How nurses in a stroke rehabilitation unit attempt to meet the psychological needs of patients who become depressed following a stroke

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INTRODUCTION

This research was undertaken in a stroke rehabilitation unit which provided a multidisciplinary rehabilitation service for patients of any age over 16 years who had survived a cerebrovascular accident and who were deemed to have the potential to recover at least some of their lost abilities. The emphasis was naturally on improving physical function and independence in activities of living. As a staff nurse in the unit, however, I became aware and concerned that patients obviously experienced emotional and psychological problems as well as physical difficulties following stroke and that these appeared to influence both the process and outcome of rehabilitation.

Some patients it seemed, could not come to terms with what was happening to them. What could explain why a patient who should ‘do well’ according to the degree of functional impairment, achieved little improvement or even deteriorated? Why should someone not wish to participate in their rehabilitation programme at all, or give up trying? What caused someone to stop eating and drinking, stop talking and withdraw from social contact? Something was seriously amiss, after all, people who were admitted into the unit were supposed to improve.

As nurses, we would discuss these problems amongst ourselves, with other members of the care team and with relatives and conclude that such patients were probably depressed. Sometimes antidepressant medication would be sought and we would wait for the ‘magic’ pills to work, not knowing what else we could do. We would try and talk to the patient, listen to them, encourage and cajole, call in the social worker or chaplain, always thinking that...
we should be able to do more and feeling inadequate about our lack of skill. Should we attend counselling courses, would that help? From such conversations with colleagues, it appeared that many of us experienced similar frustrations.

When, as part of the Sheffield Polytechnic (now Sheffield Hallam University) Certificate in Health Care Research course, the opportunity arose for me to undertake a research project in my own clinical area, I chose to investigate how the nurses I was working with actually perceived the problem of depression in stroke survivors and what they did about it when it occurred. Moreover, I wanted to know what they felt unable to do in the situation and what they thought could improve matters. Perhaps the information obtained could be used to enhance the quality of service to patients and improve rehabilitation outcome.

THE LITERATURE REVIEW

Depression in stroke survivors has been variously estimated at between 14% and 61% (House 1987b). Understanding the cause of post-stroke depression, how it might be treated and its effect on rehabilitation outcome, are the main issues addressed by research in this field.

The cause of post-stroke depression

One theory of post-stroke depression developed by a research team at Johns Hopkins University School of Medicine, Baltimore, USA, explains it as, ‘the behavioural manifestation of neurophysiological or neurochemical responses to the brain injury’ (Robinson et al 1983). That is, ‘injury to specific brain structures produces pathological mechanisms that lead to the clinical syndrome of major depressive disorder’ (Robinson et al 1990). A relationship between the actual site of the brain lesion and the psychological consequences of stroke is suggested and research has focused on isolating the exact locations of the brain lesions which are more likely to result in depression (Starkstein & Robinson 1989).

Other related issues have also been explored in connection with this theory of post-stroke depression, including links between physical and cognitive impairment and depression (Robinson & Price 1982, Robinson et al 1983, Robinson & Bolla-Wilson 1986, Starkstein et al 1988), the stability of depressive symptoms over time (Robinson et al 1984), the use of diagnostic tests (Lipsey et al 1985), depression scales (Shinar et al 1986), the impact of depression on activities of living (Parikh & Robinson 1990) and treatment for depression (Lipsey et al 1984). Depression following stroke is likely to be dependent on several factors but lesion location is considered the most significant single factor.

These researchers believe that it is erroneous to try and explain depression as a normal and expected psychological reaction of a stroke survivor to their disability and restriction of activity, and that an unquestioning acceptance of this perspective has led to the consistent overlooking of depressive symptoms in stroke survivors and consequent non-treatment of a potentially treatable condition. This view is not universally accepted, however, and intense criticism has been levelled at the Johns Hopkins research, questioning the validity of findings which are subject to numerous methodological inconsistencies (House 1987a, 1987b). Undue emphasis has thought to have been placed on depression as a specific syndrome following stroke and on the claim that depression is under-diagnosed and under-treated (House et al 1991). There is no conclusive evidence that depression found in stroke survivors differs from that found in patients with other physical illness (House 1987a, 1987b, House et al 1991, Schubert et al 1992b).

An alternative explanation is that depression does in fact occur as a result of the stroke survivor’s struggle to adjust to the experience of stroke and seems to be associated with the emotional crisis of grief reaction after severe illness (Jarman 1978, Kotila et al 1984, 1985, Dudas 1986, Mumma 1986).

An individual’s coping strategies may be important in adjustment to stroke. Illness and injury challenge a person’s assumptions about their life and the world around them and if they interpret the world negatively, then they will be more likely to become depressed (Holland & Whalley 1981, Thompson et al 1989). In this view, depression is more likely to occur in people who cannot cope and in those who set themselves high standards (Jarman 1978).

Finally, social support has been identified as an important factor in post-stroke depression (Jarman 1978, House 1987a) and clinical trials have been conducted to determine the role of family function, social support and caregiver relationships in promoting post-stroke adjustment (Evans & Bishop 1990). A correlation may exist between the levels of social support and the incidence of depression amongst stroke survivors (Robinson et al 1990). Good social support aids adjustment, though it must be noted that over-protection by carers can foster dependency and helplessness and consequent poor adjustment (Thompson et al 1989).

The effect of depression on recovery from stroke

The Johns Hopkins researchers found no correlation between severity of physical impairment and depression, but once subjects had become depressed those who were most depressed remained the most impaired in carrying out activities of living (Starkstein et al 1988). The impact of depression on activities of living showed that long-term depressed subjects had more impairments (Parikh &
Robinson 1990) Elsewhere, depressed stroke patients have been found to have greater functional disabilities (Schubert et al 1992a) and also needed longer hospitalization and rehabilitation stays (Eastwood et al 1989). In short, depression may accentuate physical impairment and lead to poor recovery and delayed rehabilitation (Agrell & Dehlin 1989).

One study of the effects of post-stroke depression on rehabilitation outcome has evaluated subjects for depression and coping strategies. The depressed subjects had a higher degree of functional impairment on admission and on discharge and their coping strategies showed a low level of participation in the rehabilitation process (Sinyor et al 1986). Depression, it appears, exerts a negative impact on the rehabilitation process and outcome.

The Johns Hopkins researchers often remarked that the depressed subjects identified in their studies went untreated (Robinson & Price 1982, Robinson et al 1983, Robinson et al 1984) and they themselves gave little attention to treatment studies. One small clinical trial was undertaken, demonstrating greater improvements in those subjects who had been given tricyclic antidepressants (Lipsy et al 1984). The trial was considered successful and representing a potentially important advance in the treatment of depressed stroke patients. Some similar successes have also been claimed in the use of the antidepressant drug Trazadone (Reding et al 1986) and other small but inconclusive drug studies have also taken place (Lim & Ebrahm 1983, Finklestein & Weintraub 1987).

Electroconvulsive therapy (ECT) has also been considered in treating post-stroke depression and in a retrospective study where patients' treatment records were examined it was concluded that ECT could be safely and effectively used for post-stroke depression (Murray et al 1986).

On the basis of this limited body of research into the effectiveness of physical treatments, it has been asserted that post-stroke depression can be treated by physical means (Starkstein & Robinson 1989).

Psychological therapies for post-stroke depression have likewise received little attention from researchers. There is no research evidence that psychological rehabilitation programmes work and no evidence that counselling or follow-up of patients by a rehabilitation worker specifically interested in stroke would influence the occurrence of mood disorder (House 1987b). The efficacy of psychotherapeutic techniques, including group and family therapy, have not been examined in controlled treatment trials (Starkstein & Robinson 1989). However, the benefits of group psychotherapy, for instance, have been suggested (Oraldei & Wate 1974). In a rehabilitation setting, grief must be recognized as a serious, unique process which requires the same attention as the other sequelae of disability (Stewart & Shields 1985).

Cognitive therapy, group psychotherapy or peer support groups might be effective forms of treatment for depression following stroke and this could be arranged prophylactically as an integral part of post-stroke care (Ahlosio et al 1984). Problem-focused therapy with family members has also been attempted (Watzlawick & Coyne 1980). The attitudes and outlook of staff in stroke rehabilitation units may be in themselves instrumental in providing a better psychological atmosphere for recovery (Goldberg et al 1979) but milieu therapy in this context remains unresearched.

METHOD

Data collection

As the aim of the research project was to elicit information from nursing colleagues about their everyday nursing practice, some means had to be found of asking them questions and it was decided that individual, guided interviews would enable all the information required to be obtained. An interview schedule was devised comprising a mixture of 14 open and closed questions which would hopefully yield the information wanted (see the appendix). This would be recorded on audiotape. A pilot interview with a colleague who was about to leave the unit confirmed the usefulness of the interview schedule and the practicality of using a tape recorder.

It was decided to interview only qualified nurses, the criteria for selection being that participants had experience of the subject under investigation and an ability to articulate the experience. There were 14 qualified staff on each of the two stroke unit wards, eight registered general nurses (RGNs) and six enrolled nurses (ENs), covering...
three shifts. Interviewing all of them would have been ideal but even a cursory scan of the duty rotas for the coming weeks revealed that this was not practical. The total number was halved and exactly half of the RGNs and ENs were chosen at random from each ward. Each nurse was seen individually, and the purpose of the research project and how it would be conducted explained. All the nurses consented and interview dates were timetabled. Assurance of confidentiality was given in writing at the beginning of each interview.

Data analysis

Following each interview, the tape was transcribed as soon as possible and notes were made about recurrent themes. When all the interviews had been transcribed, photocopies of the transcriptions were cut up and the sets of answers to each question pasted together. The responses were read through several times and recurrent themes underlined. Notes were also made of answers that were at odds with the majority.

RESULTS

Data fell into three broad categories corresponding to the questions asked:

1. What the nurses understand by the term ‘depressed’ and the relationship between depression and the experience of stroke (questions 1–6)
2. What the nurses do to help the depressed patient and what constraints they face in attempting to meet the patients’ psychological needs (questions 7–10)
3. How the situation might be improved (questions 11–14)

What nurses understand by the term ‘depressed’ and the relationship between depression and the experience of stroke

Depression was described in terms of mood and observable patient behaviour and explanations were offered for what was observed. Depression was seen as a change from normal mood and characteristics and these changes included ‘not wanting to communicate with anybody’, being ‘very quiet’, ‘withdrawing’ and becoming ‘very introverted’. Depressed patients appeared to be ‘lacking in motivation’ and ‘not wanting to do things’. They appeared ‘very miserable’ and ‘just really fed up with life in general’.

All the nurses ventured explanations as to why patients might become depressed following a stroke, focusing on change, loss, grieving, handicap and disability ‘losing the responsibility for your own welfare’, ‘not being able to do the things they were doing before the stroke’, and ‘grieving for the loss of their previous life and possibly a dread of the future’.

All but one of the nurses believed that depression was a normal, natural response to stroke, to grieve ‘as part of coming to terms with how things were going to be in the future’.

The nurses also recognized that depression may affect a patient’s rehabilitation, accepting that active involvement in a rehabilitation programme is difficult when the person needs time to grieve ‘They have to come to terms with what’s happening to them first, until they do this the rehabilitation is going to be a little difficult for them’.

When asked about the assessment of patients’ psychological status, 10 of the 14 nurses interviewed said that they did not attempt to do so and even those who did found it difficult in the absence of skills and training. Assessment was seen as a continuing, on-going process over a period of time. Assessment was based on observation ‘just by looking at somebody you can tell more or less what kind of state they’re in, just by their appearance’.

By noting changes in behaviour, a nurse may be alerted to a patient’s depression. Such changes in behaviour include social withdrawal, crying, not taking an interest in things, losing interest in appearance or eating, not sleeping, and not participating in rehabilitation. Body language, facial expressions and gestures were all cues picked up by nurses that alerted them to a change in the patient’s psychological state.

What nurses do to help the depressed patient and what constraints they face in attempting to meet the patient’s psychological needs

All the nurses interviewed tried to help depressed patients, spending as much time with them as possible, talking and listening. They would talk to other nurses, other members of the multidisciplinary team, and involve relatives. However, they all felt constrained in their efforts. Lack of time was considered to be a major problem, mainly due to pressures on the ward and the precedence given to physical care. It was not just the lack of actual time either but being able to be there at the right time. Not being able to get the patient to open up was also identified as a problem and some nurses blamed themselves for this, feeling that they were letting the patient down if they needed to hand the problem over to someone else. They felt guilty or even disappointed with themselves, even inadequate, about not having enough time, or not being supportive enough.

Of the 14 nurses interviewed, half said that they had received no teaching at pre-registration level in how to deal with psychological problems. Five had had some psychiatric nursing experience in their pre-registration training and only two had done any counselling and psychology at this level. Two of the nurses who had no basic training had subsequently attended counselling courses in
their own time. This lack of knowledge and skills was identified by all the nurses.

**How the situation might be improved**

In response to the question as to whether it would be useful to have more teaching in how to deal with psychological problems, all the nurses replied in the affirmative. Post-registration education was considered as important as pre-registration input, an on-going thing, with input at regular intervals. Counselling courses were mentioned but were considered too expensive to access.

As previously mentioned, lack of time was a major constraint to helping the depressed patient and having more time was clearly identified as a way of improving the existing situation, along with improved staffing levels and more emphasis on psychological as opposed to physical care.

The nurses stated that they wanted to be able to take on the psychological care of their patients themselves and clearly identified a role in giving psychological support. They also recognized the value in having access to someone skilled in giving psychological support, who could be used as a resource not only by nurses but by the whole multidisciplinary team. Medical staff were identified as being able to liaise with psychiatric services or prescribe appropriate medication if indicated and social workers were thought to be able to give more psychological input because of their training. Therapists had the advantage of having prolonged one-to-one contact with patients.

The attitude and approach of all staff who came into contact with the depressed patient was considered important. Access to expert help would benefit staff and patients alike. It was also recognized that a patient might benefit from talking to someone outside the ward team.

**DISCUSSION**

Amongst the nurses interviewed, no mention was made of the theory linking depression with specific neurological damage that might have been caused by the stroke. This is not so surprising. The only references to this research that were encountered in the nursing literature were in American nursing journals (Bronstein 1991, Bruckbauer 1991). There was some understanding that depression was not a single, uniform condition, and varying degrees of depression and a recognition of the difference between low mood and major depression were described.

The term depression can cover a variety of unpleasant mood states from early adjustment reaction, like normal grief, to later major depression associated with persistent symptoms (House 1987a). The characteristics of depression described by the nurses correspond with those in the diagnostic criteria for major depressive disorder (Diagnostic and Statistical Manual 111, American Psychiatric Association 1980), though depression was clearly associated with an adjustment reaction to physical disability and multiple losses.

Problems arise with accurate assessment. Some of the vegetative symptoms of depression, for instance, are similar to the physical sequelae of stroke and some patients might therefore look and speak as though they are depressed when this is not in fact the case (House 1987b). No psychological assessment tools were available to the nurses in the stroke rehabilitation unit. The activities of daily living model was used in the assessment and planning of patient care (Roper et al.) and there is no component in this ADL strategy that facilitates questions about mood or psychological state. Assessments are therefore more intuitive than objective and the accuracy of such assessments has been questioned.

For example, in one community-based study of nurses’ ability to detect mood disorder during routine clinical work, nurses were asked to report their impressions of mood after visiting a patient at home. They consistently failed to identify a number of depressed patients (House et al. 1988). In fairness to the nurses in this community study, however, none of them had received any training or gained any experience in psychiatry, but then neither had many of the nurses who had been involved in the current study.

One study of nurses’ ability to identify psychiatric disorder in patients, showed that 43% of the cognitive deficits and 41% of emotional disorders were missed. In consequence, patient behaviour was misinterpreted and problems were incorrectly identified, assessment being based on empathy and the nurses’ subjective interpretation of patients’ behaviour (Lucas & Folstein 1980).

**Ongoing assessment**

Other studies have demonstrated nurses’ poor recognition of patients’ worries (Johnson 1982) and misperception of patient needs (Farrell 1991). Lack of awareness in both cases led to the over-estimation of the number of worries, physical needs and emotional needs. Other patients (Johnson 1982) and relatives (House et al. 1988), have been seen to be better than nurses at identifying problems. However, a number of nurses in the present study indicated that assessment is not a one-off activity but an on-going process. Everyday contact with the patient facilitated continuous assessment, with input from various professional and lay sources. Still, the accuracy of even this continuing assessment remains difficult to measure.

Having assessed a patient and identified a problem, decisions have to be made about how to meet identified needs. As nurses in the study identified the depressive characteristics in patients as consistent with the grieving process or adjustment reaction, a natural course of action would be some form of psychological therapy. Medication was recognized as an option but not recommended as
treatment The nurses in this study recognized the need to sit and talk with the patient, giving them time and building trust, supporting the view that, ‘psychological reactions are a normal process and must be respected and facilitated’ (Nichols 1984a)

Early confrontation of problems is painful but the patient can work through loss and grief and move on (Oradei & Waite 1974) Nursing plays a major role in helping the individual and family through the painful process towards adaptation and rehabilitation and nurses can do much to assist patients through the grief process (Cheyney 1984) In the rehabilitation setting, the length of time spent with patients is important in broadening and extending nurses’ care beyond the alleviation of physical ills to the problems and needs of the whole patient The psychological role of the nurse expands in the rehabilitation setting (Rimon 1979)

Not providing sufficient time for patients was seen as a major constraint to effectively meeting patients’ psychological needs Physical problems take priority when time has to be divided More time to listen and talk was seen as a practical solution to the problems nurses face in meeting the psychological needs of the patient

Knowledge and skills

Lack of knowledge and skills also hindered nurses in meeting the needs of depressed patients It has been claimed in fact, that lack of skill in providing psychological care leads to patients not only being neglected but actually psychologically damaged (Nichols 1984b) Education in psychological care was unanimously stated to be a need by the nurses interviewed As previously mentioned, only half of the nurses had gained experience in psychiatry during basic training Psychiatric placements for general nurse learners have been identified as having potential for learning about aspects of nursing which can be of value in the care of both medical and psychiatric patients (Wilkinson 1982) Apart from this limited opportunity, nurses received little education in how to recognize, assess and manage psychological problems in patients (Whitehead & Mayou 1989)

Finally, it should also be borne in mind that nurses do not work in isolation but as part of a multidisciplinary team Consistency of approach and good communication between the team members was seen as essential in this study, in helping the depressed patient Other members of the team had a practical contribution to make, the regular and extended contact that therapists had with patients putting them in a position to provide psychological care (Nichols 1984b) Nurses suspected, however, that doctors and therapists were no better educated in managing psychological problems than they were themselves and access to expert help could provide a source of advice and support to all staff as well as a source of help to the patient

CONCLUSION AND RECOMMENDATIONS

The nurses interviewed for the purpose of this research study clearly recognized that patients may suffer some psychological distress, in the form of depression, following a stroke They clearly wanted to give these patients the psychological care that they need in such circumstances and, indeed, tried to do so They were constrained in their efforts by lack of time, limitations in knowledge and skills and the absence of expert help Finding solutions to these problems could significantly improve the psychological care depressed patients receive, with the implication that their rehabilitation would be more successful as a result

To consider first the issue of lack of nursing time, as already noted, in an area which focuses primarily on the patient’s physical function, time for psychological care is of a lower priority and has to be fitted into a busy, tiring work routine Setting aside time for a patient, with the guarantee of no interruptions, is difficult and, as one of the nurses commented, even if time were available the nurse may not feel able to offer herself and take on board a patient’s distress The value of being able to call on someone else in such circumstances is clear

When asked whom such an ‘expert’ might be, only the social worker or chaplain were mentioned by title This may be because nurses were looking only at the resources currently available to them as sources of support There was no access to a psychologist for instance and nurses unfamiliar with the psychologists’ role may be unaware of the contribution that they could make In some health care settings, a strong working alliance between nurses and clinical psychologists has been forged, for the benefit of patients and nursing staff alike (Nichols 1984a)

Another ‘expert’ professional resource is psychiatric liaison nurses, these are psychological support nurses who can be called on by general nurses to assist in the care of patients with psychological problems Their role is described in detail elsewhere (Jones 1989, Tunmore 1989, 1990a, 1990b) When nurses identify that they haven’t the time or skills to give the psychological care a patient needs, the liaison nurse can assess the patient and suggest how the nurses might best spend their limited time with the patient (Tunmore 1990b) They can also assist by giving support to the nursing staff Good psychological care can prove quite taxing and support is needed to undertake this role (Woodhams 1984) Indeed, it has been suggested that ‘to undertake work of this nature without adequate support and attention to self-care is irresponsible and unprofessional’ (Nichols 1984b)

In addition to professional support to staff, however, nurses also need appropriate educational input if they are to give psychological care to patients on a day-to-day basis One such educational programme has been described by the psychologist Keith Nichols Basic theoretical input is suggested during basic nurse education and built upon
with practical skills once the nurse is qualified and practising (Nichols 1984b). There are numerous books devoted to counselling skills and the provision of psychological care in nursing but merely understanding the principles of psychological care and actually delivering it may not be one and the same thing.

There is not only a need for theoretical knowledge but the need for a body of supportive practical nursing skills which can be used with patients in distress (Peterson 1988). A positive relationship between receiving supervised skills practice and the quality of interpersonal care has been identified elsewhere (Hills & Knowles 1983). The solution would appear to be a combination of theoretical knowledge and practical skills to facilitate nurses' assessment of psychological problems and the means whereby to help, with access to professional support and supervision, as well as a resource for patients when deemed appropriate. A psychologist or psychiatric liaison nurse might fulfil this role, leading to greater satisfaction for nurses in their quest to provide holistic rehabilitation care and as a means of improving the outcome of stroke rehabilitation.

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Post-stroke depression

APPENDIX 1 INTERVIEW SCHEDULE

Q1 You may hear it said that patients sometimes become depressed following a stroke, what do you understand by the term ‘depressed’?
Q2 Why do you think that a person might become depressed following a stroke?
Q3 Do you think that depression following a stroke is a normal reaction?
Q4 How do you think depression might affect a person’s rehabilitation?
Q5 As part of the assessment process, do you try to assess a person’s mental state when they are admitted into the unit?
Q6 In your experience, what sort of things would lead you to suspect that a person might be becoming depressed?
Q7 What do you do about this?
Q8 What do you feel unable to do about this?
Q9 Why?
Q10 Have you had any teaching about how to deal with psychological problems such as depression?
Q11 Would it be useful to have more teaching about how to deal with psychological problems?
Q12 What, ideally, would you like to see done for a patient who is depressed?
Q13 What do you expect other members of the multidisciplinary team to do for a depressed patient?
Q14 Would it be useful to have someone specialized in dealing with psychological problems available to the unit and if so, how might this person be used?
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