

Depression and other emotional problems after stroke

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Affective

Behavioural

Cognitive

Somatic

Depression
- transient
- persistent

Tearfulness

Hopelessness
Suicidal ideas

Anorexia
Weight loss

Anxiety
- pervasive
- phobic

Reassurance Seeking

Worry
Hypochondriasis

Insomnia
Pain
Tension

Irritability

Non-compliance
Aggression

Apathy

Inertia

Helplessness

Lethargy

Anhedonia

Social withdrawal

Indifference

Carelessness

Down-playing

Euphoria

Accident-proneness

Denial of
disability/handicap



Some common measures of symptom burden

- Hospital Anxiety and Depression Scale: HAD 14 items
- General Health Questionnaire: GHQ 12, 28, 30, 60 items
- Beck Depression Inventory: BDI 21 items
- Patient Health Questionnaire: PHQ-9 items



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Major depression:

- depressed mood or loss of interest or pleasure
- and during the same 2 week period >3 from:
 - Weight loss or weight gain, or marked change in appetite
 - Insomnia or hypersomnia
 - Agitation or retardation
 - Fatigue or loss of energy
 - Worthlessness or guilt
 - Poor concentration or indecisiveness
 - Thoughts of death or suicidal thinking



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What cognitions really count?

Is it the *presence* of negative ones?

- Hopelessness
- Sense of personal worthlessness
- Sense of life not worth living
- Suicidal ideas

Or the *absence* of positive ones?

- Positive forward directed thinking
- Optimism
- *Ikigai*
- Pleasure, or enjoyment in life



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- Distress as symptom burden
- Emotional disorders as specific syndromes
- The central importance of individual features (such as cognitions, behaviours or physical symptoms)



Non-drug approaches to emotional problems



Understanding the challenge

e.g. education/information

Mobilising resources

e.g. increased social support

Re-appraise success

e.g. active follow up



identify ALL problems

break them down

set priorities

generate possible solutions

pick a solution and try it

assess outcome; re-iterate



Some common problems associated with depression

- Stroke-related disability
- Beliefs about stroke – consequences, cure+control
- Experience of healthcare
- Life problems outside stroke
- Emotions in significant others



- Tackling avoidance
 - Spotting the exposure-withdrawal cycle
 - Spotting high-risk situations
 - Planning a graded approach to exposure without withdrawal
- Tackling reassurance-seeking
 - Spotting when helpful talk has moved to unhelpful (repetitive) reassurance
 - Finding ways of saying “No”



	MONDAY	TUESDAY	WEDNESDAY
9-10	Went back to bed	Asleep	Hospital
10-11	Still in bed	Went to shops	Watch telly
11-12	Watch telly	Shops	Called friend
12-1	Went to shop	Ate lunch in town	Washing
1-2	Made lunch	Watch telly	Made lunch

Activity scheduling

Monitor current activity

- in itself a task
- involves patient in planning
- teaches that everything's an activity
- serves as a focus for the next stage

schedule new activities

- look at flat spots
- pick an activity and break it down

check out reasons for success or failure



	MONDAY	TUESDAY	WEDNESDAY
9-10	Went back to bed MO PO	Asleep MO PO	Hospital M2 PO
10-11	Still in bed MO PO	Went to shops M3 PO	Watch telly MO P1
11-12	Watch telly MO P1	Shops M3 PO	Called friend MO P2
12-1	Went to shop M1 PO	Ate lunch in town MO P3	Washing M3 PO
1-2	Made lunch M2 P2	Watch telly MO PO	Made lunch M2 P1



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Cognitive-behaviour therapy (CBT)

Main focus is on unhealthy thoughts:

- content e.g. misattributions of symptoms
- style e.g. black and white thinking

Or unhealthy behaviour:

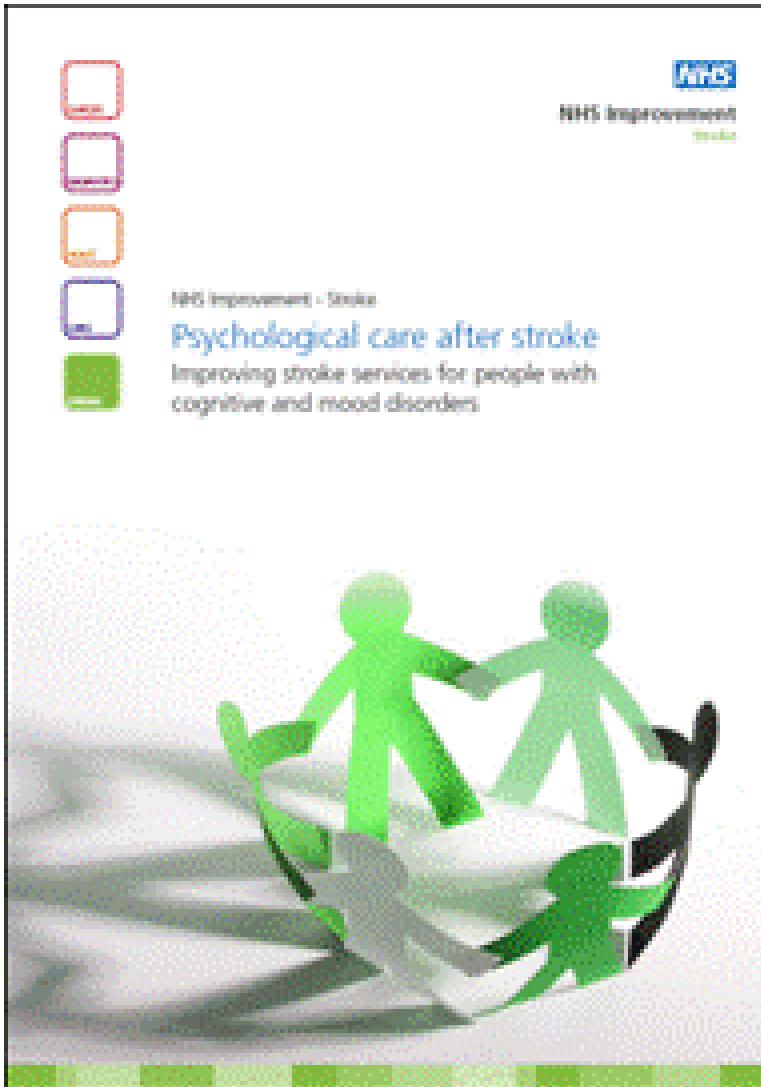
- Especially passive or avoidant



Interpersonal psychotherapy [IPT]

Main focus is unhealthy relationships:

- grief
- disputes
- role transitions
- deficits



Google:

NHS Improvement – stroke

Psychological care after stroke

- Check for distress – a simple self report questionnaire is a good start
 - Early on (2-4 weeks)
 - During rehab (2-4 months)
 - Later in recovery (6 months)
 - At the end of the first year (12 months)
- Clarify the nature of distress – emotions; behaviours; cognitions; symptoms
- Think about help using the stepped care approach



The stepped care model

The recommendations in this guideline are presented within a stepped care framework that aims to match the needs of people with depression to the most appropriate services, depending on the characteristics of their illness and their personal and social circumstances. Each step represents increased complexity of intervention, with higher steps assuming interventions in previous steps.

Step 1: Recognition in primary care and general hospital settings

Step 2: Treatment of mild depression in primary care

Step 3: Treatment of moderate to severe depression in primary care

Step 4: Treatment of depression by mental health specialists

Step 5: Inpatient treatment for depression

	Who is responsible for care?	What is the focus?	What do they do?
Step 5:	Inpatient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT
Step 4:	Mental health specialists, including crisis teams	Treatment-resistant, recurrent, atypical and psychotic depression, and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 3:	Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, social support
Step 2:	Primary care team, primary care mental health worker	Mild depression	Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
Step 1:	GP, practice nurse	Recognition	Assessment

The steps in stroke care:

1. Few/no symptoms

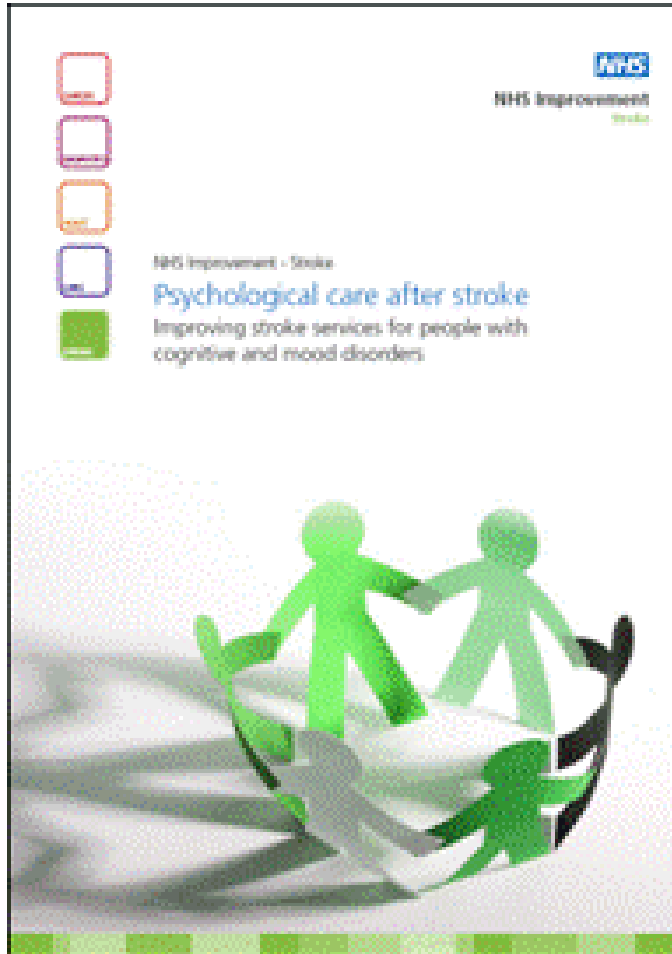
- Watchful waiting

2. Mild/moderate symptoms

- Stroke team; IAPT

3. Severe or persistent symptoms

- Mental health services



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