

THE UNIVERSITY *of York*
The Department of Health Sciences

Psychological care after stroke



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A few questions

1. *What do we mean by ‘psychological care’?*
2. *How common are mood problems after stroke?*
3. *Are any treatments effective?*
4. *How can psychological care be provided within stroke services?*

A condensed talk for the very tired

1. *So what is this 'psychological care' thing?*

It's to do with cognitive impairments, emotional problems and the perhaps understandable problems patients have in dealing with a disabling illness of sudden onset.

2. *Tell me, how common are mood problems after stroke?*

There's a lot of it about, perhaps 1 patient in 3.

3. *And are any treatments effective?*

There's not a lot of evidence. Talking treatments might work, as might drugs. But don't be too rash with the drugs and be prepared to stop them.

4. *One last thing, how can I provide psychological care within my stroke service?*

You could try the stepped care approach – NICE recommends it. Make sure you assess all the patients, treat most problems in-house and refer to a specialist when essential.

- **Depression**
- **Anxiety**
- **Worry**
- **Emotionalism**
- **Adjustment**
- **Fatigue**
- **Coping**
- **Apathy**
- **Anger**
- **Social re-integration**

- **Depression**
- **Anxiety**
- **Emotionalism**
- **Adjustment disorder**

NHS Improvement – Stroke.

Psychological care after stroke. Improving stroke services for people with cognitive and mood disorders.

2011

- **May occur in 1 in 3 patients in the first year after stroke.** (e.g. Hackett et al. *Stroke* 2005; 36: 1330-1340).
- **Associated with increased long-term disability, re-admission and mortality.** (e.g. House et al. *Stroke* 2001; 32: 696-701).

Major depression:

- symptoms persist for at least 1 month
 - Affect
 - Cognitions (thoughts)
 - ‘Biological’ aspects (sleep; appetite; energy)

Cochrane systematic review. Hackett et al 2008.

- 17 trials (13 drug trials; 4 psychological treatment trials).
- Methods diverse and generally poor.
- Some evidence for benefits of antidepressant drugs (but increased adverse events);
- Use ADs with caution.
- No evidence for psychological treatments.

Anxiety disorders:

- symptoms persisting at least 1 month
 - Excessive worry or fear
 - Physical and psychological symptoms
 - General anxiety disorder
 - Panic disorder
 - Phobias (including social phobias)
 - Obsessive compulsive disorder (OCD)
 - Post-traumatic stress disorder (PTSD)

Systematic review of frequency studies.

Campbell Burton et al. Under review.

44 studies; N = 5,737

Diversity of settings; countries; timings; measures; etc

In other words, diversity, diversity, diversity.

Acute (<1 month): **15%** (95% CIs 8.5 to 22%)

Mid-term (1-5 months): **22%** (18 to 26%)

Longer-term (>6 months): **21%** (14 to 27%)

Cochrane systematic review. Campbell Burton et al. 2012.

2 trials (3 interventions); N = 175

Patients had both anxiety and depression.

No evidence of effect (NB **NOT** evidence of no effect).

From other settings:

- Drugs;
- Relaxation therapy;
- Graded exposure;
- Cognitive behavioural therapy (CBT).

See NICE Guidance on management of anxiety in the general adult population.

Emotionalism (or ‘emotional lability’ or ‘pathological laughing and crying’):

- Uncontrolled;
 - Crying more common than laughing;
 - Distressing and embarrassing;
 - Emotionally laden situations.
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- No definitive rate
 - Most common in first month post-stroke
 - Appears to have a neurological cause

Cochrane systematic review. Hackett et al. 2010

- 7 trials; N = 239 participants
- 5 trials showed large treatment effects of antidepressants
- ? Rate of adverse events

- Distraction may be useful clinically
- Information and support essential for patients and carers (as it is in all psychological problems)

Some of the features of major depression. May be short-lasting.

- Affect
- Cognitions (thoughts)
- Biological aspects (sleep; appetite; energy)

- May be single severe symptom (e.g. feeling worthless; seeing life as hopeless)

- Start antidepressants only if unless symptoms are severe or disorder is having a significant impact.

NHS Improvement – Stroke.

Psychological care after stroke. Improving stroke services for people with cognitive and mood disorders. 2011

A ‘Stepped Care’ approach

See NICE guidance on the management of common mood disorders in the general adult population. 3 RCTs

No stroke-specific evidence.

Level 3: Severe and persistent disorders

Level 2: Mild or moderate symptoms

Level 1: 'Sub-threshold' problems (at a level common to many or most people with stroke)

Level 3: Severe and persistent disorders

Managed by a specialist

Level 2: Mild or moderate symptoms

Managed mostly in-house (possibly by designated staff, supervised by specialist)

Level 1: 'Sub-threshold' problems (at a level common to many or most people with stroke)

Managed in-house (by all staff)

Level 3:

Severe or persistent symptoms (refer and treat)

Also treat those not responsive to information, support and advice

Level 2:

Mild or moderate symptoms (provide information, support and advice to patients and carers as first line of treatment)

Level 1:

Assess all admitted patients (questionnaire)

Symptomatic patients: detailed interview (confirm symptoms; possible causes; history; impact; treatment preferences)

Level 3:

Severe or persistent symptoms (refer and treat)

Also treat those not responsive to information, support and advice

Level 2:

Mild or moderate symptoms (provide information, support and advice to patients and carers as first line of treatment)

Level 1:

Assess all admitted patients (questionnaire)

Symptomatic patients confirmed with interview

Level 3:

Severe or persistent symptoms (refer and treat)

**Also treat those not responsive to Level 2 information,
support and advice**

Level 2:

Mild or moderate symptoms (provide information, support and advice to patients and carers as first line of treatment)

Level 1:

Assess all admitted patients (questionnaire)

Symptomatic patients confirmed with interview

1. Which assessment tool & when?
2. How to assess patients with communication problems?
3. What level of symptoms results in follow-up interview?
...or movement to Level 2? ...or to Level 3?
4. Who will provide information, support and advice?
5. Who provides the training & supervision?
6. Who will assess the effects of treatment?
7. Who will provide treatment (either drug or psychological)?
8. When will the patient be reviewed?

And finally...

**...the stepped care model does need
evaluation in stroke!**

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