

The Effect Of Emotional Distress On Functional Outcomes In Acute Stroke Patients

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Introduction

Stroke rehabilitation is often described in physical terms: mobility, balance, strength, speech, and independence in daily activities. Yet recovery also takes place within an emotional life altered by sudden illness. The article “The Effect of Emotional Distress on Functional Outcomes in Acute Stroke Patients” by Gunal, Baskurt, and Baskurt examines whether distress measured early in hospitalization is associated with functional status and rehabilitation gains. The original review correctly recognizes that depression, anxiety, fear, irritability, and loss of interest may interfere with participation, but it sometimes treats association as direct proof of causation and makes broader claims than the study can support. A careful analysis should distinguish the study’s findings from later evidence, identify measurement and design limitations, and explain how emotional assessment can be integrated into stroke care without blaming patients for slow recovery. Current systematic reviews support the clinical importance of post-stroke depression and anxiety, while also showing that outcomes are shaped by neurological severity, disability, cognition, social support, treatment access, and many other factors. (Gunal & Baskurt, 2019)

The Clinical Problem

A stroke can abruptly change movement, communication, sensation, vision, cognition, and the ability to perform ordinary tasks. Emotional distress may arise from brain injury itself, awareness of disability, uncertainty about recovery, pain, hospitalization, loss of roles, financial pressure, or separation from familiar support. Depression and anxiety are not signs that a patient lacks motivation. They are clinically important conditions that may reduce energy, concentration, sleep quality, appetite, confidence, and willingness to attempt difficult activities. Emotional lability, apathy, anger, and fear of another stroke can also affect rehabilitation. At the same time, severe physical impairment can create distress, so the direction of influence may run both ways. This reciprocal relationship is essential. A patient may function less well because of depression, become depressed because of disability, or experience both effects within a complex recovery process.

Purpose and Design of the Reviewed Study

Gunal and colleagues studied 91 people with acute stroke, including 51 women and 40 men, who received rehabilitation according to their functional needs. Emotional distress and functional performance were assessed using several instruments. The Patient Distress Scale was used to characterize distress, while mobility and independence were assessed through the Physiotherapy Functional Mobility Profile and the Functional Independence Measure. Rehabilitation gain was examined with the Montebello Rehabilitation Factor Score, which attempts to relate observed improvement to the amount of potential improvement available. These tools allow emotional and functional variables to be compared, but they do not transform an observational study into an experiment. The researchers did not randomly assign patients to different emotional states, and many clinical characteristics may affect both distress and function. The study can therefore identify relationships and support screening, but it cannot prove that distress alone produced a particular outcome.

Main Findings

The study reported that emotional state was associated with independence in activities of daily living, mobility in lying, sitting, and standing, and rehabilitation gains during a relatively short hospital stay. These findings are clinically plausible. Rehabilitation requires repeated practice, attention, communication with therapists, and confidence that effort may produce improvement. Distress can make each of these tasks more difficult. However, the results should be expressed with care. “Directly affected” in the authors’ conclusion describes the observed statistical relationship, not an isolated mechanism. Stroke location, severity, cognitive impairment, fatigue, aphasia, pain, medication, previous mental-health history, and family support may influence both measured distress and functional results. The small sample and single clinical setting also limit generalization. The study’s importance lies less in establishing a universal effect size than in showing that emotional health should not be treated as separate from acute rehabilitation.

Evidence from Later Systematic Reviews

More recent research strengthens the general conclusion while preserving uncertainty. A 2024 systematic review in *PLOS ONE* found that post-stroke depression is frequently associated with poorer functional outcomes, although the included non-experimental studies varied in design, timing, measurement, and adjustment for confounders. Another 2024 systematic review of psychological interventions reported improvements in anxiety, depression, activities of daily living, quality of life, and functional impairment among included trials. These results suggest that emotional support may contribute to recovery, but they do not mean one intervention will work for every patient. Some reviews include studies from limited regions or with risk of bias, and treatment effects may depend on

severity, communication ability, timing, and the type of intervention. The appropriate clinical lesson is that screening and treatment deserve attention, not that distress explains every poor outcome. (Zhao et al., 2024)

Screening Without Stigma

Early screening can identify patients who need further assessment, but a questionnaire score is not a complete diagnosis. Stroke can affect language, attention, facial expression, sleep, appetite, and movement in ways that overlap with symptoms of depression. Aphasia may make standard verbal tools difficult to use, while cognitive impairment can change how questions are understood. Clinicians should select validated instruments appropriate to the patient's communication and cognitive abilities and combine scores with observation, history, family input, and professional judgment. Screening should also be repeated because emotional symptoms can emerge or change after discharge. The purpose is not to label a patient as "difficult" or "unmotivated." It is to identify treatable barriers, suicide risk, caregiver strain, and support needs. Respectful explanation can reduce stigma by presenting psychological care as a routine part of stroke rehabilitation.

Integrated Rehabilitation Planning

A strong rehabilitation plan coordinates physical, psychological, cognitive, and social care. Physiotherapists and occupational therapists can observe avoidance, fear, fatigue, frustration, and changes in participation. Nurses often notice sleep disturbance, appetite changes, tearfulness, confusion, and family concerns across the day. Speech-language professionals may identify communication barriers that intensify isolation. Physicians, psychologists, psychiatrists, and social workers can evaluate mood, medication, cognition, risk, finances, housing, and community support. Shared goals should be specific and achievable, such as transferring safely, walking a defined distance, dressing with less assistance, or communicating a basic need. When a patient sees progress, confidence may improve; when goals are unrealistic, repeated failure may deepen distress. Integrated care therefore does not place psychology beside rehabilitation as an optional extra. It recognizes emotion as part of how people engage with recovery.

Psychological and Social Interventions

Intervention may include education about stroke, supportive counseling, cognitive-behavioral strategies, problem-solving therapy, behavioral activation, peer support, caregiver involvement, medication when clinically indicated, and referral for specialist care. The selection should reflect the patient's preferences, symptoms, medical condition, communication ability, and cultural context. Psychological care is not limited to formal therapy sessions. A consistent daily routine, understandable information, opportunities to make choices, respectful communication, and continuity

among team members can reduce uncertainty. Families also need guidance because overprotection may restrict independence while unrealistic pressure can produce shame. Community nursing and follow-up services may support adherence, monitor mood, and connect patients with resources after discharge. Evidence suggests potential benefit, but intervention quality and availability vary, and patients should not be promised a guaranteed functional recovery.

Suicide, Substance Use, and Safety

The original review mentions death, suicide, alcohol, and drug use, but these topics require precise framing. Post-stroke depression can be associated with suicidal thoughts and increased health risk, so clinicians should take warning signs seriously. It is inappropriate, however, to assume that a distressed patient will misuse substances or attempt suicide. Assessment should be individualized and confidential, with urgent action when a person expresses intent, has a plan, or cannot remain safe. Medication interactions, impaired judgment, and reduced mobility may increase risks from alcohol or sedating substances. Safety planning can include family participation with consent, removal of immediate means, crisis contacts, and rapid mental-health evaluation. Treating these concerns as medical and psychosocial issues rather than moral failures supports disclosure and improves the chance that patients will accept help. (Butsing et al., 2024)

Limitations of the Original Study

The study's modest sample size, short admission period, and observational design limit causal conclusions. Emotional distress may have been measured at a time when patients were still adapting to an acute emergency, and scores could change rapidly. The selected instruments may not capture every form of post-stroke emotional disturbance, particularly apathy, emotionalism, trauma symptoms, or communication-related frustration. Functional scales also have ceiling and floor effects and may be influenced by the amount of therapy provided. The Montebello Rehabilitation Factor Score is designed to adjust for potential gain, but no single calculation can represent the full meaning of recovery. The article would be stronger with longer follow-up, repeated emotional measures, detailed adjustment for stroke severity and cognition, and a more diverse sample. These limitations do not erase the findings; they help clinicians use them at the correct level of confidence.

Implications for Nursing and Interdisciplinary Practice

Nurses and other team members can apply the article by incorporating emotional observations into routine handovers, care plans, and discharge preparation. A sudden decline in participation should prompt assessment for depression, anxiety, delirium, pain, infection, medication effects, sleep problems, and new neurological changes rather than an immediate judgment about attitude.

Communication should use plain language and allow additional time. Teams can document what encourages participation, what triggers fear, and which family members provide effective support. Discharge planning should include follow-up for mood as well as physical function because the transition home can reveal new challenges. Quality improvement measures might track screening rates, completed referrals, treatment follow-up, patient-reported distress, caregiver needs, and functional outcomes while protecting privacy. The goal is coordinated care, not the reduction of a person to a score.

Conclusion

Emotional distress is an important component of stroke recovery, and the reviewed study contributes evidence that distress is associated with mobility, independence, and rehabilitation gain during acute care. Its findings should not be interpreted as proof that emotion alone determines function or that patients are responsible for delayed recovery. Stroke severity, cognition, communication, medical complications, environment, treatment intensity, and social support interact with depression and anxiety. Later systematic reviews reinforce the value of screening and psychological intervention, while also revealing variation and methodological limitations. The most defensible clinical response is integrated, repeated, and respectful assessment followed by individualized support. Rehabilitation is more effective when teams attend to the person who is recovering, not only to the impaired limb or task. Emotional care and physical rehabilitation are therefore connected parts of safe, evidence-informed stroke practice.

References

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