I will become overwhelmed and drown in grief,'* and *'I am blocked from the inside out and unable to access my past*.' Before these cognitions could be challenged, it was first essential to help BZ build insight into them. This was achieved using psychodynamic reflection, wherein BZ was encouraged to reflect on things she might be avoiding, and the reasons behind these avoidances. By gently and consistently discussing avoidances in therapy, BZ was able to develop insight into their frequency. The cycle of ruminating about how things could have gone differently, avoiding external triggers, and suppressing emotions in maintaining and prolonging grief were discussed in this context, as was the functional and occupational impact this was exerting on her life.

Once BZ had developed insight into her pattern of avoidances, psychoeducation around cognitive-behavioural therapy for grief was delivered. Once BZ was able to understand that by not dealing with her grief she was effectually perpetuating it, cognitive challenging of maladaptive appraisals commenced. First, BZ's belief that her heart would stop if she thought about her mother's death was challenged using a series of behavioural experiments, wherein she thought about her mother's death for brief periods while monitoring her heart rate. Other cognitions and maladaptive appraisals were also challenged, such as her belief that she was '*blocked*' and unable to access memories, and her belief that she could not cope with death anniversaries without using dexamphetamine. Cognitive restructuring / reinterpretation of the loss helped BZ to find meaning, (e.g. the idea that her identity and family history were not erased, and still formed a large part of her sense of self).

Table 1: Outline of session contents and treatment strategies

Session number	Session focus	Treatment strategies
1–2	Assessment	Rapport building, sensitive assessment of difficulties, establishment of treatment goals.
3–4	Weight stabilisation	Assessment of eating habits and body image factors, psycho-education around the risks of low weight, continued liaison with psychiatric and nursing staff to ensure supportive therapy and progression of eating disorder referral and meal supervision.
5–7	Psychodynamic reflection, mood stabilisation, problem solving.	Psychodynamic reflection used to build insight into avoidances.
8	Conquering avoidance	Motivational interviewing/decision making aide implemented to address avoidance of medical procedures.
9	Behavioural activation	Increasing mastery through playing music.
10–11	Introduction to grief processes	A film with themes of loss and different coping mechanisms watched to open a dialogue around different grieving styles.
12	Reflection, psycho-education around grieving styles	Quotations around grief and loss used to continue philosophical discussion around grief in general. Personal impact of film discussed.
13–14	Imaginal exposure to avoided memories	BZ was encouraged to recall pleasant memories mentally. Contextual cueing was used to deepen the experience and prevent blocking.
15–18	Narrative exposure to avoided memories	Engagement with familial history to address avoidances through verbally recounting memories.
19	Cognitive challenging	Cognitive challenging of maladaptive appraisals about the loss and her capacity to cope with the future, cognitive restructuring/reinterpretation of the loss (i.e. finding meaning).
20	Dealing with anniversaries	The anniversary of her mother's death was discussed. BZ was affirmed for coping without misusing dexamphetamine.
21–22	Behavioural exposure	Photos of previous homes viewed, and impact discussed.
23	Genogram	Creation of a family genogram that displayed deceased family members. Grounding exercises (i.e. mindfulness scripts).
24	Identification of 'hot spots'	Identification of worst memories.
25–27	Narrative exposure	Confrontation of worst memories, restructuring, and acceptance.
28	Heritage and continuing bonds	Discussion of the importance of continued integration of familial history to sense of self and indentity.
29	Reaching out	Discussion around previously 'estranged' sister. Communication re-established. Consideration of sister's shared experiences of memories, attachment, and grief. Planning for future interactions.
30–31	Memento and future	Future-focused goals discussed, affirmation of progress, presentation of a time-line of events to facilitate re-integration of self-identity and engagement with familial history.

Behavioural activation and mastery

BZ was a talented musician and composer, and music had been a large part of her life previously. Behavioural activation and mastery were developed through encouraging BZ to attend the ward's weekly music group, and eventually, begin playing and composing music once again. BZ was

encouraged to listen to her favourite compositions from her past. Eventually, BZ was able to engage with musical compositions she had written about her mother. This strategy may also be effective for patients who are not trained musicians, as music is a known powerful means of eliciting strong emotions and memories among individuals (Singer *et al*, 2016).

Opening a dialogue around grief

This is a strategy that we would recommend applying flexibly and creatively, tailoring it to the individual's needs. In the case of BZ, the topic of grief was first broached through a philosophical discussion around grief in general. Quotations were read out about grief, and BZ was asked to reflect on whether she resonated with them, or had a different viewpoint. She engaged well with this exercise. Extensive psycho-education around the heterogeneity of grief responses, and the individual nature of grief was delivered. *Healing trajectories* versus prolonged and complex experiences of grief were discussed in this context. A film was watched over two sessions with themes of loss, grief and coping, and BZ was asked to identify and comment on different styles of grief exhibited by characters in the film. Using this as a vehicle to discuss her own grief, she began comparing and contrasting the characters' experiences with her own. The personal impact of the film for BZ was then discussed.

Integrated cognitive-behavioural exposure

Due to BZ's unwillingness to discuss her grief, imaginal exposure was first used with pleasant memories. She was asked to go over memories in her mind with the support of the therapist. Contextual cueing was used to deepen the experience and prevent blocking (e.g. '*what were you feeling at the time*', '*what could you hear/see/smell*). Eventually, BZ took pleasure in retelling pleasant memories. For homework, she was asked to bring a new memory into each session. Insight was built through pointing out how successful she was at accessing memories, despite her strong belief that she was '*blocked*.' An integrative narrative focus was taken, as BZ began constructing a genogram and timeline of life events in collaboration with the therapist, using information from her medical history and own recollections. Photographs of previous family residences retrieved from the internet were used as part of the exposure therapy. Once she was fluently able to access pleasant and neutral memories, hot spots (i.e. the worst memories) were identified. Through the same imaginal strategy, BZ began engaging with the worst parts of her grief (such as learning of the deaths, and her initial response, who was around, and how she remembered feeling).

Relapse prevention and termination

At the end of the therapeutic intervention, clear future goals were discussed to foster future-focused thinking. BZ was encouraged to continue with her exposure therapy through visiting important landmarks and avoided locations from her history (i.e. she reported avoiding whole suburbs because they brought up memories of deceased family members). A relapse prevention plan was collaboratively created, and the long-term benefits of confronting, exploring, stabilising, and ultimately accepting her emotions and cognitions around grief were also discussed.

Response to treatment

BZ initially presented as highly avoidant. She was emotionally unengaged, and felt unable to complete assessment measures. She was ambivalent about discussing the past, as she feared that she would become overwhelmed and unable to cope. Consequently, the treatment necessitated a plan that was flexible and responsive to her labile mental state.

The importance of re-integrating her family history into her sense of self through engaging with her past and ultimately transforming her grief formed the crux of the treatment. The anniversary of her mother's death occurred around the time of discharge from therapy, and BZ learnt that she was able to cope for the first time without substance use.

Treatment limitations

Several caveats to the treatment warrant mentioning. Firstly, as BZ was on concomitant psychoactive medication, treatment outcomes must therefore be interpreted with caution. Secondly, BZ had no access to family photographs or artefacts due to her squalid living circumstances. Exposure to photographs may have facilitated treatment outcomes. Lastly, it would have been beneficial to have a family session with BZ's sister to share family histories and plan future interactions. Despite planning, her sister was unavailable to attend before termination of therapy.

Outcome

Upon completion of therapy, reductions were observed in prolonged grief scores on the PG-13, stress on the DASS-21, and depression on the BDI-II (Table 2: Pre- and post-treatment measures). Anxiety remained moderate.

Behavioural indices of change

Medical

i. Stabilisation of weight through psycho-education and implementation of a meal plan.

Social

i. Increased social engagement was evident through BZ's contact with her previously estranged sister, the purchase of a mobile phone to maintain contact, and her newfound interest in outings with other patients. This was achieved through goal setting, behavioural activation, and reinforcement and review of progress.

Table 2: Pre- and post-treatment measures

Measure	Baseline	Follow-up
Depression	Moderate	Severe
Anxiety	Moderate	Moderate
Stress	Moderate	Normal
BDI-II	Moderate	Normal
Prolonged Grief Disorder (PG – 13)*	40/55	32/55

*M = 24.43; SD = 8.77, range: 11-53; Schaal *et al*, (2009)

Psychological

i. BZ was no longer adopting the present tense to speak about her deceased family members. This was observed in session and fed back to her.
ii. BZ exhibited an overarching newfound acceptance of circumstances.
iii. BZ began future planning through discussing life after her admission. Future goals were set and a relapse prevention plan was discussed.
iv. Behavioural activation (attending appointments without OT support, playing music, creative writing) was achieved through the implementation of behavioural charts, support and reinforcement of adaptive behaviours.
v. There was evidence of insight into previous patterns of avoidance and other maladaptive cognitions and coping mechanisms. This was achieved through confronting and facing avoidances and reflecting on therapeutic achievements.
vi. A reduction in behavioural avoidances was observed (attending appointments (i.e. dental), being able to look at photographs, a timeline, and genogram through the implementation of an exposure paradigm.
vii. Reduced emotional avoidance was evident by BZ's willingness to complete assessment measures without assistance mid- and post-treatment.
viii. Engagement with familial history was observed as BZ began spontaneously volunteering memories without prompting.
ix. Confrontation of worst/most avoided memories was achieved through graded exposure.

Conclusions and recommendations

This case-report presents one patient's experience and positive response to treatment with integrative CBT for PGD. The results of this report must be examined in light of several treatment caveats, as well as the fact that the psychotherapeutic intervention was offered as an adjunct to pharmaceutical treatment. Further, while single-case studies can offer richer detail into treatment strategies and responses than larger group studies, this methodology is strengthened when randomised and controlled (Evans *et al*, 2014; Howick *et al*, 2011). Further researchers may wish to bolster this body of research by reporting on integrative treatments and patient responses using a more rigorous methodology.

Nevertheless, this case demonstrates the utility of considering a PGD diagnosis and integrative CBT treatment plan when formulating complex patients with a history of unresolved grief. It also highlights the importance of identifying precursory and perpetuating factors driving complex presentations, and implementing a flexible, responsive and evidence-based treatment plan that sensitively addresses the core of the patient's issues. This is imperative in inpatient settings, where comorbidities and pre-existing diagnoses may mask underlying PGD. It is recommended that clinicians are able to differentiate PGD from non-clinical bereavement, mood disorders, GAD, and PTSD, thereby offering appropriate support and intervention. This may be achieved through familiarisation with PGD/complex bereavement diagnostic guidelines. Further, with complex patients with a history of loss, measures such as the PGD-13 should be administered alongside routine psychometric baseline measures. ■

Editorial comment

Emotional anaesthesia

While one always hopes that a holistic approach will reduce the need for people who seek help after bereavements to need a variety of specialists, this is not always possible or desirable. This case study is a good example of the contribution that a clinical psychologist can make to a mental health team faced with a person suffering from a number of complex yet interacting problems that necessitated in-patient care in a psychiatric unit. It is not unrealistic to expect that the improvement in this person's overall levels of anxiety, depression and grief, that resulted from focused treatment of long-standing complications of bereavements, will also have benefited the psychosis and other psychological problems from which this unfortunate woman suffered.

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