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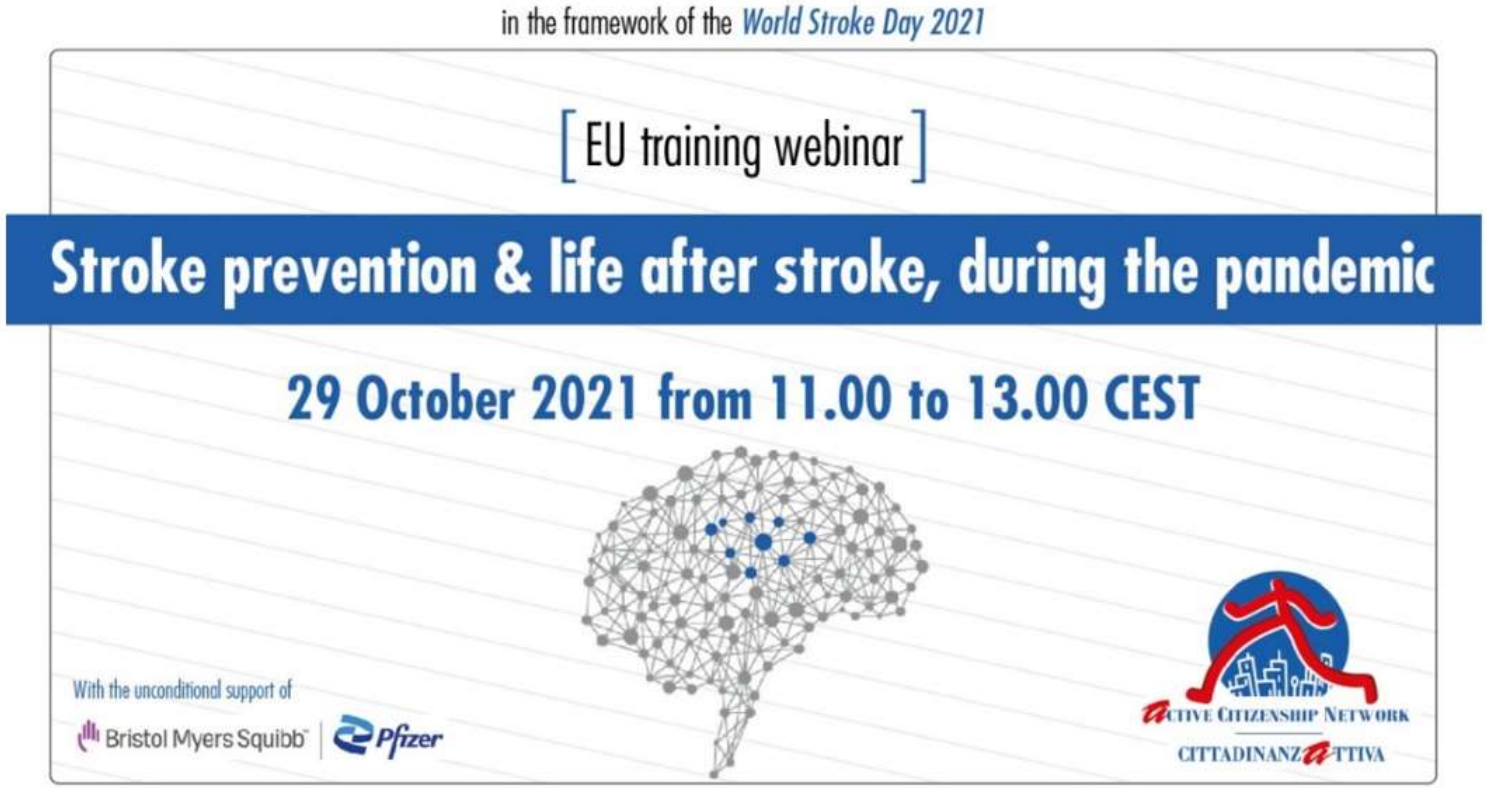
ECHDO
European Congenital Heart Disease Organisation

Psychosocial aspects in Stroke



Presentation overview

- Post stroke depression
- Cognitive impairment post stroke
- Caregiver burden and outcomes
- COVID-19 impact on psychosocial outcomes in stroke
- Psychological interventions after stroke
- Integration of Clinical Psychology Service and Peer to peer support

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Ageing Research Reviews

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Post stroke depression and risk of stroke recurrence and mortality: A systematic review and meta-analysis

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- Close association of stroke with the development of psychiatric symptoms (Bolaños, Moro, Lizasoain, & Almeida, 2009).
- Post-stroke depression (PSD), whose major symptoms are melancholia, dysphoria and vegetative signs such as sleep disorders, reduced libido and energy level (Paradiso, Vaidya, Tranel, Kosier, & Robinson, 2008; Tateno, Kimura, & Robinson, 2002; Whyte & Mulsant, 2002)

PSD and stroke

- PSD has a prevalence of approximately 30% among all stroke survivors (Ayerbe, Ayis, Wolfe, & Rudd, 2013; Hackett & Anderson, 2005) and it is associated with a significantly increased risk of mortality in stroke survivors (Cai, Mueller, Li, Shen, & Stewart, 2019)
- Lacking a gold standard for PSD assessment, depression after stroke often remains underdiagnosed and undetected (Llorca, Castilla-Guerra, Moreno, Doblado, & Hernández, 2015; Meader, Moe-Byrne, Llewellyn, & Mitchell, 2014)
- Effective management of depression could potentially reduce stroke recurrence and mortality, although this requires empirical evaluation.

Predicted poor outcomes in stroke due to PSD

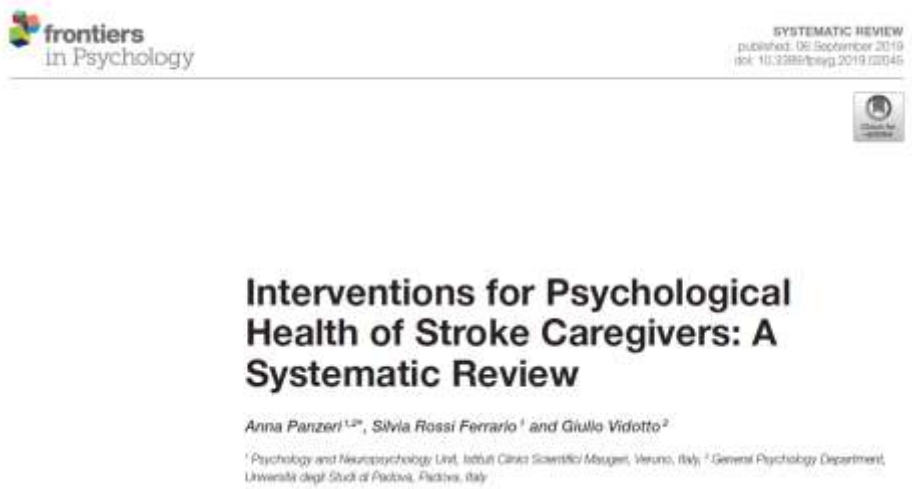
- Limitations in daily activities (Pohjasvaara, Vataja, Leppävuori, Kaste, & Erkinjuntti, 2001),
- Cognitive disorders (Chemerinski, Robinson, & Kosier, 2001; Serrano, Domingo, Rodríguez-Garcia, Castro, & del Ser, 2007)
- Poor rehabilitation outcomes, social isolation (Boden-Albala, Litwak, Elkind, Rundek, & Sacco, 2005)
- Suicidal ideation (Bartoli, Di Brita, Crocamo, Clerici, & Carrà, 2018)
- and suicide attempts (Eriksson, Glader, Norrving, & Asplund, 2015)

Psychological interventions for managing cognitive impairment after stroke (Protocol)

Hickey A, Merriman NA, Bruen C, Mellon L, Bennett K, Williams D, Pender N, Doyle F

- Cognitive impairment is a common outcome of stroke and has been reported to have a prevalence of over 50% in patients six months post-stroke (Mellon 2015), with 38% of stroke survivors exhibiting a level of cognitive impairment one year after stroke that does not meet the criteria for dementia (Sexton 2019).
- Post-stroke cognitive impairment is associated with increased disability and poorer quality of life for both patients and their carers (Blake 2002; Nys 2006; Patel 2002), and progression from cognitive impairment to dementia is quite common, particularly in the context of recurrent stroke (Pendlebury 2009).
- There are a number of psychological interventions currently in use in this regard, in particular:
  - Cognitive rehabilitation.
  - Cognitive training (including cognitive skills training).
  - Psychological or behavioural interventions, or both,

specifically aimed at managing cognitive impairment.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SYSTEMATIC REVIEW
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Interventions for Psychological Health of Stroke Caregivers: A Systematic Review

Anna Panzeri[1,2]*, Silvia Rossi Ferrario[1] and Giulio Vidotto[2]

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2 main areas of “caregiver burden” (Rigby et al., 2009).

1. “Objective” area comprises practical, financial, and physical-health difficulties;
2. The psychological and social area, such as depression, anxiety, poor well-being, and relational troubles (Camak, 2015; Rossi Ferrario et al., 2019).

Possible outcomes for caregivers:

- Strain or burden depression
- Anxiety
- Stress
- General health
- Physical health
- Somatic complaints
- Social support
- Quality of life and well-being
- and caregiving competency or mastery

Post Stroke Anxiety and Depression (PSA & PSD) during COVID-19

- Admission with acute stroke during the COVID-19 pandemic was independently associated with increased anxiety, fatigue, depression, sleep disturbance, pain interference, and reduced physical function, and participation in social roles and activities.
- Report of a high incidence of PSA in elderly patients after the COVID-19 outbreak. Female gender, high depression and stroke severity and outcome scores were the independent risk factors for PSA.
- The rise in PSD is related to stroke severity and this has not changed significantly during the pandemic; however, PSA showed a noticeable peak. Social deprivation and the lacking levels of rehabilitation related significantly to both.

The Prevalence and Predictors of Post-Stroke Depression and Anxiety During COVID-19 Pandemic

Zakaria M. Ahmed, MD,*†‡[1] Mohamed F. Khalil, MD,*†‡[2] Ahmed M. Kohail, MD,*†[3] Islam F. Eldesouky, MD,*§[4] Ahmed Elkady, MSc,¶[5] and Ashfaq Shuaib, MD#[6]

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ORIGINAL RESEARCH

High Prevalence of Post-stroke Anxiety in Elderly Patients Following COVID-19 Outbreak

Meiling Yao, Hongjie Li, Ying Luo, Ling Li* and Jian Yu*

Journal of Neurology
https://doi.org/10.1007/s00415-021-10819-9

ORIGINAL COMMUNICATION

The impact of the UK COVID-19 pandemic on patient-reported health outcomes after stroke: a retrospective sequential comparison

Hatice Ozkan[1,2] · Gareth Ambler[3] · Gargi Banerjee[4] · Edgar Chan[1,5] · Simone Browning[1,2] · John Mitchell[1] · Richard Perry[1,2] · Alex P. Leff[1,2] · Robert J. Simister[1,2] · David J. Werring[1,2] on behalf of the SIGNaL collaborators

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> Being able to talk to someone in the early days who really knows what you're going through helps to stop you having to go to a psychiatrist six months later.
>
> **Person with aphasia - Connect**

Figure 1: Stepped care model for psychological interventions after stroke.
Adapted from IAPT model with input from Professor Allan House and Dr Posy Knights

LEVEL 3: **Severe and persistent disorders of mood and/or cognition** that are diagnosable and require specialised intervention, pharmacological treatment and suicide risk assessment and have proved resistant to treatment at levels 1 and 2. These would require the intervention of clinical psychology (with specialist expertise in stroke) or neuropsychology and/or psychiatry.

LEVEL 2: **Mild/Moderate symptoms of impaired mood and /or cognition** that interfere with rehabilitation. These may be addressed by non psychology stroke specialist staff, supervised by clinical psychologists (with special expertise in stroke) or neuropsychologists.

LEVEL 1: **'Sub-threshold problems' at a level common to many or most people with stroke.** General difficulties coping and perceived consequences for the person's lifestyle and identity. Mild and transitory symptoms of mood and/or cognitive disorders such as a fatalistic attitude to the outcome of stroke, and which have little impact on engagement in rehabilitation. Support could be provided by peers, and stroke specialist staff.

Psychological needs are not defined in relation to time post-stroke. The support mechanisms therefore need to be flexible to support self referral back into the system at any time.

PERGAMON

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INTERNATIONAL JOURNAL OF NURSING STUDIES

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Peer support within a health care context: a concept analysis

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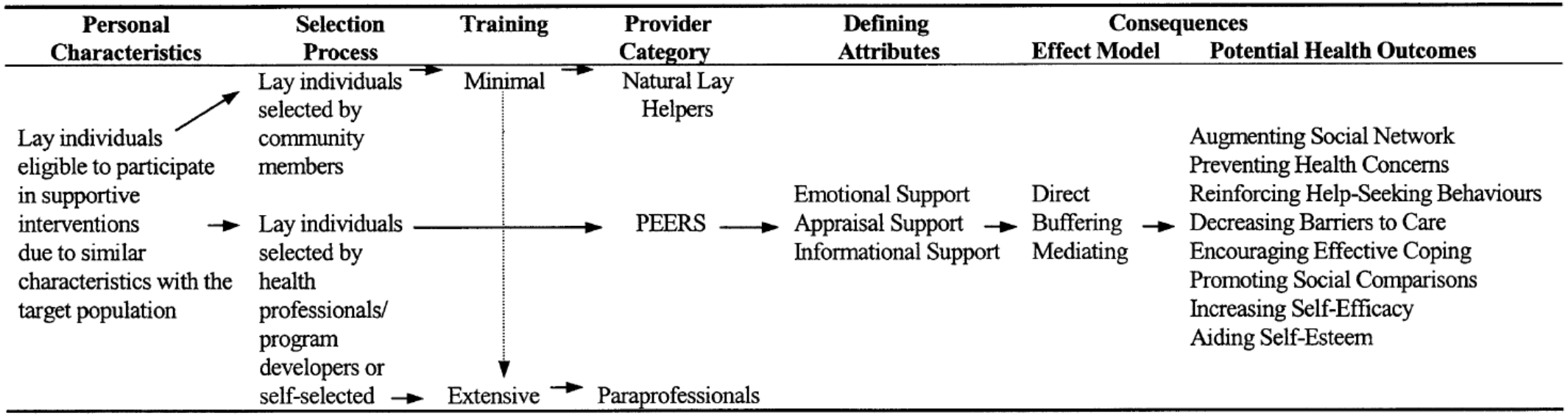
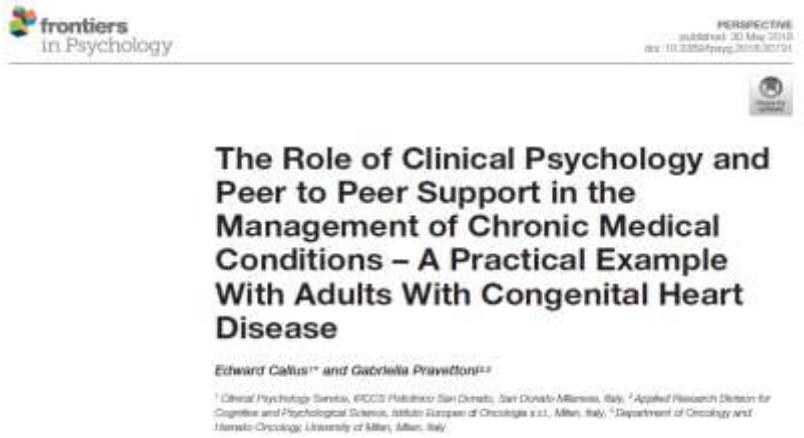


Integration of Clinical Psychology Service and Peer to peer support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PERSPECTIVE

The Role of Clinical Psychology and Peer to Peer Support in the Management of Chronic Medical Conditions – A Practical Example With Adults With Congenital Heart Disease

Edward Callus and Gabriella Pravettoni

Operative instruction Clinical Psychology Service

- Presence of the psychologist during daily meetings of medical staff
- Psychosocial evaluation of all ACHD patients prior intervention
- Psychological interventions are provided according to the results of the evaluation and the indications of the medical, paramedical and psychosocial staff and also patient requests

Non-profit association activity (Associazione Italiana Cardiopatici Congeniti Adulti – AICCA)

- Presence during the weekly multidisciplinary psychosocial meeting and the daily patient admission, to verify if there are any psychosocial issues.
- Provision of assistance when it comes to logistic, economic and bureaucracy issues, in relation to the condition.
- Social activities and outings are organized for the patients, their families, and their friends approximately once every 2/3 months.

Conclusions

- Psychological distress is often undetected and undertreated in stroke
- Psychosocial montiroing and the provision of the right treatment support is paramount
- The literature indicates that the pandemic situation has excacerbated psychological distress in this population, increasing the importance of enacting these measures