

**The Psychological Effects of a Cardiovascular Accident on
a Patient**

A Case Study

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Our patient, Peter, is 42 years old. He is married and has two children, a daughter, who is 13 and a son, who is 11. Peter is highly qualified; whose job requires a lot of travelling and human contact. He suffered a cardiovascular accident when he was at home with his family a month ago. His life lacks certain risk factors, he does not smoke; drinks only socially and frugally. He is emotionally stable and enjoys a happy marriage and family life.

In his life there are risks present, has one great source of stress, his work. He has a familiar history of cardiovascular disease and his blood pressure is high as well.

The cardiovascular accident he suffered affected him in many ways. His emotional and psychological well-being. His adjustment to the environment, his movement has changed. His right side shows weakness and he has a mild expressive dysphasia. Certain therapeutic goals have been set for him, e.g. improve walking, dressing practice, and work around the house.

His wife reported situations when he gets irritated with her or with the children. He has difficulties to sleep and has occasional episodes of uncontrollable crying or laughter. The psychologist working with him helps to set goals in the process of recovery. She tries to find negative thoughts and unhelpful thinking styles and turn them into ones that are more positive. The psychologist analyzes his behaviour for unproductive patterns and discusses them with Peter. She involves the members of the family, particularly his wife to find the best ways to help him. She encourages Peter to express his thoughts and feelings about his losses and cooperates with him to explore new motivational pathways. She tries to teach him effective strategies to manage his difficulty to sleep, to control his irritability and to cooperate

more effectively with the persons in his environment. Peter has a changed relationship with her wife; he feels their relationship lost some of the previous intimacy.

A cardiovascular accident is a life-changing event by most of the patients, not only for Peter. Survivors require a lot of physical and emotional effort on the way of recovery every day. Certain symptoms are more perceptible and obvious, but others are less evident even for the patients and their families. (Thompson, Ryan, 2009) Cardiovascular accident patients can have various symptoms and areas of problems. They could suffer from incontinence because of limited ability to move and communicate. The inadequate nutrient intake is based on their difficulty of eating. They are at risk of immobility syndrome due to paralysis and impaired consciousness, as well as increased risk of accident. They show lower level of adjustment and adaptation, have insufficient communication and their social relationships are weakened. Lower self-esteem is also very characteristic, and problems with everyday tasks, e.g. dressing. Dressing is a serious problem for cardiovascular accident survivors, because 54% of them are unable to dress independently six months after the cardiovascular accident. (Walker, et al. 2011)

Post-stroke depression is the most common consequence of a cardiovascular accident; it is also the most accessible for therapeutic intervention. Other frequently occurring symptoms are dementia, anxiety disorders, emotional incontinence, paranoid disorders and mania. Post-stroke symptoms and especially depression are left without recognition and therapy. (Altindag, et al. 2008) The correlation between the localization of the cerebral lesion and post-stroke depression is a much-debated issue. Biological factors are more important in the early phases of cardiovascular accident, but in the late phase, social factors play a more important role. After the cardiovascular accident, the situation of the patient changes

dramatically in the social environment. Impairment, the limited ability of movement, problems of communication and the accompanying somatic complications have a negative impact and these factors strengthen each others effect as well.

The changes in the behaviour and mood of the surviving cardiovascular accident patients present a great concern of their families. Depression is more likely to appear in hospitalized patients than in patients recovering at home. Depression is associated with the loss of leisure and social activities of the patient. Cardiovascular accident rehabilitation patients are susceptible to abnormal illness behaviour or abbreviated AIB. (Clark, Smith, 1999) AIB refers to maintaining sick role and illness behaviour when it is no more appropriate. Better family functioning is associated with greater compliance with treatment programs and more patient satisfaction with rehabilitation. We must be aware of the fact, that cardiovascular accident survivors perceive their home to be the safest place for them and this contributes to the diminution of their social activities. (Thompson, Ryan, 2009)

Vickery et al. (2009) discuss self-esteem in cardiovascular accident survivor patients. The cardiovascular accident has been found to have a negative impact on the patients' self-esteem and lower rating of self-esteem is associated with higher levels of depressive and anxiety symptoms. Low level of self-esteem leads to poorer functioning after acute cardiovascular accident treatment, compared to a sample of patients with higher levels of self-esteem. Depression is a very common symptom in the early post-stroke phase, on the average 38 % suffer from it. Self-esteem stability is predicting the level of depressive symptoms. The impairment of mobility has been found a particularly damaging factor to self-esteem in cardiovascular accident patients, according to Vickery and his co-workers (2009). Downward fluctuations in self-esteem represent a risk factor for emotional disturbances.

When considering post-stroke depression, the following consequences should be taken into account as well. Depressed patients face a more difficult rehabilitation and the prognosis of cardiovascular accident is worse. They can suffer from an increased number of complications, higher level of mortality and face a longer period and higher cost of hospitalization. These patients are more complicated to reintegrate to the original social environment. The patients' willingness to cooperate deteriorates and an increased risk of another cardiovascular accident is present, therefore increased long-term mortality.

Post-stroke depression has a negative influence on the life-quality of the patient, but also the family of the patient is seriously affected. Without therapeutic measures for two-third of the patients the mood disorder becomes chronic. The patient's direct life expectancy gets objectively worse as well, long-term mortality in depressed cardiovascular accident survivors is significantly greater than in stroke surviving patients without depressive symptoms.

In certain cases, the recognition of post-stroke depression is not easy. The patient's aphasia and communication problems prevent the proper evaluation of the symptoms. The cardiovascular accident cannot only cause depressive symptoms, but it can surface anxiety disorders as well. A significant comorbidity can be observed between depression and anxiety after cardiovascular accident in patients. In both cases, medication can be used to treat either depression or anxiety. Medication in itself is often not enough to solve the problems and dysfunctions associated with post-stroke depression and/or anxiety, a humanistic attitude, the understanding of the family functioning and the exploration of the patient's psychosocial connections are also required to provide help. (The Stroke Association, 2006)

The patient faces inevitable losses; the previous roles in the family, at work or in the society cannot be fulfilled as effectively as before or not at all. The inability to fulfil accustomed roles also represents a perceived loss of control over the events of their own life of the patients. The patient therefore experiences growing levels of frustrations, which may lead to mood disorders. (Thompson, Ryan, 2009) The mood disorders even more undermine the patient's position in the family. He becomes more sensitive and falsely interprets the changed social positions and structure of the family. Apathy is often characteristic for cardiovascular accident patients as well; they lose initiative and lack motivation to improve the current situation. (Hama, et al. 2007) According to the authors, apathy, just like depression is a predictor of poorer functional recovery after a cardiovascular accident.

The most common and psychologically relevant symptoms after a cardiovascular accident are social isolation, the individual's lower level of participation in the wider community, financial decline, the lurch of the position in the family system and the development of major depression.

Cardiovascular accident survivors are often less tolerant and more irritated with their spouses, they are more frequently arguing with them and irritability is associated with higher levels of stress. Patients depend increasingly on their spouses and this can be another source of frustration for them, leading to more irritation and conflicts. The spouses' over-protective attitude can represent a source of marital conflicts as well. (Smith, et al. 2012) Discouraging patients from activities before the cardiovascular accident has a demoralizing and confidence-undermining effect. Over-protection leads to dependence in many cases, patients report spouses not to allow them to participate in such activities that are within their current limits of ability. (Thompson, Ryan, 2009)

The familial relations are not only affected between the spouses, but the children of the patients are also affected. Parental cardiovascular accident and remaining symptoms cause stress for the children. Children interpret parental illness as a source of stress, because they are unable to react adequately and the consequences related to the cardiovascular accident exceed their cognitive and emotional capabilities. Children could develop both internalizing (depression, anxiety or physical symptoms) and externalizing problems (aggression or delinquency) related to the illness of the parent. (Sieh, Meijer, Visser-Meilly, 2010)

The psychological follow-up of the patient must also focus on the (often informal) caregiver. Caregivers are exposed to increased levels of physical and emotional stress. The prevalence of emotional problems among caregivers is ranging between 20 and 55%, e.g. anxiety, strain and depressive symptoms. (Sieh, Meijer, Visser-Meilly, 2010) This stress can potentially lead to depression in caregivers as well, therefore short problem-focused discussions or psychotherapy can prevent severe exhaustion and psychological problems. For caregivers the mental decline, depression and conduct disorders of the patient represent a far greater challenge than the actual care tasks resulting from the movement disability of the patient. (Greenwood et al. 2008, Smith, et al. 2012)

Less is known about the sexual dysfunctions of the cardiovascular accident patients. They affect the patient and the partner as well; usually both libido and actual sexual behaviour is disturbed. A cardiovascular accident can rarely lead to sexual hyperactivity. Spousal relationships are often transformed in terms of sexual activities, the balance shifting from a husband-wife relationship to a carer-patient relationship. (Thompson, Ryan, 2009) The fear of recurrence of the cardiovascular accident and prescribed medications are common causes to

avoid intimacy and the loss of sexual desire between the partners. Otherwise, normal acts of intimacy, such as kissing and cuddling are also avoided, because partners often fear these could lead to intercourse.

Cognitive behaviour therapy, various aspects of positive psychology or reality-oriented trainings can have great effect in the improvement of life quality of both the patient and the family. The focus of the therapy can (and probably should) be extended to family members as well, providing opportunities to ventilate feelings. Psychological support or subtle changes in the cooperation of family members can bring great results in the reduction of symptoms. (The Stroke Association, 2006)

Nursing is often criticized to consider cardiovascular accidents as purely medical problems and its failure to recognize individual difference, past experiences of the patients and individual psychological needs. (Thompson, Ryan 2009)

Relatives of cardiovascular accident patients reported in 80% of the patients changes in personality. These were in most cases referred as negative. The patient's emotional and social adjustment is affected in a cardiovascular accident. Cognitive impairments can occur as coexisting symptoms as well. (Robertson, 2010) In the early phase of a cardiovascular accident, every patient is considered to have also suffered a loss in the cognitive abilities.

Cardiovascular accident survivors often fail to return to their best functional capacity despite their relevant physical recovery. The most affected areas are of psychological and social nature. Survivors of a cardiovascular accident have dramatic decline in leisure and other

social activities. (Clark, Smith, 1999) However, self-efficacy could be an important factor to return to full functionality, according to the research of Jones and Riazi (2011).

To summarize the findings, we can state that a cardiovascular accident can change the life of the patient and his or her social environment as well. This change is seen as very negative in most cases and impacts various areas of life severely, e. g. social interactions, physical and emotional well-being, work-related issues, mobility, language use, sexuality, self care and many more. Patients, family members, formal and informal carers often do not know enough about the illness and its consequences and effects to be able to cope successfully. In most cases, rehabilitation is possible, but it is a long and not easy way to go for all concerned. Psychological help could be essential to find new motivation, to reframe elements of the current situation and to find a new balance of changed roles in the environment. The condition of the patient is the most important issue, but the care for carers and family members can provide benefits as well. Their physical and emotional well-being could be essential in the recovery process and their appropriate help can have a significantly more positive effect on the patient.

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