ADDRESSING THE EMOTIONAL NEEDS OF STROKE SURVIVORS

ABSTRACT

Background: Stroke survivors report a range of psychological difficulties. The emotional effects following a stroke may make it difficult for patients to engage in rehabilitation. Emotional support should also be made available for staff working with stroke patients.

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Method: A group intervention was developed for patients on a stroke rehabilitation ward.

Results and discussion: The group was piloted, and feedback indicated the sharing of experiences was the aspect perceived as the most helpful.

Conclusion: Patients’ emotional needs should be identified in a timely manner on a stroke ward. Attention should be given to psychological intervention to protect against factors that may impede rehabilitation.

BACKGROUND
Stroke is reported to be the second leading cause of death worldwide, resulting in post-stroke disability in 50–75% of survivors (World Health Organization, 2004). Emotional and cognitive functioning may be affected (Wilz, 2007; Macniven et al, 2005). Common psychological difficulties include anxiety, depression, grief, frustration, reduced emotional control and anger (Stroke Association, 2008).

National guidance on rehabilitation outlines several areas in which patients may require assessment and support (Intercollegiate Stroke Working Party, 2008). These include physical difficulties as well as depression and anxiety, which highlights the importance of multidisciplinary team input.

Reflecting on her personal experience of recovering from stroke, one nurse stated: ‘If stroke only caused paralysis and a danger of death, it would be a terrible affliction, yet the biggest tragedy of stroke lies in its mental effects’ (Lanza, 2006).

The interaction of psychologists and nurses provides an opportunity to normalise patients’ reactions to post-stroke difficulties. Psychologists and nurses can exchange evidence-based and patient knowledge with each other.

The stroke rehabilitation ward at Moseley Hall Hospital is one of several wards in a hospital for older adults. The multidisciplinary team has input from: clinical psychology; dietetics; medicine; nursing; occupational therapy; physiotherapy; and speech and language therapy. A weekly case conference is held in which the care, progress, patient goals and plans for each patient are discussed and referrals for psychological input are received.

From one-to-one sessions with patients and feedback from nursing and medical staff, it was noted that similar experiences and emotional difficulties in adjusting to life following a stroke were often reported. Although nurses may receive the first disclosure of how patients feel, the nature, availability of resources and time constraints (Barreca and Wilkins, 2008) may make it difficult for them to respond. Working with psychologists to address patients’ emotional difficulties affords nurses the possibility of being the first point of contact.

Practitioners know they have the option to refer patients to psychologists on the ward. Patients had said that it may be helpful to share their experiences of having a stroke and its challenges with others in a similar situation. It was felt this interaction could be facilitated in a small group setting. Considering the extensive impact of stroke, we were surprised by the lack of literature on group interventions with these patients at the rehabilitative stage.

Barton et al (2002) described a seven-session psychological intervention designed for patients approximately six months post-stroke. The group’s purpose was to support patients in psychological adjustment after a stroke, through sharing and processing experiences. Townsend (2003) designed a structured group programme comprising 11 sessions for patients within two years of having a stroke. On reviewing sessions in the latter group, it became apparent that the content of some sessions was perhaps more suited for stroke survivors in the community.

Although the groups outlined above (Townsend, 2003; Barton et al, 2002) have similar objectives to those in this intervention, they were not felt to be suitable for patients in the early to mid stages of recovery on a rehabilitation ward. This is because patients are not likely to have experienced life at home yet. The emphasis may be on different issues, depending on the stage in recovery. Furthermore, we felt fewer sessions would suit the nature of the ward better regarding admission to rehabilitation as well as discharge.

IMPLICATIONS FOR PRACTICE

- Healthcare staff working on stroke rehabilitation wards have an important role in identifying their patients’ psychological needs.
- The emotional effects following a stroke should receive as much attention as physical disabilities, as these are likely to impact on patients’ engagement in rehabilitation.
- The timing of psychological intervention may be important.
- Emotional support should also be made available for staff working with stroke patients.
AIM
An inpatient group intervention was developed for use with patients in the early to mid stages of recovery. Its aims were to:
- Normalise reactions and emotions experienced by stroke survivors;
- Support the ‘rebirth’ of identity, as stroke survivors often report loss of their ‘old self’;
- Give patients the space and opportunity to regain control and realise the importance of exercising choice;
- Encourage discussion in the group and the sharing of experiences;
- Raise awareness of the role of mood on engagement in rehabilitation.

METHOD
Group sessions used a pan-theoretical approach, comprising target elements from:
- Cognitive behavioural therapy (interaction of thoughts, feelings and behaviour);
- Psychodynamic therapy (containment);
- Systemic therapy (roles in the group);
- Solution-focused therapy (coping and scaling questions and resources).

The group met five times over two and a half weeks. Each session was designed to last for around an hour so it was not too taxing on patients’ emotional processing as well as attentional and physical abilities. The sessions were facilitated by a clinical psychologist and an assistant psychologist. On most occasions, nursing students were also present. The group has been designed to be led by allied health professionals as well as by psychologists. However, it is important that group leaders have experience of working with stroke survivors and a sound psychological understanding of their difficulties.

Group inclusion criteria
Inclusion criteria were as follows:
- Patients referred to the intervention by the multidisciplinary team;
- Patients of a similar age (due to discussion of likely difficulties and issues of concern);
- Ability to give informed consent (both verbal and written was obtained);
- Ability to maintain concentration for the duration of the session;
- Ability to verbalise or communicate their thoughts (for example through use of a communication aid);
- Absence of severe sensory or visual impairments;
- Absence of sexual or verbal disinhibition (although such patients could benefit from the group material on a one-to-one basis).

The notion of recovery and the rehabilitative process as a journey was used throughout. The experience of having had a stroke was likened to finding oneself on an unexpected journey without having been able to prepare for it, and the session handout depicted a man lost in a forest without a map. Patients were encouraged to design an individualised ‘route plan’, identifying their current and desired position (similar to the start and end of a trip) through setting several smaller and more specific goals.

A manual to accompany the group includes suggested ground rules, consent form, objectives and outline of each session, guidelines, feedback forms and patient monitoring forms. Each session has several visual aids to support themes discussed. A PowerPoint presentation was also produced. Box 1 outlines the sessions’ themes.

Participants
The group was piloted with an opportunistic sample of six inpatients on the ward. They were identified as having difficulties with adjustment after stroke. Seven potential candidates were identified; one woman declined to attend after having agreed initially. The group comprised two men and four women, aged between 71 and 90 years (mean=83 years, SD=6.54). One woman dropped out after the second session.

The types of strokes were: a post-operative stroke following cardiac surgery; a right middle cerebral artery infarct (two patients); small vessel disease; left cerebral bleed; and a left parietal infarct.

Patient feedback
Patients were asked to indicate the degree to which they liked each session on a Likert-rating scale ranging from 1 (‘strongly disliked’) to 5 (‘liked it very much’), with a score of 3 indicating they ‘neither liked nor disliked’ the session.

The minimum rating for any of the sessions by patients was 3 (‘neither liked nor disliked’), with the majority indicating they liked each session (score=4).

For the following questions, data was pooled across all the sessions, with results indicating the overall percentage who found aspects of the sessions helpful or unhelpful.

REFERENCES


suggested the majority of patients (70%) found them helpful.

Patients were asked about the perceived helpfulness of the different aspects of the group. These included: meeting other patients; discussion/sharing experiences; the group as a structured ward activity; activities covered within the group or ‘other’.

Discussion and sharing experiences in group sessions was perceived to be the most helpful aspect, indicated by the majority (61%) on this item (Fig 3). Patients appeared to find comfort in realising that others expressed similar concerns and seemed to benefit from discussing difficulties and generating possible solutions. This may be supported by the finding that 31% of all responses showed patients felt meeting others on the ward to be the most helpful outcome. It was noted that patients from different bays on the ward tended not to interact with each other; however, some who attended the group were seen talking to each other on the ward following sessions. No responses were obtained from patients for the categories of ‘activities’ or ‘other’.

A considerable proportion of responses did not identify any aspects of the group as unhelpful (71%). Ten per cent suggested that discussion and sharing experiences was the least helpful aspect (Fig 4). This finding may be due to several factors. For example, some patients appeared confused by the change in the wording of the two questions – the only word that differed was most/least. Also, those with limited awareness or who perhaps had not begun to accept post-stroke changes and impairments may not have been ready to focus on their difficulties and discuss them.

Indeed, the woman who dropped out stated she found the group discussion unhelpful as it made her think about her difficulties more after the two sessions. No responses were obtained for the categories of ‘activities’ or ‘meeting other patients’.

The finding that the group as a structured ward activity was perceived to be the least helpful aspect (14% of responses) was a little unexpected as it was felt patients may have liked having a timetabled group due to the limited number of ward activities outside physical rehabilitation sessions. Stroke patients may experience variable levels of energy and may be likely to tire quicker, which may affect willingness and ability to engage in ward activities.

When considering the aspects rated both as most and least helpful, it is important to note that a higher number of patients commented on aspects that were helpful. Some patients stated they could not comment on aspects of the group they found least helpful. In total, 26 responses were given regarding the perceived most helpful aspects of the group, with only five responses for the least helpful. It is possible there were still some aspects that patients may have found unhelpful.

### BOX 1. CONTENT OF GROUP SESSIONS

**Session 1 – I had a stroke: my unexpected journey**
- To enable patients to share experiences and discuss how the stroke has affected them;
- For example, sharing common thoughts – ‘Why me?’, ‘Is it going to happen again?’, ‘Will I get back to the way I was?’

**Session 2 – New problems, new directions**
- To encourage patients to generate possible solutions to identified problems;
- For example, if a keen gardener is unable to maintain their garden to the same standards following a stroke, what could they do to work around this?

**Session 3 – Step by step**
- To raise awareness of the importance of breaking goals down into smaller, more achievable steps;
- For example, introducing SMART goals (specific, measurable, achievable, realistic and timed).

**Session 4 – The rocky road**
- To normalise experiences of different emotions and encourage patients to see how managing emotions can facilitate their recovery;
- For example, discussion about the possible impact of various emotions on thoughts, body and actions.

**Session 5 – The long winding road ahead**
- To remind patients of things that may be helpful while recognising the often slow and complex nature of recovery;
- For example, developing a ‘survival kit’ by identifying factors that may be important in the recovery process.
The feedback form was redesigned following the pilot group as we felt it may have been difficult for patients to differentiate between some of the questions. The form has been simplified and now contains fewer questions.

Staff feedback
Staff from several disciplines reported seeing the group as a positive and much-needed intervention for patients. Also, nursing staff felt the group content helped to address some of the common issues and concerns often expressed by patients.

Facilitator reflection
Minor alterations were made to the order of some activities to improve the flow of sessions. However, few changes were needed as the group was designed with stroke patients on the rehabilitation ward in mind.

Problems experienced centred on logistics of planning and group organisation. Groups had to be run close to busy areas of the ward due to lack of space. Also, it was often difficult to start sessions on time due to demand on nursing staff to help patients get ready. As some patients were heavily dependent on assistance, nursing staff helped to hoist them out of bed, position them comfortably in wheelchairs or take them to the group room with walking aids.

In future, it may be beneficial to work more closely with staff to discuss how to reduce the impact of practical issues. This could perhaps include discussions to avoid timetabling other therapy sessions immediately before a session to avoid tiring patients. Also, it may be helpful to discuss the timing of nursing duties to avoid placing pressure on nursing staff to help patients prepare for the group.

Some patients did not feel well enough to attend all sessions, which meant there were different group dynamics in the sessions.

We were unable to use the PowerPoint material because of difficulties with displaying it so handouts for each session were provided. Presenting with PowerPoint may be a better option as it would not emphasise differences in abilities and require patients to use several different skills at once, for example holding several handouts, completing activities and following discussion. The animations could also be used as an ice-breaker to reduce anxiety when joining an unfamiliar group.

DISCUSSION
The group can be seen as having created a safe environment (containment), enabling patients to share experiences and fears.

Feedback indicated patients valued sharing experiences, which is consistent with findings from other studies on group programmes (Townsend, 2003; Barton et al, 2002). Patients reported regaining as much independence as possible as a major goal in recovery, while increased dependence on others following stroke may contribute to feelings of loss of control, ‘loss of self’ (Murray and Harrison, 2004) and depersonalisation (Olofsson et al, 2005).

The potential benefit of psychological intervention is highlighted at this stage. Although patients expressed feelings of uncertainty, some also expressed a positive attitude towards their post-stroke life and were looking forward to life following discharge from hospital. This is consistent with the findings of Popovich et al (2007). It is strongly believed that psychological input has a role in providing patients with tools and strategies in protecting against negative thought systems, where these could impede the recovery process (Lewis et al, 2001).

The current study has several limitations. The pilot group was run with an opportunistic sample of patients on the stroke rehabilitation ward. All patients were white, so results are not generalisable to patients from black and minority ethnic groups. In addition, the sample is small so results cannot be generalised. It is expected that future groups will be run and further evaluation conducted.

Emotional support
We also feel that more attention should be given to emotional support for staff working on a stroke rehabilitation ward. This could be achieved through clinical supervision and debriefing.

Debriefing from group sessions raised interesting discussions about the group’s effect on its leaders. Group leaders reported a sense of weakness and fatigue after facilitating discussions.

It is normal practice for psychologists working in clinical settings to receive supervision in which feelings following interaction with patients are addressed. This raises an important question regarding how nursing and medical staff may be left to process the emotional impact of patients they are working with. Running the group has led us to believe that psychologists working on a stroke ward may have a role in supporting staff in acknowledging and normalising the sense of helplessness that may be transferred to them.

CONCLUSION
It is crucial to address patients’ emotional needs following a stroke and attention should be paid to psychological intervention. Patients reported finding the opportunity to share experiences with others in similar situations as the most helpful aspect of the stroke group.

REFERENCES


