



Importance of Structured Stroke Education Programmes as a Family Therapy

Author

Dr S J B Bokhari

B Sc, M D ,M Sc (Psy), D H A , PGDCA,

Asst Professor, P G Dept of Moalijat (Gen Med), Govt Nizamia Tibbi College, Charminar, Hyderabad

Email: drsjobokhari@gmail.com, 919885691909

Abstract

With the improved health care facilities and better availability of health services, the after stroke complications are on the decline in financially well to do patients. But lower income group patients who suffer an episode of Stroke are at increased risk of developing both physical and psychological disability due to various reasons. The association of physical and psychiatric disorders is well established by several studies. Government Nizamia General Hospital, Charminar, Hyderabad, is a referral hospital for the patients who opt for Unani System of Medicine. This paper is presented to highlight the importance of Structured Stroke Programmes to be taken up in the Govt. Nizamia General Hospital, Hyderabad. and at the community levels as a family therapy.

Key Words: Stroke Education, Impact, Ma'ul Usl, Munzij, Tabreed, Mus'hil, Muqawwiyat, Family Therapy

The Acute Stroke Patient

Government Nizamia General Hospital, Charminar, Hyderabad, is a referral hospital for the patients who opt for Unani System of medicine when asked to see a patient who has just had a stroke; we want to see the patient at the earliest moment possible. In our hospital we have a protocol for the treatment of acute stroke. That is :

1. Pre-Treatment

2. Active Treatment

3. Rehabilitation

1. Pre-Treatment: This is the period which usually spans 3 days prior to active treatment .This period involve:

- a) Keeping the patient on N B M (i.e., nothing by mouth) for 3 days
- b) Starting on Ma'ul Usl (Honey Water) for 3 days
- c) Investigating.

It also includes alerting of the nursing Staff, and the scholars, who will usually be of P G Moalijat (General Medicine) department, about the case, as most of the philanthropists throng the hospital to provide fruits or food material for the admitted needy patients, especially during the month of Ramadan, which may be a restricted diet to the patient. When we see the patient, we look for the numerous factors which are the predictors of stroke outcome: the patient's age, location and size

of the vascular lesion (the area of the brain affected), made so much easier nowadays by the CT scans, 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?

2. The Active Medical Treatment

After giving Ma'ul Usl for three days, we start on Munzij therapy for 21 days; followed by Mus'hil alternating with Tabreed for 3 days. Common progression in care for a stroke patient is three to five weeks on the active side (acute care) of the hospital where the active medical treatment is given.

3. Rehabilitation

Then the treatment continues in our Physiotherapy unit and Out Patient Unit, where we can monitor the blood pressure, blood chemistry, prothrombin times, change dressings, catheters, etcetera. Here the patient has one to one sessions with physiotherapist. The family is encouraged to see the patient in therapy to receive instructions. During this period we instruct the patient as well as the attendee to involve in talking i.e., the speech therapy. Although strokes are such a common occurrence in our society - 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 tries out so easily.

As the patient moves from the active or acute treatment 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 him 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 a ward boy who stands by as the patient struggles to propel his wheelchair down the corridor, but this is done for a reason.

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 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 any of Unani drugs/depressants very helpful in reversing the depression which follows stroke.

Structured Stroke Education Programme as a Family Therapy

It is at this stage that structured stroke education programme for the patient, family and friends is so vital. Though we give a Stroke Education to the family members or the attendants throughout the stay of the patient in our hospital. But structured programmes or sessions of the stroke education are not scheduled ones, which may allow ample time for questions and discussion.

Structure of education:

1. It should involve an explanation of the causes and mechanism of stroke,
2. The risk factors such as cardiac disorders, hypertension, diabetes, and overweight which to be brought under control and monitored to prevent a recurrence
3. The Complications and the prognosis,
4. The importance of Family and Friend's support

The doctor, the nurse, and the physiotherapist, each should explain their role in stroke rehabilitation. The hospital Superintendant should speak about the impact of stroke on the husband and wife's relationship and the need for love, understanding and spiritual support. The concerned physician should be in a position to explain the emotional impact of stroke. The pharmacist explain the medications used in stroke patients. We should also have individual counseling 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 should also encourage O P visits. These are very reassuring to both patient and family, and it provides an opportunity for family to anticipate problems which may arise when the patient leaves the hospital. The speech therapy in particular can be of 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 O P Unit and physiotherapy unit the patient usually moves on. we may see the patient regarding any intercurrent illness or we can arrange consultation with any of the medical specialties as indicated as it often avoids admission to a nursing home.

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.

Importance of Stroke Education programme:

As a staff, I cannot over-state how valuable SEP has been, in helping the several hundred persons in our community who have had strokes. As a result of a stroke, family finances are often disrupted, especially if the person who has had the stroke is the salary or wage earner. 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 and Structured Stroke Education

Programmes (SSEP) will definitely change the scenario.

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 doctors, 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. we 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.

Conclusion

Through this paper I want to emphasize the need of 'Structured Stroke Education Programmes' to be administered to the family and friends as a Family Therapy at community levels and at Govt. Nizamia General Hospital, Charminar, Hyderabad, as awareness about psychological disorders can potentially reduce the cause and outcomes of the illness.