

POST-STROKE DEPRESSION AND UNRESOLVED LOSS IN CLINICAL REHABILITATION: A CASE STUDY



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In patients with post-stroke depression, biological, psychological and social factors must all be taken into consideration in order to arrive at a better understanding of the phenomenon for diagnostic and therapeutic purposes. In this study, pre-morbid personality, lesion location (Solms and Turnbull, 2002) and attachment style (Bowlby, 1980) were examined as factors that in mutual interaction influence the process of loss elaboration and the restructuring of the Self subsequent to the lesion (Feinberg and Keenan, 2005). This study analyses a clinical case in accordance with an integrated approach in practical clinical rehabilitation.

Clinical picture

Case history

A 56-year-old woman who had suffered a right cerebral ischemic stroke three years previously was treated for two months in our intensive rehabilitation centre. On admission, the patient had limited physical mobility (she spent the entire day in bed). She presented marked symptoms of depression as well as severe social isolation and social shame. She grew up in a small town in the south of Italy and now lives in a large city in central Italy. Married with two children (both born by Caesarean section), her eldest daughter recently married, while her son still lives at home with his parents. The patient took early retirement from her job as midwife (a job she loved and misses). **Family of origin:** A very strict and authoritarian mother and an affectionate father who died prematurely (when the patient was 11), a sister aged one year older (ambivalent relationship, currently characterized by great dependence). The patient's mother is alive and currently confined to a wheelchair by a pelvic fracture sustained at the same time as the patient's stroke. **Education:** On her father's wishes, the patient lived away from home (in the city where she now resides) during her lower-secondary and upper-secondary school years. **Relationship with significant others:** The patient feels closest to her children. Her son alternately treats her affectionately and badly, while her daughter is more gentle and understanding. She was always very protective of both children, but particularly of her daughter. She feels her husband is distant (his work keeps him away from home). The patient's carer is extremely depressed and reports that the patient's behaviour is "tyrannical".

Lesion location

A TC scan showed damage to the right cerebral hemisphere: an ischaemic nucleo-capsular lesion associated with a deep frontal and temporo-mesial white substance lesion. There was a temporary moderate mass effect on the homolateral anterior ventricular horn during the period subsequent to the acute event (which occurred three years ago).

Psychiatric and psychological evaluations

On admission, the clinical and psychometrical evaluations showed a **depressive disorder** with associated **anxiety** and a **narcissistic personality disorder** which had already existed prior to the stroke. **The Adult Attachment Interview (AAI)** (George et al., 1985) was also administered using the criteria of the Dynamic-Maturational Model (DMM) (Crittenden, 1999). **An insecure Dismissing Attachment Style (Type A)** was evident, with markers for unresolved loss, unresolved trauma and depression. In the relationship with her mother, there are some elements of insecure-preoccupied attachment. There are intrusions of negative affects such as fear and anger.

Questionnaires	Admission	Discharge	Questionnaires	Admission	Discharge
HAD anxiety	13	10	QUID sensory	0,52	0,33
HAD depression	12	9	QUID affective	0,87	0,60
CES-D	34	28	QUID evaluative	0,76	0,67
SF-12 Physical Index	26.20	27.87	QUID mixed	0,54	0,85
SF-12 Mental Index	24.35	23.71	VAS	9,8	7,2

1. HAD- Hospital Anxiety and Depression Scale: Zigmond, A. S., Snaith, R. P. (1983) The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavica*, 67, pp. 361-370.
2. CES-D- Center for Epidemiologic Studies-Depression Scale: Radloff, I. S. (1977) The CES-D Scale: a self-report depression scale for research in general population. *Applied Psychology Measurement*, 1, pp. 385-401
3. SF-12: (Ware, Kosinski, Keller, 1996) A 12-Item Short-Form Health Survey: construction of scales and preliminary tests of reliability and validity. *Med Care* 34, pp.220-233
4. VAS-Visual Analogue Scale: : Scott J and Huskisson, E. (1976) Graphic representation of pain. *Pain*; 2:175-184.
5. QUID (Italian version of McGill Pain Questionnaire) De Benedittis G., Massei R., Nobili R., Pieri A., Corli O. (1988) Il questionario Italiano del Dolore (QUID), *Algos*, 5, 50-63

Neuropsychological evaluations

Indications of frontal distress characterized by difficulty accessing the mental lexicon and disturbed abstractive abilities. Negligence was not found, not even at a sub-clinical level. The patient had previously been treated for neglect, but this treatment had been suspended on account of interference from the symptoms of anxiety and depression.

Physiatric evaluations

On admission, the patient presented profound left-side paralysis, severe muscular hypertone in her arms and legs, serious difficulty walking and deficits in both tactile and kinesthetic sensitivity. FIM(Dodds,1993) on admission:63, FIM on discharge:81

Medical evaluation

The patient suffered from autoimmune thyroiditis(a chronic illness)prior to the stroke

Treatment

MAIN ISSUES

It is evident that the issues of **unresolved loss** and **non-acceptance of the illness** through the activation of abnormal psychological defences also affect the somatic sphere. In fact, observations made in the rehabilitation gym showed that pressure on the hemiplegic side of the body induced **pain**, but more particularly **dizziness and fear of falling** that resembled panic attacks. The personnel involved working with the patient, and especially her physiotherapists, reported feelings of intense **anger** related to the patient's tendency to control the relationship and the treatment. These experiences initially interfered with the patient's therapy but, above all, were recurrent in her everyday life, which was therefore restricted, not only as regards a lack of activities, but also with respect to affective-relational functioning

Medical treatment

- focused specifically on spasticity.
 - Thyroid replacement therapy
- Physiotherapy** aimed at:
- reducing hypertone,
 - restoring body scheme,
 - increasing sense of security in standing and walking.
- Psycho-pharmacological therapy** was based on a combination of low dosages of both citalopram and trazodone.

The patient's **clinical progress was discussed** on several occasions in **team meetings**, where the personnel involved with the patient exchanged information with a particular focus on the emotional problems that emerged.

INTEGRATED THERAPY

Psychological treatment:

- **interviews** with the patient and her close relatives with a view to facilitating loss elaboration and the acceptance of the changes required so as to adapt the entire immediate and extended family framework to the new situation;
- **Psychoanalytic psychotherapy** with corporal mediation: gym sessions were carried out with the participation of the patient's physiotherapist in an effort to facilitate the patient in restructuring her Self.

Conclusions

FACTORS THAT CAN INFLUENCE DEPRESSION

1. Pre-morbid personality structure and unresolved loss
2. Attachment style and failure of adaptive strategies
3. Stroke lesion location
4. Endocrinological (thyroidal) dysfunction
5. Reduced physical activity
6. Social isolation

Need to modify setting for psychoanalytic interviews and psychotherapy in integrated therapy

RESULTS OF THE INTEGRATED THERAPY

1. Improved physical mobility
2. Reduction of physical pain,
3. Reduction of the depressive and emotional suffering
4. Improved interpersonal relationships
5. Recovered hope and shared planning capability