Introduction to Clinical Psychology Services in Stroke

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Outline of Talk

- Introduction to Neuropsychology
- Consequences of Stroke
  - Neuropsychological
  - Psychological
- Stroke Specific Recommendations for Psychology
- Stepped Care Model
  - Nuts and Bolts
- Where to start
Neuropsychology Emphasises the Interaction of cognition with mood for holistic assessment and rehabilitation planning.
Neuropsychology is Holistic

The individual is seen from a biopsychosocial perspective

- Bio – lesion, lesion location, medical and physical health, age …
- Psychological – cognition and emotional changes, premorbid mental health and coping strategies…
- Social – the context of the individual – family and social support, environment, culture, education
Neuropsychological Consequences of Stroke

• Cognitive
  – attention, memory, executive function, perceptual, neglect, agnosia, apraxia, apathy

• Communication
  – aphasia

• Post-stroke Fatigue

• Behaviour Issues
  – Driving
  – Decision Making
  – Return to Work
Psychological Consequences of Stroke

• Emotional Problems
  – Adjustment/reactions
  – Depression & Anxiety
  – Anger
  – Lability & Pseudobulbar
  – Fear of Falling
  – Pain & Fatigue

Carer Impact
Most stroke survivors have cognitive problems (Lesniak et al 2008) -> affect rehabilitation outcome (Hommel et al 2009) and clinical management.

Depression, fatigue and cognitive problems 1 year post-stroke predict of mobility decline (van de Port et al., 2006)

40% of people will reach criteria for depression after stroke (Hackett 2005)

10-40% Emotionalism (Lincoln 2012)

Anxiety 25% (De Wit, 2008)
Neuropsychological Difficulties

Impede recovery, prolong adjustment and increases the cost of rehabilitation, reduce quality of life, and are difficult for the team (carrying out treatment and morale)

Carers -> cognitive difficulties & “personality” change most difficult (Murray et al 2003)
Stroke Specific Recommendations for Psychology:

- National Stroke Strategy Q2, 3, 8, 15, 16
- National Service Framework for Older People
- NICE
  'All patients after stroke are screened within 6 weeks of diagnosis, using a validated tool, to identify mood disturbance and cognitive impairment'.
- RCP –SSNAP– screening for mood and cognition
- Stroke Improvement Programme – Stepped Care
3.2.1. B

“Each stroke rehabilitation unit and service should be organised as a single team of staff with specialist knowledge and experience of stroke and neurological rehabilitation including clinical psychologists
Stepped Care Model
(Psychological Care after stroke)

Level 3: Severe and persistent disorders of mood and/or cognition.

Level 2: Mild/moderate symptoms of impaired mood and/or cognition.

Level 1: ‘Sub-threshold problems’ at a level common to many or most people with stroke.
Level 1 Care – Whole team provide this

Subclinical emotional distress – worries, feeling low, frustrated, emotions fluctuating

• Mood and Cognitive Screening /repeat screening – direct, observational, corroborative.
• Discuss with Unit Psychologist at MDT meeting
• Support primarily from staff
• Know when to move to, step up to Level 2
Nuts and Bolts of Level 1 Support

- Raise awareness of mood and cognitive problems to whole team
- Conscious communication and information
- Validating patients experiences - “I can see you are upset”
- Normalising patients difficulties and emotions – e.g. *It is normal to feel very tired after a stroke, It is understandable you feel worried sometimes*
- Goal setting – breaking things down into steps
- Use environmental strategies – eg reduce noise
- Culture of psychology
Level 2- Mild/Moderate Mood or Cognitive

Duration, severity and number of symptoms are having a greater impact – may affect ability to rehabilitate.

Team needs a clear pathway for referral to psychological services.

Intervention may be recommended by Clinical Psychologist but carried out by other members of the team.
Level 3 – Severe/persisting mood or anxiety difficulties

• Referral Pathways to Clinical Psychology and also for emergency situations through psychiatry
• Risk Assessments
• Individual intervention by Clinical Psychologist & ongoing review
• Dual therapy may be indicated
• Ensure robust management and follow up plan
What Will the Psychologist in Stroke Do?! 

**Indirect work** through consultation and team/joint sessions

**Direct work with families**  Assessment of impact on families and their needs
  - Family interventions

**Direct work with patient**
  - Assessment of mood, cognition, mental capacity, driving, pain, fatigue to identify the nature and degree of impairment
  - Specific interventions to promote emotional adjustment and cognitive rehabilitation
  - Promotion of long-term psychological adjustment

- Managing risk
- Dissemination of psychological skills/understanding of stroke issues

Contributions to service development, team working, training and research.
Psychological Approach to Mood

Structured Assessment
- Interview, assessment tools (Q and FA), corroborative information, pmh...consider cognition
- Formulation

Therapy
- Behaviour Therapy
- Adapted Cognitive Behaviour Therapy
- Systemic Therapy
- Motivational Interviewing
Neuropsychological Approach to Cognition

- Comprehensive assessment of cognitive function (attention, memory, executive functioning, language, visuospatial skills, co-ordination)
- Interpretation based on normative data
- Comparison with function, MDT reports, observation
- Facilitate rehabilitation using evidenced based strategies – eg Errorless learning
Examples of direct work

Direct work

• Intervention for affective problems
  – e.g. fear of falling in physiotherapy: graded exposure

• Use of appropriate behavioural techniques for behaviour management
  – e.g. shouting

• Use of appropriate techniques to help with neuropsychological problems
  – e.g. autotopagnosia and mirrors
Stepped Care Across the Care Pathway, Embedded within Stroke Teams

Acute → Appropriate Environment

“access to a comprehensive range of rehabilitation, advice and support to meet their continuing and changing needs, increase their independence and autonomy and help them to live as they wish”

*National Service Framework for Long-term Neurological Conditions Standard 5*
Neuropsychology Across the Pathway

Early consideration of neuropsychological factors is essential to:

- Clarify diagnostics
- Ensure whole team works within a holistic and realistic framework for each patient
- Prevent secondary problems
- Facilitate long-term reintegration into the community
Stroke Psychology: Where to Start

- Raise awareness of these issues – enables issues to be flagged up and help with interventions e.g. at a Level 1 skills
- Nottingham National Project – making psychological care part of the culture – so it’s allowed for staff to spend time with the patients – compassionate caring
- Building links with local psychology services – e.g. neuropsychology, older adults psychology, IAPTS, voluntary sector
Useful Reading

Psychological Care After Stroke 2011
NICE Guidelines 2009b
National Service Framework for Older People 2001