“How are you feeling today?”
Mood Management After Stroke

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Overview

- Post-Stroke Mood Changes (Depression)
- Mood Assessment
- Practical tips on managing mood

Question & Answers

Resources
Losses that our patients face

- Loss of function
- Loss of independence
- Loss of employment
- Loss of income
- Loss of role / relationships
- Loss of future plan
Common Post-Stroke Mood Changes

- Confused and lost
- Angry and frustrated
- Overwhelmed
- Fear
- Grief
- Depression
Depression

• One of the most common effects

• Prevalence estimates vary between 20%-65%  
  (Robinson, 2003)

• Biological and psychosocial dimensions

• Longest lasting compared to grief
Depression

- Lesion location is considered the most significant single factor

- Depression in elderly stroke patients can be missed. Depression is not a normal part of aging.

- Carers, family members and friends also experience depression
Impact on therapy

- Unable to concentrate
- Having difficulty with new learning tasks
- Feeling overwhelmed or confused
- Becoming angry or tearful
- Denial of loss may lead to unrealistic expectations or goals
- Wanting or needing to talk about the loss

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Slower progress
Longer hospital stay
Assessment

Screening of depression:

• the acute phase (first few months after stroke onset)
• before transfer in rehabilitation
• to reduce disability, caregiver burden and costs (Carota & Paolucci, 2007)
• Ongoing monitoring particularly in the first six months of returning home
Typical stroke patient presentations

Left Hemisphere
• Left side & middle of brains (amygdala) → depression
• Insight is retained → higher risk for depression
• Reduced inhibition and an inability to communicate → aggression
• Catastrophic reaction – predictor of depression
  (Carota et al 2001)

Right Hemisphere
• Teary and affect the ability to control emotions, so can laugh or cry inappropriately
• Emotions change very quickly
• Altered ability to perceive other people’s emotions
• Patient can seem flat or blunted
Assessment

- Personality / behavioural changes (emotional lability, poor impulse control, aggressive outbursts, apathy) are part of a dysexecutive syndrome

- Disorders of emotional expression (pathological crying, emotionalism, catastrophic reactions) are not primary disturbances of feelings.
Assessment

• Assessment of mood in patients with memory and/or executive dysfunction requires
  – a detailed cognitive examination
  – incl behaviour, interaction, functioning, and patient’s emotional life before
    (Carota & Paolucci, 2007; Thomas, 2007)

• Special attention given to nursing descriptions of the patient’s behaviour since nurse spend the most time at the patient’s bedside.
Mood Screening

Systematic, thorough initial assessment of:

- safety and suicidality
- mental status: mood, affect, thought processes, intellectual processes
- physiologic and psychomotor activities
- behavioral and social activities  (Videbeck, 2004)

- Special populations – elderly, dysphasic
Mood Scales

- Beck Depression Inventory (BDI)
- Hospital Anxiety and Depression Scale (HADS)
- Structured Assessment of Depression in Brain-Damaged Individuals (SADBD) (Gordon et al., 1991)
- Stroke Aphasic Depression Scale (Sutcliff and Lincoln, 1998)
- Yale-Brown (Watkins et al., 2007)
  - single item screening question “Do you often feel sad or depressed?”
  - useful screening tool for those without severe cognitive or communication problems.
Delivering patient care is complex!
Hospitalization is an emotional experience!
Grieving patients

- Recognise the effect of grief
- Different grief reactions
  - denial; bargaining; displacement; anger; blame; apathy; guilt; depression; fear
- Look at the cultural context
- Validate their emotional experience
- Make sure they understand grief is a process that takes time
Effective Communication

- Prevents patient and therapist distress
- Builds trust and cooperation
- Leads to positive outcomes for all
Communicate clearly

• **Active Listening / Affirmation**
  - **Listen** – gather information
  - **Reflect Back** – confirm what you hear
  - **Explore** – ask questions
  - Goal: To get ‘Yes, that’s what I feel/want’

• **Assertive Communication Style**
  - I count and you count too.
Empathy

- ‘For You’ language
  - makes patients realise that it is being done for them
  - “Let me open that for you”

- POSITIVE INTENT
  - “I really want to help you”

- POSITIVE REGARD
  - “I admire your courage”; “I appreciate your patience.”

- Combined = Powerful statements
  - ‘I’m sorry you were frustrated, I’m here now, and I want to help!’
Examples of Caring Language

- It’s making you really mad’
- ‘I can see how upset you are’
- ‘You feel you’ve reached your limit’
- ‘Have I understood you?’
- ‘This must be so hard for you’
- ‘You seem discouraged’
Address patient needs

• **Build solutions together** that acknowledge and value the patient needs.
• Even if the solution is not ideal, the patient will feel differently about the outcome.
• It may be possible to say no, yet still meet the underlying need.

BUT...
Realize ‘NO’ hurts

• Immediate gratification is always much nicer
• Offer ‘the balm of regret’ with each refusal
  – ‘I’m very sorry I don’t have time …’
  – ‘I know you really wanted pain relief medication and I’m sorry to disappoint you, but I can give you a heat pack.’
Prevent Patient Desperation

• **Quick connecting**
  – devote 3-5 minutes to individual
  – transforms care relationship into a caring one

• **Comfort rounds**
  – hourly or daily comfort rounds makes the patient less demanding and more trusting because they know they don’t have to beg for attention.

(Lebov, 2007)
Show faith / confidence

- Remember patients believe in you and trust you
- Let them know you have faith in them too
- “I believe you can get through this. Let’s try your relaxation strategies. I think you can do this.”
What else can I do to support the patient?

- Provide routine, written instructions
- Use simple language
- Allow the person to make choices
  - (don’t give orders, e.g., “you must...”)
- Don’t trivialise / avoid talking about their losses
- Don’t lie or provide false reassurance
- Don’t describe the stages of grief
- Don’t become emotionally attached
- Don’t use touch unless you feel comfortable
What else can I do to support the patient?

• Encourage them to self identify (i.e., they are unable to work on therapy) rather than allow your therapy to become grief therapy

• If you think there may be significant grief/mood issues (impacting on therapy) speak to the psychologist involved
How to manage ourselves

• Be aware of your feelings; own them and process them.
  – Is this person’s experience bringing up memories for you?

• Seek appropriate support yourself
  – e.g. peer support, staff counselling service, advice from psychology etc.
Summary

• Depression is a common consequence of stroke.
• Screening for mood changes is important.
• There is no right way to grieve.
• When emotions get in the way of therapy, it is ok to guide our patients to get appropriate support.
• Effective communication makes a difference.
Thank you!

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References


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