"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

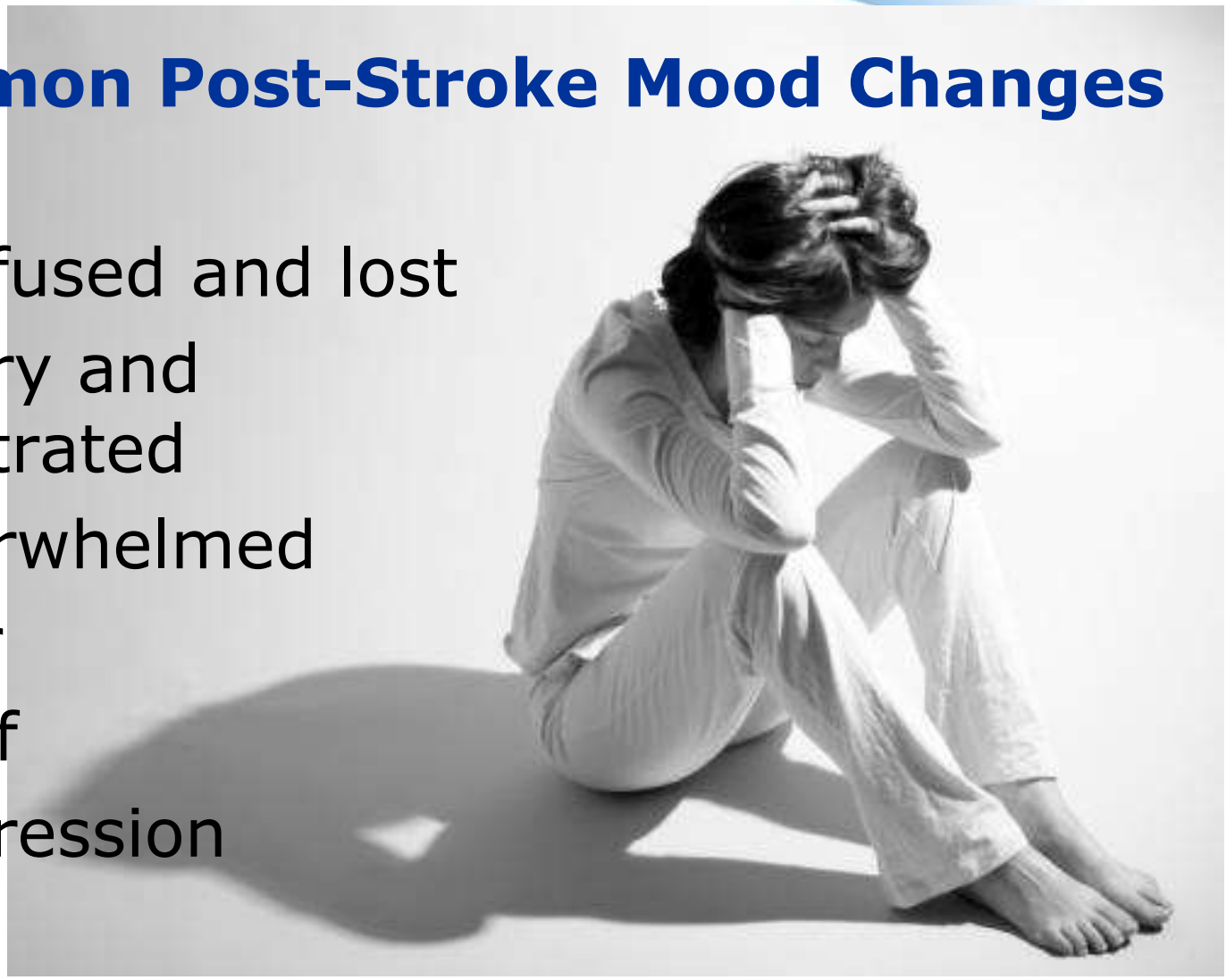
Question & Answers

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

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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.

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Delivering patient care is complex!

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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.

(*Leebov, 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.

Sunrise at Abu Simbel, Egypt

Thank you!

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