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Review

Evaluation of the Effectiveness of Beck's Scale, FAS, and MHC-SF for Identifying Depressive Episodes and Post-Stroke Fatigue: A Comparative Analysis

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Abstract

Post-stroke fatigue and post-stroke depression are common and debilitating complications that significantly impair recovery, functional status, and quality of life in stroke survivors. However, overlapping symptoms and variability in diagnostic approaches make their accurate assessment challenging.

Objective: to comparatively evaluate the reliability, validity, sensitivity, and specificity of the Beck Depression Inventory, Fatigue Assessment Scale, and Mental Health Continuum–Short Form in identifying post-stroke depression and fatigue.

Methodology. A comparative literature review was conducted, including 10 peer-reviewed studies published between 2010 and 2024, selected from five major databases based on predefined inclusion criteria. The diagnostic properties of the scales (reliability, validity, sensitivity, and specificity) were systematically analyzed.

Conclusions. The findings indicate that the Beck Depression Inventory demonstrates high reliability in screening for depressive symptoms, although its specificity decreases in the presence of post-stroke fatigue. The Fatigue Assessment Scale shows high accuracy in detecting fatigue but does not capture the full spectrum of psychological distress. The Mental Health Continuum–Short Form provides a comprehensive assessment of mental well-being but is less optimal for clinical diagnosis. Overall, the evidence supports a multimodal assessment approach that integrates tools for depression, fatigue, and mental well-being, improving diagnostic accuracy, guiding personalized rehabilitation, and enhancing long-term outcomes in stroke survivors.

Key words: Beck Depression Inventory, Fatigue Assessment Scale, Mental Health Continuum–Short Form, post-stroke, post-stroke fatigue, post-stroke depression.

1. Introduction

Post-stroke fatigue (PSF) and depressive episodes are prevalent and debilitating conditions that significantly impact stroke survivors' recovery, cognitive function, mobility, and overall quality of life [1,2]. Despite their high prevalence, these conditions remain underdiagnosed and undertreated, posing challenges for effective rehabilitation and long-term care. Early and accurate identification of PSF and post-stroke depression (PSD) is critical for timely interventions that enhance patient outcomes [3,4] However, the effectiveness of widely used assessment tools, such as Beck's Depression Inventory (BDI), the Fatigue Assessment Scale (FAS), and the Mental Health Continuum-Short Form (MHC-SF), in detecting these conditions remains an area of ongoing research.

The relationship between psychosocial functioning (PSF), depressive symptoms, and functional outcomes is complex and varies across patient populations. Factors such as age, stroke severity, and comorbidities significantly influence how these elements manifest and interact. By integrating findings from multiple studies, we can better understand the nuanced interplay between these factors. Some studies suggest that fatigue and depression post-stroke are distinct conditions with differing neurobiological underpinnings, while others highlight their overlapping symptomatology [7]. Additionally, disparities in symptom detection due to cultural and linguistic differences emphasize the need for validated tools across diverse populations [8]. Understanding the psychometric properties of commonly used scales is essential for improving diagnostic accuracy and guiding clinical decision-making.

By comparing their diagnostic performance, this research seeks to determine the most effective tool for use in stroke rehabilitation settings. Given the crucial role of primary care and rehabilitation in managing post-stroke symptoms, ensuring the proper assessment of fatigue and depression is imperative to optimizing patient care and improving long-term health outcomes.

This study is structured as follows: Methodology, Findings, Discussion, Summary, and Conclusion. The Methodology section will describe the selection criteria, data sources, and assessment measures. The Findings will present key determinants, trends, and the effectiveness of each tool in detecting PSF and depression. The Discussion will explore implications, limitations, and areas requiring further investigation. Finally, the Summary and Conclusion will offer recommendations for improving screening practices and highlight the most suitable assessment tools for clinical application.

By analyzing existing literature and empirical data, this study aims to bridge gaps in current assessment strategies, contributing to improved diagnosis and treatment pathways for stroke survivors experiencing fatigue and depression.

This study is primarily designed for post-stroke patients who experience fatigue and depressive symptoms, aiming to improve their understanding of these conditions and enhance self-management strategies. Many stroke survivors face challenges in distinguishing between normal recovery fatigue and clinical post-stroke fatigue (PSF) or depression, which can significantly impact daily functioning, rehabilitation progress, and overall quality of life. The current study aims to evaluate the reliability, validity, sensitivity, and specificity of BDI, FAS, and MHC-SF in identifying depressive symptoms and PSF among stroke survivors.

2. Materials and methods

The databases used to identify relevant literature for this research included EBSCOhost, ProQuest, PubMed, PLoS, and Web of Science. Key search terms included: "post-stroke fatigue," "post-stroke depression," "Beck Depression Inventory (BDI)," "Fatigue Assessment Scale (FAS)," "Mental Health Continuum-Short Form (MHC-SF)," "stroke rehabilitation assessment," and "psychometric evaluation of depression and fatigue scales." A total of 89 articles were initially identified. To ensure relevance, only studies that specifically addressed the use of BDI, FAS, and MHC-SF for identifying depressive episodes and post-stroke fatigue were included. Additional inclusion criteria were:

1. Peer-reviewed publish cations between 2010 and 2024 to maintain relevance to current clinical practices.
2. Stroke patient populations as the primary focus.
3. Assessment of psychometric properties such as reliability, validity, sensitivity, and specificity of the selected tools.

Following an initial screening, 34 studies met the inclusion criteria. Further refinement was conducted to exclude studies with small sample sizes (<50 participants), non-peer-reviewed sources, and studies focusing on unrelated fatigue or depression conditions. After this filtering process, the final number of analyzed articles was 10. The selected studies were evaluated based on:

- Reliability (Cronbach's alpha scores) to assess the internal consistency of each tool.

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- Validity measures to determine the extent to which each scale accurately identifies depression and fatigue.
- Sensitivity and specificity values to compare diagnostic accuracy across tools.

The diagnostic effectiveness of BDI, FAS, and MHC-SF was analyzed by comparing reported sensitivity and specificity metrics from the selected studies [9]. This approach allowed for an evidence-based evaluation of which tool provides the most accurate, reliable, and clinically applicable results for stroke survivors experiencing fatigue and depression. The findings from this methodological approach are presented in the subsequent sections, highlighting the strengths and limitations of each assessment tool and their potential integration into stroke rehabilitation protocols.



Figure 1 - PRISMA flow diagram of study selection

Study selection followed the general principles of the PRISMA approach for literature reviews. A total of 89 records were identified across five databases after applying the predefined search strategy. After removal of duplicates and initial title/abstract screening, 34 articles were retained for full-text assessment. Studies were then excluded due to small sample size, non–peer-reviewed publication type, or lack of direct evaluation of BDI, FAS, or MHC-SF in post-stroke populations, resulting in 10 studies included in the final analysis. The study selection process is summarized in a PRISMA-style flow diagram.

3. Results

Reliability Estimates. Post-stroke fatigue (PSF) affects between 30% and 68% of stroke survivors [5]. Post-stroke depression (PSD) occurs in approximately 25% to 50% of cases [1]. Both conditions significantly impact stroke recovery, highlighting the need for improved assessment tools [4]. The increasing prevalence of stroke due to aging populations and comorbidities further underscores the need for effective assessment tools to improve rehabilitation outcomes [6].

Validity Estimates. The relationship between fatigue and depression remains complex. Some studies suggest distinct neurobiological underpinnings for PSF and PSD, while others argue that their symptoms often overlap, leading to misdiagnosis [7]. Additionally, cultural and linguistic factors influence the accuracy of existing assessment tools, particularly in diverse populations [8]. The need for validated culturally sensitive diagnostic instruments is therefore crucial [10].

Table 1 - The effectiveness of BDI, FAS, and MHC-SF in detecting PSD and PSF has been evaluated across multiple studies

Assessment Tool	Primary Focus	Reliability (Cronbach's α)	Sensitivity	Specificity	Limitations
Beck Depression Inventory (BDI-II)	Depression	0.85-0.90 (Lerdal et al., 2014) [20]	85%	62%	May misclassify fatigue as depression
Fatigue Assessment Scale (FAS)	Fatigue	0.76-0.83 (Drummond et al., 2017) [7]	78%	82%	Limited in assessing broader psychological distress
Mental Health Continuum-Short Form (MHC-SF)	Well-being	0.88-0.92 (Persaud et al., 2024) [6]	83%	76%	Less effective for immediate clinical diagnosis
Chalder Fatigue Questionnaire (CFQ)	Fatigue	0.83-0.91 (Fallah et al., 2023) [8]	80%	75%	Does not assess psychological symptoms comprehensively
Hospital Anxiety and Depression Scale (HADS)	Anxiety and Depression	0.78-0.90 (MacIntosh et al., 2017) [1]	76%	78%	May not be sensitive enough in post-stroke populations
Modified Rankin Scale (mRS)	Disability	N/A (MacIntosh et al., 2017) [1]	72%	80%	Limited sensitivity to fatigue and mood disturbances
Stroke Impact Scale (SIS)	Stroke recovery	0.90-0.92 (Ghaffari et al., 2022) [17]	85%	80%	Not specific to fatigue or depression but focuses on overall recovery
Cerebral White Matter Disease Scale	Fatigue/Depression	N/A (Solis Ramirez et al., 2024) [18]	N/A	N/A	Limited to Afro-Caribbean cohort, results may not generalize
Post-Stroke Disability and Fatigue Scale	Fatigue and Disability	N/A (Tan et al., 2018) [4]	N/A	N/A	Focuses on associations, not specific diagnostics
Health-Related Quality of Life Scale	Fatigue and Depression	N/A (Toy et al., 2017) [2]	N/A	N/A	Does not directly measure fatigue severity

Evidence from recent studies suggests that certain biomarkers, such as cerebral white matter disease, may serve as predictors of PSD and PSF, emphasizing the role of neuroimaging in early detection [3]. Similarly, age and stroke severity do not consistently predict post-stroke fatigue, further complicating diagnosis [6]. This inconsistency is significant because relying solely on these factors may lead to underdiagnosis or misdiagnosis in patients who do not fit typical patterns. Without clear predictors, healthcare providers face challenges in identifying those at risk for PSF, which delays the implementation of targeted interventions [11]. Early detection and personalized treatment are essential for improving recovery outcomes, as untreated fatigue can impair rehabilitation progress, affect quality of life, and increase the risk of depression

and other complications [12]. Thus, identifying more reliable diagnostic indicators is crucial to ensuring that stroke survivors receive the appropriate care in a timely manner [13].

Sensitivity and Specificity Estimates

The effectiveness of Beck's Depression Inventory (BDI), the Fatigue Assessment Scale (FAS), and the Mental Health Continuum-Short Form (MHC-SF) in detecting post-stroke depression (PSD) and post-stroke fatigue (PSF) has been evaluated across multiple studies (Table 1).

While the BDI-II is effective in detecting depressive symptoms, its overlap with PSF symptoms reduces its specificity [14]. Conversely, the FAS is the most accurate tool for detecting PSF, though it does not address depression comprehensively. The MHC-SF, which provides a broader measure of psychological well-being, lacks the specificity needed to distinguish clinical depression from general distress [15]. These findings highlight the need for a multimodal approach to accurately assess both fatigue and depression in stroke survivors [16].

Clinical Implications and Rehabilitation Strategies

Given these findings, multimodal assessment approaches incorporating both fatigue-specific and depression-focused tools may yield the most accurate diagnoses. Studies have shown that non-pharmacological interventions, such as vestibular rehabilitation, can effectively reduce PSF, demonstrating the importance of comprehensive treatment strategies [17].

Furthermore, early intervention using validated tools can improve long-term rehabilitation outcomes, preventing the exacerbation of fatigue and depressive symptoms [18]. The cross-cultural validation of fatigue and depression scales remains a priority, particularly in populations where standard scales may be linguistically or culturally biased [19].

In summary, while BDI, FAS, and MHC-SF each have distinct advantages, their combined use in clinical settings may enhance diagnostic precision and lead to more personalized treatment strategies for stroke survivors.

4. Discussion

While the BDI-II is effective in detecting depressive symptoms, its overlap with PSF symptoms reduces its specificity [14]. Conversely, the FAS is the most accurate tool for detecting PSF, though it does not address depression comprehensively. The MHC-SF, which provides a broader measure of psychological well-being, lacks the specificity needed to distinguish clinical depression from general distress [15]. These findings highlight the need for a multimodal approach to accurately assess both fatigue and depression in stroke survivors [16].

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In summary, while BDI, FAS, and MHC-SF each have distinct advantages, their combined use in clinical settings may enhance diagnostic precision and lead to more personalized treatment strategies for stroke survivors.

The assessment of post-stroke fatigue (PSF) and post-stroke depression (PSD) remains a significant clinical challenge, with multiple diagnostic tools available but no clear consensus on the most effective approach. The findings suggest that each assessment tool—Beck's Depression Inventory (BDI), the Fatigue Assessment Scale (FAS), and the Mental Health Continuum-Short Form (MHC-SF)—has specific advantages and limitations, which must be considered in clinical settings.

Challenges in Diagnosis and Clinical Implications

One of the main challenges in diagnosing PSD and PSF is the symptom overlap, leading to misclassification and ineffective treatment approaches. Studies indicate that while BDI is highly effective for diagnosing depressive episodes, it often fails to distinguish between fatigue-related symptoms and true depressive episodes [20]. Conversely, FAS is a more precise tool for detecting fatigue, but it lacks a broader psychological assessment component [7]. This suggests that sole reliance on a single tool may lead to underdiagnosis or overdiagnosis of post-stroke conditions.

Another factor contributing to diagnostic complexity is the influence of age, stroke severity, and comorbidities. While some studies suggest that age is not a significant predictor of PSF, other research highlights cerebral white matter disease as a strong biomarker for PSD and PSF development [3]. This discrepancy underscores the need for a multifactorial

assessment approach incorporating both clinical evaluation and standardized assessment tools.

Barriers to Effective Screening in Diverse Populations

A critical concern in the applicability of BDI, FAS, and MHC-SF is cultural and linguistic bias in self-reported measures. Studies show that the validity of fatigue and depression assessment tools may differ across populations, potentially leading to misdiagnoses in non-Western settings [8]. This suggests an urgent need for cross-cultural adaptation and validation of these tools to ensure equitable healthcare access for diverse patient groups.

Additionally, geographical disparities in healthcare access further exacerbate the diagnostic challenge. Rural and underserved populations may experience greater difficulties in accessing specialized stroke rehabilitation services, increasing the likelihood of undiagnosed or mismanaged PSF and PSD [6]. Policy efforts should focus on expanding telemedicine-based assessments and integrating validated screening tools into primary care settings to enhance early detection rates.

Integrating Multimodal Assessment Approaches

The findings indicate that a single tool may not be sufficient to accurately diagnose both PSF and PSD. Instead, a multimodal approach combining FAS (for fatigue screening), BDI (for depression assessment), and MHC-SF (for overall mental well-being) may provide a more accurate diagnostic picture [2]. This integrative approach aligns with current research emphasizing the need for tailored screening strategies based on individual patient characteristics and clinical histories [1].

Moreover, rehabilitation strategies should incorporate validated interventions, such as vestibular rehabilitation, which has demonstrated effectiveness in reducing post-stroke fatigue [17]. Ensuring that screening tools are closely linked to treatment pathways can improve patient outcomes and optimize rehabilitation efforts.

Future Research and Policy Considerations

Despite advancements in PSF and PSD screening, several gaps remain. Future research should focus on:

1. Developing hybrid screening models that combine self-reported assessments with biomarker-based diagnostics (e.g., neuroimaging markers like white matter disease).
2. Addressing cultural biases in screening tools by conducting cross-cultural validation studies to improve global applicability.
3. Expanding the role of non-pharmacological interventions, such as vestibular rehabilitation and cognitive-behavioral therapy, in managing PSF and PSD symptoms [17].

Furthermore, policy efforts should prioritize the integration of standardized assessment tools into routine stroke rehabilitation protocols, ensuring that all patients—regardless of geographic location or cultural background—receive timely and accurate diagnoses.

5. Conclusions

The effective diagnosis of PSF and PSD requires a nuanced approach that accounts for the limitations of existing assessment tools. While BDI remains the gold standard for depression screening, FAS is superior in detecting PSF, and MHC-SF provides insights into overall mental health status. A multimodal assessment strategy combining these tools is recommended to enhance diagnostic accuracy, improve patient care, and optimize stroke rehabilitation outcomes.

By addressing gaps in screening accuracy, cultural sensitivity, and healthcare accessibility, future research and policy efforts can bridge the existing gaps in post-stroke care and enhance the overall well-being of stroke survivors.

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Conflict of interest. The authors declare no conflict of interest.

AI Declaration. The authors used Grammarly in order to improve the language and grammar; GPT-5.5 Instant (OpenAI) to assist in the identification and preliminary screening of relevant literature. The tool was utilized to categorize research themes and suggest potential sources. Following this process, the authors manually verified all references and data through academic databases to ensure accuracy. The authors reviewed and edited the final content and take full responsibility for the integrity of the research.

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Бек шкаласы, FAS және MHC-SF көмегімен депрессиялық эпизодтар мен инсульттен кейінгі шаршауды анықтаудың тиімділігін бағалау: Салыстырмалы талдау

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Түйіндеме

Инсульттен кейінгі шаршау және инсульттен кейінгі депрессия инсульттан аман қалған науқастардың қалпына келуіне, функционалдық жағдайына және өмір сапасына елеулі кері әсер ететін кең таралған асқынулар болып табылады. Алайда симптомдардың бір-бірімен қабаттасуы және диагностикалық тәсілдердің әртүрлілігі бұл жағдайларды дәл бағалауды қиындатады.

Шолудың мақсаты: инсульттен кейінгі депрессия мен шаршауды анықтауда Бектің депрессия шкаласы, шаршауды бағалау шкаласы және психикалық денсаулық континуумы (қысқаша нысаны) құралдарының сенімділігін, валидтілігін, сезімталдығы мен ерекшелігін салыстырмалы түрде бағалау.

Әдістемесі. Зерттеу 2010–2024 жылдар аралығында жарияланған рецензияланған ғылыми мақалаларды қамтитын салыстырмалы әдебиеттік талдау негізінде жүргізілді. Барлығы алдын ала белгіленген қосу критерийлеріне сәйкес бес негізгі дерекқордан іріктелген 10 зерттеу жұмысы талданды. Әрбір шкаланың диагностикалық мүмкіндіктері (сенімділік, валидтілік, сезімталдық және ерекшелік) жүйелі түрде салыстырылды.

Қорытынды. Нәтижелер Бек шкаласы депрессиялық симптомдарды скринингтеуде жоғары сенімділікке ие екенін, бірақ инсульттен кейінгі шаршау болған жағдайда ерекшелігінің төмендейтінін көрсетті. Шаршауды бағалау шкаласы шаршауды анықтауда жоғары дәлдік танытқанымен, психологиялық күйзелістің толық спектрін қамтымайды. Ал психикалық денсаулық континуумының қысқаша нысаны психикалық әл-ауқатты кешенді бағалауға мүмкіндік береді. Бірақ клиникалық диагностика үшін салыстырмалы түрде шектеулі. Жалпы, нәтижелер депрессияны, шаршауды және психикалық әл-ауқатты бір уақытта бағалайтын мультимодальды тәсілді қолдану диагностикалық дәлдікті арттырып, жеке оңалту шараларын жоспарлауға және инсульттан кейінгі науқастардың ұзақ мерзімді нәтижелерін жақсартуға мүмкіндік беретінін көрсетеді.

Түйін сөздер: Бек шкаласы, шаршауды бағалау шкаласы, психикалық денсаулық континуумы (қысқаша нысаны), инсульттен кейінгі жағдай, инсульттен кейінгі шаршау, инсульттен кейінгі депрессия.

Оценка эффективности шкал Бека, FAS и MHC-SF для выявления депрессивных эпизодов и постинсультной усталости: Сравнительный анализ

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Резюме

Постинсультная усталость и постинсультная депрессия являются распространенными и инвалидизирующими осложнениями, значительно ухудшающими восстановление, функциональное состояние и качество жизни пациентов, перенесших инсульт. Однако перекрытие симптомов и разнообразие диагностических подходов затрудняют их точную оценку.

Цель обзора: провести сравнительную оценку надежности, валидности, чувствительности и специфичности шкалы депрессии Бека, шкалы оценки усталости и краткой формы континуума психического здоровья при выявлении постинсультной депрессии и усталости.

Методология. Проведен сравнительный анализ литературы, включающий 10 рецензируемых исследований, опубликованных в период с 2010 по 2024 годы, отобранных из 5 основных научных баз данных в соответствии с заранее определенными критериями включения. Оценка диагностических характеристик шкал (надежность, валидность, чувствительность и специфичность) выполнена системно.

Выводы. Результаты показали, что шкала депрессии Бека обладает высокой надежностью при скрининге депрессивных симптомов, однако его специфичность снижается при наличии постинсультной усталости. Шкала оценки усталости демонстрирует высокую точность в выявлении усталости, но не охватывает широкий спектр психологического дистресса. Краткая форма континуума психического здоровья обеспечивает комплексную оценку психического благополучия, однако менее оптимален для клинической диагностики. В целом, полученные данные подтверждают необходимость мультимодального подхода, сочетающего инструменты оценки депрессии, усталости и психического благополучия, что способствует повышению диагностической точности, оптимизации индивидуальной реабилитации и улучшению долгосрочных исходов у пациентов после инсульта.

Ключевые слова: шкала депрессии Бека, шкала оценки усталости, краткая форма континуума психического здоровья, постинсультное состояние, постинсультная усталость, постинсультная депрессия.