Foreword: Dr. Claude H. Vipond's 1983 address to the delegates of the National Symposium Banquet, still pertinent today, remains an excellent overview of many of the concerns that spouses and families may have when a loved one has a stroke, and as such is an ideal departure point for dealing with these issues in more detail.

The Acute Stroke Patient

When asked to see a patient who has just had a stroke, as a specialist in rehabilitation, I want to see the patient at the earliest moment possible. In our hospital we have a protocol for the treatment of acute stroke. This includes the alerting of the Rehabilitation Team: physiotherapy, occupational therapy, speech, social service, nursing coordinator of the rehabilitation unit, and the physician, who will usually be a physiatrist (a specialist in rehabilitation medicine).

When I see the patient I look for the numerous factors which are predictors of stroke outcome: the patient's age, location (right or left brain) and size of the vascular lesion (the area of the brain affected), made so much easier nowadays by the CAT scanner, cardiac status, previous medical history (hypertension, diabetes), and weight, motivation, etcetera.

As important as any of these and more important than most is the patient's social and domestic background. Does the patient have a loving, supportive spouse? Is there good family support? Does this person have a family and friends to help him or her and help each other through this catastrophe, both in the crisis and over the long haul ahead?

Early Recovery

Although strokes are such a common occurrence in our society - some 50,000 in Canada each year - each one comes as a bolt from the blue, nearly always unexpected, often involving a spouse who may not be in the best of health and by reason of age may have a limited capacity to adjust to such a crisis. For the first few days the main concern is whether the patient will survive; then for a few weeks the question is how much recovery will occur. Gradually the situation becomes clearer while the family is learning to adjust to a loved one who may have trouble understanding them, who may not be able to communicate thoughts and feelings, is often emotionally labile (has a loss of emotional control due to brain injury), who probably has problems getting about, has visual deficits, needs help even in the simplest activities of daily living, and who tires out so easily.

The Importance of Support

As the patient begins to recover he or she may become very depressed. To some extent this is a good sign, in that it shows understanding and an awareness of what has happened. Here is where the husband or wife, family and friends are so important in assuring the patient that he or she is still loved and wanted, and that there are those who care and want to help. We - therapists, nurses, physicians, and volunteers can show we care and can provide technical help and support, but we do not have the time nor the personal involvement which our patient needs. I have not found anti-depressants very helpful in reversing the depression which follows stroke - all too often they add to the confusion and fatigue from which the patient is already suffering.

Rehabilitation

As the patient moves from the active or acute care area to the rehabilitation area, there is a change in the care of the patient which may be confusing to the family. Family members may interpret as poor nursing care the efforts of the team to get the patient to do more for himself or herself and to be more independent. We often have to insist that the wife not feed her husband - and it doesn't help a nurse's morale to be asked, "Why don't you feed my husband? That is what you are paid for". The family may object to the therapist or orderly who stands by as the patient struggles to propel his wheelchair down the corridor, but this is done for a reason.

Stroke Education

It is at this stage that stroke education for the patient, family and friends is so vital. We give a Stroke Education Program which all our patients and their families are urged to attend. It consists of four sessions given in the evening, allowing ample time for questions and discussion.

I lead off with an explanation of the causes and mechanism of stroke, the process of recovery, prognosis, and risk factors such as cardiac arrhythmia, hypertension, diabetes, and overweight which must be brought under control and monitored to prevent a recurrence.

The nurse, the physiotherapist, the occupational therapist, and the speech / language pathologist each explain their role in stroke rehabilitation.

The hospital chaplain speaks about the impact of stroke on the husband and wife's relationship and the need for love, understanding and spiritual support.

The clinical psychologist explains the emotional impact of stroke. The pharmacist explains the medications used in stroke patients. The public health nurse attends and also a representative of our Day Hospital, who explains the role of the Day Hospital in the rehabilitation program.

We also have individual case conferences for each patient when we can reasonably predict what the length of stay in hospital will be and the patient's level of function. We encourage visits home, for a few hours at first, then overnight and then for a weekend. These are very reassuring to both patient and family, and it provides an opportunity for family and rehabilitation team to anticipate problems which may arise when the patient does leave hospital.

The Progression of Care

A common progression in care for a stroke patient is two to three weeks on the active side (acute care) of the hospital where the rehabilitation team sees the patient and initiates therapy, then treatment continues in our rehabilitation unit where the patient's reactivation is accelerated. Here the patient has one to one sessions with physiotherapist, occupational therapist and speech pathologist as well as group therapy. We have a recreationist who arranges social events, such as a pub night, shopping trips, parties to mark special days, and more. We have pet days.

The family is encouraged to see the patient in therapy to receive instructions in transfers, etcetera. The speech therapist in particular can use a great deal of help by the family. Valerie Eaton Griffith's book, "A Stroke in the Family", has a great deal of valuable advice on how the family can help with language training.

After 10 to 12 weeks in our rehabilitation unit the patient usually moves on to the Day Hospital, which the patients attend from approximately 9:00 A.M. to 3:30 P.M. having therapy, group exercise, recreational activities and lunch. While the patient is at Day Hospital the nurse can monitor blood pressure, blood chemistry, prothrombin times, change dressings, catheters, etcetera. I may see the patient regarding any intercurrent illness or we can arrange consultation with any of the medical specialties as indicated. Family conferences are a frequent event here too and, as in the other conferences in the rehabilitation unit, we encourage the family doctor to attend.

Our Day Hospital has been enthusiastically accepted by the community and especially by our patients and their families. It enables us to discharge patients from hospital earlier, and often avoids admission to a nursing home. It provides a caring community for the patient and support for the family. One of the important by-products of the Day Hospital program is that it provides some free time for the spouse or caregiver to rest, go shopping, visit the hairdresser, or engage in some other form of respite.

A Place for SRC

As a specialist in rehabilitation medicine I cannot over-state how valuable SRC has been in helping the several hundred persons in our community who have had strokes.

As the result of a stroke, family finances are often disrupted, especially if the person who has had the stroke is the salary or wage earner. Here is where our social service department helps. It is appropriate to remark here how fortunate we are to have a plan of medical and hospital care which protects the patient from the very high medical costs of major illness and a Department of National Health and Welfare which acknowledges the value of a symposium such as we are participating in here today.

Sexual Adjustment after Stroke

Another area which merits more discussion is the Sexual Adjustment necessary following stroke. The affected person has a diminished self-image and may doubt whether he or she is still lovable and here is where love and patience and understanding are all important. Usually stroke does not diminish libido or potential for orgasm. The resumption of sexual intercourse is a major milestone in the rehabilitation process. Dr. Charles Clay Dahlberg, an American psychiatrist, describes his own stroke and recovery in an excellent book entitled, "Stroke", published by Norton and Company. He writes, "One morning about three weeks post-stroke, I woke up with an erection and it was a pleasant sensation. Life was coming back to me, so very shortly after I was cleared by the latest brain scan we decided it was time for action. I think we were both nervous but all went well and afterward Jane asked me how I felt. I replied, "Good". I asked her the same question and received the same reply".

Alex Comfort in his book, "Sexual Consequences of Disability", writes in summary that far too little is known scientifically of sexual dysfunction related to stroke. Some sexual difficulties relate to emotional causes: ongoing anxiety about a potential recurring stroke, overwhelming fear after the catastrophic event, anxiety about sexual failure or performance, possible unresolved guilt, or a clinical depression. These are all reversible with an explicit, clear discussion of sexual function, or sex counseling or appropriate antidepressant. Separate loneliness can be avoided

in the years following a stroke by promoting optimum closeness, and the quality of life for the stroke survivor may thus be improved.

(See Stroke and Sexuality)

The Long Slow Road

Reaction to a stroke somewhat parallels the reaction to death, with the same stages as described by Elizabeth Kubler-Ross, namely denial, anger, bargaining, depression, and acceptance. As therapists, as family and friends we must recognize that these do not follow each other in a nice orderly sequence. There are frequent reversals to denial and anger and depression on the way to eventual acceptance, and then the long slow road to recovery and readjustment to a different way of life.

I have seen husbands and wives faced with the responsibility of caring for and sharing life with a spouse who has had a stroke, who is aphasic and hemiplegic, rise to levels of love, devotion and sacrifice which makes me humble to observe and which restores my faith in the essential goodness and nobility of human nature.

Dr. Claude H. Vipond

The aims and concerns of stroke rehabilitation, well expressed in Dr. Vipond's address, remain essentially the same today, yet changes have occurred in the way stroke is treated in the past twelve years. Stroke patients now generally spend less time in hospital than in 1983- in the 1990s, an earlier return to life in the community is now considered advantageous.

In the past few years, the increasing availability of new drug therapies means that the damage done by some kinds of stroke can now be greatly lessened - but only if medical help is sought within the first two or three hours after the onset of stroke symptoms, and preferably sooner. Stroke should be treated as a brain attack - the consequences of not doing so are at least as serious as a casual response to a heart attack. If you or a family member displays any symptoms of a stroke, call 911 immediately!

(See Stroke is an Emergency)