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Pain and Sleep Disturbances are Associated with Post-stroke Anger Proneness and Emotional Incontinence

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Keywords

stroke; sleep quality; post-stroke headache; emotional disorders; post-stroke depression

Abstract

Background: Emotional disorders are common findings after a stroke episode. Despite evidence linking pain and sleep disorders to various post-stroke emotional conditions, their roles in the prevalence of post-stroke anger proneness (PSAP) and post-stroke emotional incontinence (PSEI) remain unclear. We investigated the influence of composite and different components of post-stroke pain (PSP) as well as post-stroke sleep disorders (PSSD) on PSAP and PSEI.

Methods: Cross-sectional data on PSAP, PSEI, PSP and PSSD were evaluated through validated instruments and structured interviews for a total of 185 community-dwelling stroke survivors attending two Nigerian tertiary health facilities. Data on potential confounding variables were also assessed.

Results: The rates of PSSD, PSP, PSAP and PSEI among Nigerian stroke survivors were 36.8%, 63.3%, 23.2% and 44.9%, respectively. The results of logistic regression models showed that composite PSP was associated with PSEI (adjusted odd ratio (aOR): 0.492; 95% confidence interval (CI): 0.251-0.965). While assessing the different components of PSSD and PSP, the results showed that sleep disturbances (aOR: 1.855; 95% CI: 1.096-3.140) and post-stroke headache (aOR: 0.364; 95% CI: 0.153-0.864) were associated with PSEI. In addition, being a domain of PSP, post-stroke headache was associated with PSAP (aOR: 0.052; 95% CI: 0.011-0.238).

Conclusion: There is high prevalence of PSSD, PSP, PSAP and PSEI among Nigerian stroke survivors. Post-stroke headache is associated with both PSAP and PSEI, while sleep disturbances are associated with PSEI. Post-stroke headache and sleep disturbances are potential targets for interventions in patients with stroke to lessen the burden of PSAP and PSEI.

INTRODUCTION

Stroke, a major cause of disability globally, often results in emotional health disorders¹. The common emotional health disorders observed among stroke survivors include post-stroke depression (PSD), post-stroke anxiety (PSA), post-stroke fatigue (PSF), post-stroke anger proneness (PSAP) and post-stroke emotional incontinence (PSEI)². Among these emotional disorders, PSD, PSA and PSF have been most investigated un-

like PSAP and PSEI, whereas the occurrence of PSAP and PSEI is said to be high and equally detrimental to stroke survivors³⁻⁸. Some of the reported symptoms of PSAP are impulsive behaviours, aggression, irritability and hostility, while those of PSEI include excessive, inappropriate and uncontrollable display of emotions (e.g. laughing or crying) without apparent reason or stimuli to evoke such feelings⁴⁻⁵. The presence of PSAP and PSEI is said to be debilitating to the stroke survivors and caregivers alike. Some of

the reported negative effects of PSAP and PSEI include low quality of life, poor rehabilitation outcomes, increasing burden on caregivers, distress and embarrassment to patients, families, friends and caregivers or carers⁹⁻¹⁴.

Neurological, socio-ecological and genetic factors are known to be associated with PSAP and PSEI, however, the evidence is still inconclusive^{15,16}. Meanwhile, it appears that post-stroke sleep disorders (PSSD) and post-stroke pain (PSP) are predictors of many psychological disorders fol-

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lowing stroke, as it has been shown in several studies that both sleep disorders and pain are consistent and independent factors associated with PSD, PSA and PSF^{2,17-33}. Nonetheless, to our knowledge, there are no studies to date in which the roles of PSSD and PSP on PSAP and PSEI have been investigated.

Similar to PSAP and PSEI, post-stroke sleep disorders (PSSD) are highly prevalent among stroke survivors^{34,35}. Stroke is a known cause of sleep disorders, and in fact, stroke has been reported to worsen underlying sleep disorders if present pre-stroke³⁶. Evidence has shown that more than half of stroke survivors often present with PSSD³⁷, while the results of a meta-analysis investigating the polysomnographic characteristics of sleep in stroke revealed that stroke survivors have poorer sleep quality than the controls³⁸. Some of the traits of sleep-related issues that have been reported among stroke survivors include sleep apnea, nighttime sleep disturbances, excessive daytime sleepiness and fatigue^{34,39,40}. Alike PSSD, PSP is a debilitating co-morbidity of stroke and it is reportedly common among stroke survivors with data showing that about 11-66% of stroke survivors have stroke-related pain²⁶. Various types of PSP identified in the literature include headache, shoulder pain, pain as a result of muscle stiffness, spasm, complex regional pain syndrome and central PSP⁴¹⁻⁴³, which can manifest singularly or in combination at acute or chronic stage after stroke, even up to 5 years post-stroke^{32,33}.

Apparently, factors associated with mental health disorders in stroke survivors tend to overlap and all these emotional disorders appear to pathophysiologically interconnect². In fact, it has been shown that antidepressant usage reduces not only symptoms of depression but also aggression and emotional incontinence in a stroke cohort⁴⁴, while the presence of sleep disturbances is consistent with the incidences and prevalence of post-stroke depression, anxiety and fatigue². Furthermore, reports have emerged in which it has been stated that treatment of sleep disorders and pain after stroke improves quality of

life and reduces mortality, morbidity and emotional disorders among stroke survivors^{30-33,37}.

Consequent to the foregoing, it is important to investigate the impact of sleep disorders and pain on the high prevalence of emotional incontinence and aggression in stroke survivors since they both appear to show consistent patterns of association with other psychological disorders in stroke survivors. Understanding the effects of sleep disorder and pain on aggression as well as emotional incontinence in stroke may help deepen the knowledge and management protocols of these emotional disorders. Meanwhile, pain after stroke is reported to present with different characteristics having varying and overlapping etiological mechanisms^{30,32,33,45-47}. Furthermore, the assessment of sleep disorders as composite variables has been reported to be misleading⁴⁸, while the dearth of data on the specific link between different components of sleep disorders and stroke outcome may hamper its robust understanding⁴⁹. Thus, in this study, the prevalence and correlates of PSSD, PSP, PSAP and PSEI were examined among Nigerian stroke survivors, and the impact of PSSD and PSP as composite variables was investigated, as well as the different components of PSSD (sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleep medication and daytime sleep dysfunction) and PSP (post-stroke headache, central post-stroke pain, peripheral post-stroke pain, other pain, and pain severity) on PSAP and PSEI.

METHODS

Participants

The participants for this cross-sectional observational study, recruited from February 2021 to July 2022, were community-dwelling stroke survivors who were receiving treatment at the Physiotherapy Department, Osun State University Teaching Hospital and State Specialist Hospital, Osogbo, Nigeria. Stroke survivors

aged 18 years and older, with first-ever stroke and who had a stroke diagnosis confirmed by computed tomography or magnetic resonance imaging examination of the head were included in the study. Exclusion criteria were severe aphasia or dysarthria preventing reliable interview, the presence of other neurological ailment apart from stroke, e.g. Parkinson disease, current use of antidepressants or any other psychiatric medications, having ≤ 23 scores for the Mini Mental State Examination, and those who came to the clinics alone preventing easy access to information from caregivers to confirm the presence or absence of PSAP and PSEI [8]. By using the sample size formula for cross-sectional epidemiological studies proposed by Kasiulevicius et al.⁵⁰, with a 95% confidence interval, 0.05 precision level and 10% stroke prevalence, a minimum of 125 participants were required for this study. However, a total of 185 stroke survivors participated in this study. The Ethics Review Committee of the Osun State University Teaching Hospital, Osogbo, Nigeria gave approval for the study (LTH/EC/2021/01/496). Also, written informed consent was obtained from each participant before commencement of the study.

Measures

Measurement of post-stroke anger proneness and emotional incontinence

Post-stroke anger proneness (PSAP) and post-stroke emotional incontinence (PSEI) were examined through interviews with stroke survivors and their caregivers/relatives, as well as the use of appropriate outcome measures. The Spielberger Trait Anger Scale (STAS) was implemented to assess PSAP of the participants. The subjects were considered as being prone to anger if the post-stroke aggregate score on the STAS was higher than that for pre-stroke. The STAS is a 10-item instrument eliciting information on aggression and anger proneness. Each of the questions from the STAS was answered on a numerical scale 1 (almost never), 2 (sometimes), 3 (often) and 4

(almost always) with the aggregate scores indicating pre- and post-stroke anger status^{8,51}. In addition, the caregiver/relative living with each participant must agree that the stroke survivors developed anger proneness after stroke onset for it to be considered positive in any participant⁵. Furthermore, the participants were considered positive with PSEI if the stroke survivors had exhibited excessive or inappropriate laughing, crying or both more than in pre-stroke states. The patients must have exhibited this behaviour at least twice in the past month as confirmed by the caregiver/relatives of the stroke survivors^{4,52}. The assessment of PSAP and PSEI was undertaken the same day by one of the researchers (ABA) who had more than a decade of experience in stroke rehabilitation and was blinded to the other measures.

Measurement of post-stroke sleep disorders and post-stroke pain

The post-stroke sleep disorders (PSSD) of the participants were evaluated by the Pittsburgh Sleep Quality Index (PSQI). The PSQI is an instrument consisting of 19 items assessing subjective sleep quality for the previous month⁵³. The PSQI items are scored on a 4-point scale from 0 to 3. Each of the seven components of the PSQI (sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleep medication and daytime sleep dysfunction) was calculated based on specific scoring keys and were summed to achieve a global PSQI score. The cumulative PSQI score ranges from 0 to 21. A higher PSQI global and component score indicates poorer sleep quality. A global PSQI score of <7 was considered good sleep quality while PSQI scores of ≥ 7 were assumed as poor sleep quality or sleep disorder⁵⁴.

The post-stroke pain (PSP) of the participants was evaluated by a proprietary questionnaire/interview requiring information on whether the participants experience pain after the stroke episode. The types of PSP evaluated in this study were central post-stroke pain (CPSP), peripheral post-stroke pain (PPSP), post-stroke head-

ache (PSH) and other pain. Stroke survivors, with the presence of at least 4 out of 10 central pain symptoms (pins and needles, numbness, itching, burning, painful cold, electric shocks, tingling, touch hypoesthesia, allodynia, and pinprick hypoesthesia), assessed using the Douleur Neuropathique 4 questionnaire, were considered as having CPSP^{31,55,56}. The PPSP was confirmed positive in the presence of any of hemiplegic shoulder pain, pain due to spasticity or muscle spasm/stiffness and complex regional pain syndrome⁴⁶. The presence and confirmation of headache after stroke onset at the time of interview was considered as PSH, while pain in the back, neck, abdomen or chest was categorised as other pain⁴⁵. The participants with a record of pain were asked to rate their pain severity via the 100-mm horizontal Visual Analogue Scale for pain (VAS). The participants rated their pain severity on a 100-mm horizontal fixed line from left to right with higher scores indicating greater pain⁵⁷.

Covariates

The potential confounding variables including social support, functional independence, stroke severity, stroke type, laterality, stroke duration, body mass index, number of comorbidities/stroke risk factors (hypertension, diabetes, cancer, obesity, arthritis, cigarette smoking, alcohol consumption, respiratory disease, heart disease, kidney disease) and socio-demographic characteristics (age, gender, years of education, monthly income, and employment status) were assessed. The Duke-University of North Carolina Functional Social Support Questionnaire (DUFFS) was used to evaluate the social support available to participants. The DUFFS is a measure of perceived social support with 11 items scored on a 5-point Likert scale. The aggregate scores range from 11 to 55, with higher score suggesting higher social support availability^{58,59}. The level of functional independence was measured by the Modified Barthel Index (MBI). The MBI, which is well-validated in stroke patients, is used to assess patients' ability to perform 10 types of activities

of daily living and has a maximum of 100 scores, with higher scores indicating a greater level of functional independence^{60,61}. The National Institutes of Health Stroke Scale (NIHSS) was used to evaluate stroke severity. The NIHSS is a validated 11-item instrument with each item scoring between a 0 and 4. A higher score is indicative of higher stroke severity level. The maximum possible score is 42, with the minimum being 0⁶². Stroke duration was categorised as early sub-acute (7 days-3 months), late sub-acute (>3 \leq 6 months) and chronic (>6 months) stroke⁶³.

Data analysis

Descriptive statistics of frequency, percentage, median, mean and standard deviation were used to summarize data. The independent *t*-test and chi-square test of association were used to investigate factors associated with PSEI, PSAP, PSP and PSSD. The binary logistic regression models expressed in odds ratio (OR) and 95% confidence interval (CI) were employed to assess the impact of composite PSSD and PSP, and the different domains of PSSD (sleep quality, sleep latency, sleep duration, sleep efficiency, sleep disturbances, sleep medication, daytime sleep and PSP (post-stroke headache, central post-stroke pain, peripheral post-stroke pain, other pain and pain severity) on PSEI and PSAP. Age and gender were adjusted for all the logistic regression models including other factors significantly associated with PSEI and PSAP in bivariate analyses. Thus, age, gender and stroke severity were adjusted in PSEI models, while PSAP models were adjusted for age, gender, body mass, income, education, employment, stroke severity, social support and functional independence. The alpha level was set to $p < 0.05$. Data analysis was conducted with the SPSS 21.0 version (SPSS Inc., Chicago, Illinois, USA).

RESULTS

The general characteristics of the participants are presented in Table 1. The mean age was 58.45 ± 10.16 years,

Table 1

| General characteristics of the participants (n = 185) | |
|--|---------------------|
| Variable | Mean (SD) or N/ % |
| Age (years) | 58.45 (10.16) |
| Gender (Male) | 112/60.50 |
| BMI (Kgm ²) | 26.54 (4.09) |
| Marital status (Married) | 162/87.60 |
| Income level (High) | 118/63.80 |
| Stroke type (Ischaemic) | 140/75.7 |
| Laterality (Right) | 98/53.0 |
| Stroke duration (months) | 6 (19) ^a |
| Early sub-acute | 57/30.80 |
| Late sub-acute | 38/20.50 |
| Chronic | 90/48.60 |
| Years of education | 12.89 (4.64) |
| Employment status (Employed) | 137/74.10 |
| Number of morbidities | 2.14 (1.23) |
| NIHSS | 2.66 (2.61) |
| DUFSS | 41.85 (10.33) |
| MBI | 78.06 (24.86) |
| PSP status (Yes) ^b | 117/63.25 |
| Post-stroke headache (Yes) | 46/24.90 |
| Central post-stroke pain (Yes) | 16/8.60 |
| Peripheral post-stroke pain (Yes) | 99/53.50 |
| Other pain (Yes) | 12/6.50 |
| VAS (Pain) (mm) | 30.68 (28.98) |
| Global PSQI | 5.84 (4.63) |
| PSQI sleep quality | 0.70 (0.84) |
| PSQI sleep latency | 1.09 (1.06) |
| PSQI sleep duration | 1.02 (1.01) |
| PSQI sleep efficiency | 0.78 (0.90) |
| PSQI sleep disturbances | 0.96 (0.80) |
| PSQI sleep medication | 0.41 (0.88) |
| PSQI daytime sleep | 0.93 (1.03) |
| Sleep disorder (Yes) | 68/36.80 |
| PSEI status (Yes) | 83/44.9 |
| PSAP status (Yes) | 43/23.2 |

SD – standard deviation; N – number; % – percentage; NIHSS – National Institute of Health Stroke Scale; DUFSS – Duke University of North Carolina Functional Social Support Questionnaire; MBI – Modified Barthel Index; PSP – Post-stroke Pain; VAS – Visual Analogue Scale; PSQI – Pittsburgh Sleep Quality Index; PSEI – post-stroke emotional incontinence; PSAP – post-stroke anger proneness; ^a – median (interquartile range); ^b – some stroke survivors reported more than one type of post-stroke pain

with majority of the participants being male (60.5%). A total of 75.7% had ischaemic stroke, others were in chronic phase (48.6%) and had 2.66±2.61 mean NIHSS scores. The prevalence of PSP, PSSD, PSEI and PSAP was 63.3%, 36.8%, 44.9% and 23.2%, respectively. While considering the prevalence of different PSSD and PSP do-

main, sleep latency (mean; standard deviation: 1.09±1.06) and peripheral post-stroke pain (53.50%) were the most prevalent. The prevalence of central post-stroke pain was 8.60%, while 44 (23.8%) reported more than one type of PSP.

As shown in Table 2, PSP was significantly associated with PSEI

($\chi^2=8.498$; $p=0.004$), while participants with PSEI had significantly more stroke severity than those without, as measured by NIHSS (3.07±2.5 vs. 2.33±2.7; $t=-1.935$; $p=0.049$). Meanwhile, PSAP was significantly associated with income level ($\chi^2=5.667$; $p=0.017$) and employment status ($\chi^2=8.077$; $p=0.004$), and those with the presence of PSAP had significantly higher levels of body mass (BMI: 27.8±4.2 vs. 26.2±4.0; $t=-2.270$; $p=0.024$), more years of education (14.5±4.4 vs. 12.4±4.6; $t=-2.581$; $p=0.011$), higher stroke severity (NIHSS: 3.72±2.8 vs. 2.35±2.5; $t=-3.091$; $p=0.002$), less social support (DUFSS: 38.3±12.4 vs. 42.9±9.4; $t=2.585$; $p=0.011$) and lower functional independence (MBI: 71.4±28.6 vs. 79.6±20.4; $t=1.966$; $p=0.048$) (Table 2).

Furthermore, PSP was significantly associated with gender ($\chi^2=5.971$; $p=0.015$), marital status ($\chi^2=15.625$; $p<0.001$), income level ($\chi^2=13.608$; $p<0.001$), stroke duration ($\chi^2=24.372$; $p<0.001$), employment status ($\chi^2=5.341$; $p=0.021$), less years of education (12.1±4.5 vs. 14.3±4.5; $t=3.219$; $p=0.002$), higher stroke severity (NIHSS: 3.20±2.8 vs. 1.75±2.0; $t=-3.753$; $p<0.001$) and lower functional independence (MBI: 75.4±24.6 vs. 82.7±17.3; $t=1.935$; $p=0.049$) (Table 2). In Table 2, it is shown that PSSD was significantly associated with stroke duration ($\chi^2=24.372$; $p<0.001$), PSP ($\chi^2=9.992$; $p=0.002$), higher body mass (BMI: 27.4±4.8 vs. 26.0±3.5; $t=-2.276$; $p=0.024$), higher number of co-morbidities (2.44±1.2 vs. 1.96±1.2; $t=-2.615$; $p=0.010$) and lower social support (DUFSS: 38.8±10.8 vs. 43.6±9.6; $t=3.096$; $p=0.002$).

After adjustment, the results of binary logistic regression models demonstrated that PSP as a composite variable had significant impact on PSEI (adjusted odds ratio (aOR): 0.492; 95% CI: 0.251-0.965; $p=0.039$). However, PSSD as a composite variable had no significant impact on PSEI ($p>0.05$). While assessing the impact of different PSSD and PSP domains on PSEI, the results showed that sleep disturbances (aOR: 1.855; 95% CI:

Table 2
Factors associated with post-stroke emotional incontinence, post-stroke anger proneness, post-stroke pain and post-stroke sleep disorders (N = 185)

| Variables | PSEI | | | PSAP | | | PSP | | | PSSD | | |
|--|------------|------------|----------------------|------------|------------|---------------------|------------|------------|----------------------|------------|------------|----------------------|
| | Yes | No | Test-statistic | Yes | No | Test-statistic | Yes | No | Test-statistic | Yes | No | Test-statistic |
| Age (years) ^a | 59.1(10.1) | 57.8(10.2) | -0.840 ^{ns} | 57.3(9.58) | 58.8(10.3) | 0.844 ^{ns} | 58.8(10.2) | 57.9(10.2) | -0.562 ^{ns} | 59.7(9.3) | 57.8(10.5) | -1.224 ^{ns} |
| Gender ^b | | | | | | | | | | | | |
| Male | 47/56.6 | 65/63.7 | 0.965 ^{ns} | 23/53.5 | 89/62.7 | 1.166 ^{ns} | 63/53.8 | 49/72.1 | 5.971* | 44/64.7 | 68/58.1 | 0.781 ^{ns} |
| Female | 36/43.4 | 37/36.3 | -0.794 ^{ns} | 20/46.5 | 53/37.3 | -2.270* | 54/46.2 | 19/27.9 | -1.010 ^{ns} | 24/35.3 | 49/41.9 | -2.276* |
| BMI (Kg/m ²) ^a | 26.8(4.2) | 26.3(4.0) | 1.079 ^{ns} | 27.8(4.2) | 26.2(4.0) | 1.532 ^{ns} | 26.8(4.0) | 26.1(4.1) | 15.265*** | 27.4(4.8) | 26.0(3.5) | 0.064 ^{ns} |
| Marital status ^b | | | | | | | | | | | | |
| Married | 75/90.4 | 87/85.3 | 0.084 ^{ns} | 40/93.0 | 122/85.9 | 5.667* | 94/80.3 | 68/100.0 | 13.608*** | 59/86.8 | 103/88.0 | 0.040 ^{ns} |
| Single ^c | 8/9.6 | 15/14.7 | 0.084 ^{ns} | 3/7.0 | 20/14.1 | 5.667* | 23/19.7 | 0/0.0 | 13.608*** | 9/13.2 | 14/12.0 | 0.040 ^{ns} |
| Income level ^b | | | | | | | | | | | | |
| Low | 31/37.3 | 36/35.3 | 0.084 ^{ns} | 9/20.9 | 58/40.8 | 5.667* | 54/46.2 | 13/19.1 | 13.608*** | 24/35.3 | 43/36.8 | 0.040 ^{ns} |
| High | 52/62.7 | 66/64.7 | 0.084 ^{ns} | 34/79.1 | 84/59.2 | 5.667* | 63/53.8 | 55/80.9 | 13.608*** | 44/64.7 | 74/63.2 | 0.040 ^{ns} |
| Stroke duration ^b | | | | | | | | | | | | |
| Early subacute | 20/24.1 | 37/36.3 | 4.828 ^{ns} | 13/30.2 | 44/31.0 | 0.181 ^{ns} | 22/18.8 | 35/51.5 | 24.372*** | 15/22.1 | 42/35.9 | 22.415*** |
| Late subacute | 22/26.5 | 16/15.7 | -0.712 ^{ns} | 8/18.6 | 30/21.1 | -2.581* | 24/20.5 | 14/20.6 | -3.091** | 5/7.4 | 33/28.2 | -0.449 ^{ns} |
| Chronic | 41/49.4 | 49/48.0 | -0.712 ^{ns} | 22/51.2 | 68/47.9 | -3.091** | 71/60.7 | 19/27.9 | -3.753*** | 48/70.5 | 42/35.9 | -1.390 ^{ns} |
| Years of education ^a | 13.2(5.0) | 12.7(4.3) | 1.431 ^{ns} | 14.5(4.4) | 12.4(4.6) | 2.585* | 12.1(4.5) | 14.3(4.5) | 0.540 ^{ns} | 13.1(4.8) | 12.8(4.6) | 3.096** |
| Employment status ^b | | | | | | | | | | | | |
| Employed | 63/75.9 | 74/72.5 | 0.268 ^{ns} | 39/90.7 | 98/69.0 | 8.077** | 80/68.4 | 57/83.8 | 5.341* | 47/69.1 | 90/76.9 | 1.364 ^{ns} |
| Unemployed | 20/24.1 | 28/27.5 | -0.333 ^{ns} | 4/9.3 | 44/31.0 | -3.091** | 37/31.6 | 11/16.2 | -0.394 ^{ns} | 21/30.9 | 27/23.1 | -2.615* |
| Number of Co-morbidities ^a | 2.17(1.2) | 2.1(1.2) | -1.935* | 2.09(1.5) | 2.15(1.2) | -3.091** | 2.16(1.1) | 2.09(1.5) | 3.20(2.8) | 2.44(1.2) | 1.96(1.2) | -1.390 ^{ns} |
| Stroke severity ^a (NIHSS) | 3.07(2.5) | 2.33(2.7) | 1.431 ^{ns} | 3.72(2.8) | 2.35(2.5) | 2.585* | 3.20(2.8) | 1.75(2.0) | 0.540 ^{ns} | 3.01(2.5) | 2.46(2.7) | 3.096** |
| Social support ^t (DUFSS) | 40.7(10.2) | 42.9(10.4) | 1.235 ^{ns} | 38.3(12.4) | 42.9(9.4) | 1.966* | 41.5(10.6) | 42.4(9.9) | 1.935* | 38.8(10.8) | 43.6(9.6) | -0.365 ^{ns} |
| Functional independence ^a (MBI) | 75.5(25.5) | 80.1(19.9) | 8.498** | 71.4(28.6) | 79.6(20.4) | 0.166 ^{ns} | 75.4(24.6) | 82.7(17.3) | 1.935* | 78.9(25.4) | 77.6(24.6) | 9.992** |
| PSP ^b | | | | | | | | | | | | |
| Yes | 62/74.7 | 55/53.9 | 8.498** | 26/60.5 | 91/64.1 | 0.166 ^{ns} | 53/77.9 | 64/54.7 | 15/22.1 | 53/77.9 | 64/54.7 | 9.992** |
| No | 21/25.3 | 47/46.1 | 8.498** | 17/39.5 | 51/35.9 | 0.166 ^{ns} | 15/22.1 | 53/45.3 | 15/22.1 | 53/45.3 | 53/45.3 | 9.992** |
| PSSD ^b | | | | | | | | | | | | |
| Yes | 33/39.8 | 35/34.3 | 0.584 ^{ns} | 15/34.9 | 53/37.3 | 0.085 ^{ns} | 38.8(10.8) | 43.6(9.6) | 0.540 ^{ns} | 38.8(10.8) | 43.6(9.6) | 3.096** |
| No | 50/60.2 | 67/65.7 | 0.584 ^{ns} | 28/65.1 | 89/62.7 | 0.085 ^{ns} | 41.5(10.6) | 42.4(9.9) | 0.540 ^{ns} | 43.6(9.6) | 43.6(9.6) | 3.096** |

^a – independent t-test in mean and standard deviation; ^b – chi square in number and percentages; ^c – included the unmarried, divorced, separated or widowed; PSEI-post-stroke emotional incontinence; PSAP post-stroke anger proneness; PSP post-stroke pain; PSSD post-stroke sleep disorders; NIHSS National Institute of Health Stroke Scale; DUFSS Duke University of North Carolina Functional Social Support Questionnaire; MBI Modified Barthel Index; ns non-significance; * p<0.05; **p<0.01; *** p<0.001.

Table 3**Binary regression model relating the impact of composite post-stroke sleep disorders and post-stroke pain on post-stroke emotional incontinence**

| Variable | B | β | 95% CI of β (lower-upper) | p-value |
|-----------------|--------|---------|------------------------------------|---------|
| Age | 0.008 | 1.008 | 0.978-1.039 | 0.598 |
| Gender | 0.092 | 1.097 | 0.587-2.049 | 0.772 |
| Stroke severity | 0.052 | 1.053 | 0.933-1.188 | 0.402 |
| PSQI | 0.049 | 1.050 | 0.980-1.125 | 0.164 |
| PSP | -0.708 | 0.492 | 0.251-0.965 | 0.039* |

B unstandardised beta; β standardised beta; CI confidence interval; PSQI Pittsburgh Sleep Quality Index; PSP post-stroke pain; *significance at $p < 0.05$.

Table 4**Binary regression model relating the impact of different domains of post-stroke sleep disorders and post-stroke pain on post-stroke emotional incontinence**

| Variable | B | β | 95% CI of β (lower-upper) | p-value |
|------------------------------------|--------|---------|------------------------------------|---------|
| Age | 0.004 | 1.004 | 0.972-1.036 | 0.831 |
| Gender | -0.078 | 0.925 | 0.458-1.870 | 0.828 |
| Stroke severity | 0.049 | 1.051 | 0.918-1.202 | 0.473 |
| Post-stroke sleep disorders | | | | |
| Sleep quality | -0.071 | 0.932 | 0.550-1.579 | 0.793 |
| Sleep latency | -0.324 | 0.723 | 0.483-1.082 | 0.115 |
| Sleep duration | 0.178 | 1.194 | 0.695-2.052 | 0.520 |
| Sleep efficiency | 0.023 | 1.023 | 0.593-1.765 | 0.935 |
| Sleep disturbances | 0.618 | 1.855 | 1.096-3.140 | 0.021* |
| Sleep medication | -0.171 | 0.843 | 0.564-1.260 | 0.406 |
| Daytime sleep | 0.129 | 1.137 | 0.747-1.731 | 0.548 |
| Post-stroke pain | | | | |
| Post-stroke headache | -1.010 | 0.364 | 0.153-0.864 | 0.022* |
| Central post-stroke pain | -0.214 | 0.808 | 0.382-1.708 | 0.576 |
| Peripheral post-stroke pain | -0.032 | 0.968 | 0.269-3.485 | 0.961 |
| Other pain | 1.381 | 3.978 | 0.903-17.529 | 0.068 |
| Pain severity | 0.001 | 1.000 | 0.981-1.020 | 0.996 |

B – unstandardised beta; β – standardised beta; CI – confidence interval; * – significance at $p < 0.05$

1.096-3.140; $p=0.021$) and headache (aOR: 0.364; 95% CI: 0.153-0.864; $p=0.022$) were the only domains of PSSD and PSP that had significant impact on PSEI (Tables 3 and 4). Furthermore, PSH (aOR: 0.052; 95% CI: 0.011-0.238; $p < 0.001$) was the only domain of PSP that was significantly associated with PSAP. In addition, education (aOR: 1.223; 95% CI: 1.309-1.439; $p=0.015$), employment (aOR: 0.122; 95% CI: 0.023-0.653; $p=0.014$) and stroke severity (aOR: 1.467; 95% CI: 1.111-1.936; $p=0.007$) were significantly associated with PSAP. Nonetheless, PSSD and

PSP treated as composite variables and none of domains of PSSD were associated with PSAP in the logistic regression analyses ($p > 0.05$) (Tables 5 and 6).

DISCUSSION

In this cross-sectional observational study, the prevalence and correlates of PSSD, PSP, PSAP and PSEI were examined among Nigerian stroke survivors. It was further investigated whether PSSD and PSP, as composite variables, and the different com-

ponents of PSSD (sleep quality, sleep latency, sleep duration, sleep efficiency, sleep disturbances, use of sleep medication and daytime sleep dysfunction) as well as PSP (post-stroke headache, central post-stroke pain, peripheral post-stroke pain, other pain and pain severity) were associated with PSAP and PSEI. The findings revealed a prevalence of 36.8%, 63.3%, 23.2% and 44.9%, respectively, for PSSD, PSP, PSAP and PSEI. The most prevalent domains of PSSD and PSP in the studied cohort of stroke survivors were sleep latency and peripheral post-stroke pain.

Table 5**Binary regression model relating the impact of composite post-stroke sleep disorders and post-stroke pain on post-stroke anger proneness**

| Variable | B | β | 95% CI of β (lower-upper) | p-value |
|-------------------------|--------|---------|------------------------------------|---------|
| Age | 0.042 | 1.043 | 0.983-1.106 | 0.162 |
| Gender | 0.339 | 1.403 | 0.597-3.298 | 0.437 |
| BMI | 0.030 | 1.030 | 0.922-1.150 | 0.600 |
| Income | -0.278 | 0.758 | 0.256-2.238 | 0.615 |
| Education | 0.105 | 1.110 | 0.994-1.241 | 0.064 |
| Employment | -2.111 | 0.121 | 0.027-0.540 | 0.006* |
| Stroke severity | 0.249 | 1.282 | 1.050-1.566 | 0.015* |
| Social support | -0.032 | 0.969 | 0.929-1.011 | 0.146 |
| Functional independence | 0.002 | 1.002 | 0.983-1.002 | 0.820 |
| PSQI | -0.034 | 0.966 | 0.872-1.072 | 0.512 |
| PSP | 0.015 | 1.015 | 0.398-2.589 | 0.975 |

B – unstandardised beta; β – standardised beta; CI – confidence interval; BMI – body mass index; PSQI – Pittsburgh Sleep Quality Index; PSP – post-stroke pain; * – significance at $p < 0.05$

Table 6**Binary regression model relating the impact of different domains of post-stroke sleep disorders and post-stroke pain on post-stroke anger proneness**

| Variable | B | β | 95% CI of β (lower-upper) | p-value |
|------------------------------------|--------|---------|------------------------------------|---------|
| Age | 0.036 | 1.037 | 0.973-1.105 | 0.267 |
| Gender | -0.064 | 0.938 | 0.329-2.672 | 0.924 |
| BMI | 0.115 | 1.122 | 0.982-1.282 | 0.091 |
| Income | 0.637 | 1.891 | 0.441-8.109 | 0.391 |
| Education | 0.201 | 1.223 | 1.309-1.439 | 0.015* |
| Employment | -2.105 | 0.122 | 0.023-0.653 | 0.014* |
| Stroke severity | 0.383 | 1.467 | 1.111-1.936 | 0.007* |
| Social support | -0.028 | 0.972 | 0.925-1.022 | 0.273 |
| Functional independence | 0.007 | 1.007 | 0.983-1.031 | 0.588 |
| Post-stroke sleep disorders | | | | |
| Sleep quality | -0.055 | 0.947 | 0.471-1.903 | 0.878 |
| Sleep latency | -0.098 | 0.906 | 0.532-1.544 | 0.718 |
| Sleep duration | 0.554 | 1.741 | 0.829-3.655 | 0.143 |
| Sleep efficiency | -0.810 | 0.445 | 0.180-1.099 | 0.079 |
| Sleep disturbances | 0.322 | 1.380 | 0.662-2.879 | 0.390 |
| Sleep medication | -0.448 | 0.639 | 0.329-1.240 | 0.185 |
| Daytime sleep | -0.302 | 0.739 | 0.367-1.489 | 0.398 |
| Post-stroke pain | | | | |
| Post-stroke headache | -2.957 | 0.052 | 0.011-0.238 | 0.000** |
| Central post-stroke pain | 0.405 | 1.499 | 0.282-7.591 | 0.635 |
| Peripheral post-stroke pain | 0.261 | 1.299 | 0.160-10.553 | 0.807 |
| Other pain | 2.526 | 12.507 | 0.890-175.727 | 0.061 |
| Pain severity | -0.009 | 0.992 | 0.959-1.025 | 0.611 |

B – unstandardised beta; β – standardised beta; CI – confidence interval; BMI – body mass index; PSQI – Pittsburgh Sleep Quality Index; PSP – post-stroke pain; * – significance at $p < 0.05$; ** – significance at $p < 0.001$

Although the prevalence of PSSD, PSP, PSAP and PSEI varies depending on the instruments utilised and time of post-stroke assessment, the rates obtained in this study are comparable to the global prevalence reported in literature. In a recent systematic review and meta-analysis, the rate of PSSD, assessed using sleep quality questionnaire, has been established as between 19.8% to 69%⁶⁴, while in a review by Harrison and Field²⁶, these authors made an estimation of up to 11-66% for PSP. Moreover, the results of a meta-analysis involving 2,608 patients put the prevalence of PSAP at between 12 to 57%⁶⁵, while in reports, the prevalence of PSEI has been indicated as being up to 40%^{16,17}. Furthermore, similar to reports by other researchers, sleep latency^{31,66,67} and peripheral neuropathic pain^{33,47} were mostly prevalent among the investigated community-dwelling stroke survivors in this study.

According to the findings of this study, several factors, including PSP, stroke duration, body mass, number of co-morbidities and social support, were associated with PSSD. These factors have also been mentioned in earlier studies^{31,68-74}. Moreover, gender, marital status, income, employment status, education, stroke duration, stroke severity and functional independence were significantly associated with PSP. In previous studies, significant associations between PSP and gender, stroke duration, stroke severity and functional independence have been reported^{26,33,45}. The relationship of PSP with some socio-demographic characteristics of stroke survivors, including marital status, income level, employment status and years of education, have not been properly elucidated in the literature as done in this study, which calls for more research. It is possible that stroke survivors with no companionship, low income level, unemployed or with low education level may experience or report different pain syndromes.

Concerning PSAP, PSP and PSSD as composite variables, none were associated with PSAP. However, while assessing the influence of different PSP

and PSSD domains, PSAP was significantly associated with PSH, a domain of PSP. None of the PSSD domains were associated with PSAP in this study. While there is a lack of data to be compared with the findings of this study, PSH is a common pain subtype after stroke²⁶. Although, the pathophysiology of PSH is not yet fully known, tension headache is common in stroke survivors and involves stimulation of trigemino-vascular system resulting from brain infarction⁷⁵⁻⁷⁷. Meanwhile, the bio-psychosocial model propounded by Gatchel et al. indicates a link between emotional distress and pain⁷⁸. Evidence has earlier shown that emotional disorders, e.g. depression, are associated with pain in stroke⁷⁹. The presence of pain often increases feelings of anger and irritability⁸⁰. The findings of our study indicate that PSH, out of many domains of PSP, is implicated in anger and anger proneness among stroke survivors.

Stroke survivors exert more energy than during the pre-stroke stage while carrying out most basic activities, which often lead to physical exertion. Meanwhile, physical exertion is reportedly associated with PSH⁸⁰ due to blood vessel constriction in the face, neck and head, as well as increased blood pressure⁸¹. It is possible that these community-dwelling stroke survivors, while attempting to engage in social and physical activity, experience surges in PSH and thereby, becomes angry and irritable. Furthermore, stroke survivors may be prone to anger or become irritable if they are not able or rather willing to engage in social or physical activity when engaging in them results or precipitates headache. The findings of an earlier study had indicated that PSAP is a predictor of social isolation in patients with stroke¹⁷. In addition, the results of a qualitative study have indicated that stroke survivors with PSH may present with pain catastrophising as they opined that they may be experiencing repeat stroke or formation of a new clot with the attendant fear, heightened emotion and worry⁷⁶ which may precipitate anger. Some PSAP symptoms, including hitting or hurting others, kicking,

biting, throwing objects, cursing and screaming, impulsiveness, hostility, intolerance and being less generous, which are unfortunately often directed towards their caregivers, family, friends and colleagues^{7,82}. These symptoms of anger further decrease quality of life for stroke survivors and impair good rehabilitation outcomes^{9,10}. Therefore, appropriate attention may be needed in addressing the symptoms of PSH in this cohort for combating PSAP. This is more so as it has been indicated in reports that stroke survivors with PSP found PSH more disabling than any other domains of PSP and tend to report and use more analgesics for PSH than any other PSP domains⁴⁵. Other factors in multivariate analysis found to be significantly associated with PSAP apart from PSH were education, employment and stroke severity. Several authors have similarly found that stroke severity and motor or neurological dysfunction is a consistent correlate of anger proneness in individuals with stroke^{2,15,17,82,83}. However, there is dearth of data on the influence of socioeconomic factors, including education and employment, on PSAP as found in this study. It is plausible for stroke survivors with low socio-economic status to be more aggressive and irritable.

In respect to PSEI, PSP and not PSSD were associated with PSEI when treated as composite variables. In addition, PSH and sleep disturbances as PSP and PSSD domains were significantly associated with PSEI. This finding indicates that stroke survivors with pain may likely experience excessive laughing or crying. This is not farfetched as evidence has shown that emotional incontinence, such as moaning, groaning and crying are the main avenue for non-verbal vocalisations of pain by patients⁸⁴. Furthermore, since PSP is a known factor associated with reduction in social participation and functional activities in stroke survivors^{32,33,43,85}, the loss or decrease in social or physical participation by stroke survivors occasioned by PSP can make them feeling sorry for themselves and may lead to emotional incontinence. A feeling of helplessness or inability to perform

basic pre-stroke activities by stroke survivors may encourage rumination, which may facilitate emotional incontinence. In a previous report, it has been noted that some psychological disorders, i.e. depression, anxiety and stress are common in patients with higher ruminating tendency⁸⁶.

Similar to the findings for PSAP, only PSH from PSP domains was significantly associated with PSEI. Coupled with the evidence which has shown that PSH is very disabling to stroke survivors⁴⁵, mood disorders are reportedly associated with headache^{87,88}. Tension headache is the most common sub-type of headache in stroke which has been found to result from tension in the face and neck^{80,81}. Meanwhile, emotional incontinence such as crying also activates and tenses up the jaw, neck and facial muscles, which may trigger headache⁸⁹. Thus, there is apparent association between facial muscle tension resulting from emotional incontinence and headache after a stroke episode. Nonetheless, longitudinal studies may be warranted to ascertain the direction of association between the onset of PSH and emotional incontinence.

Furthermore, sleep disturbances as a domain of PSSD were significantly associated with PSEI. In this study, stroke survivors with emotional incontinence reported higher sleep disturbances than those without PSEI. One of the most common sleep disorders among stroke survivors is insomnia, which largely occurs from nighttime sleep disturbances^{34,39,40}. According to PSQI, sleep disturbances include waking up in the middle of the night or early in the morning, having to get up to use the bathroom, experiencing pain, etc. Stroke survivors are prone to insomnia from sleep disturbances partly due to the medications often prescribed for stroke and its co-morbidities⁹⁰. For instance, it has been reported that anti-hypertensive medications such as beta-blockers and diuretics induce insomnia, disrupt the rapid eye movement (REM) cycle, cause early morning wakeness, bad dreams and painful calf cramps while asleep⁹⁰. Apart from strong evidence linking sleep disturbances to

limited functional recovery and social participation, insomnia is strongly connected with poor life satisfaction among stroke patients [90], thus, it is possible for stroke survivors with sleep disturbances to be more prone to emotional disorders such as PSEI. It is common knowledge that sleep deprivation is an independent predictor of many psychological disorders, including depression, anxiety, fatigue and cognitive impairment⁹¹, therefore, it is not surprising that sleep disturbances are associated with another related disorder, PSEI.

The brain tissue damage following stroke is related to sleep disturbances and emotional disorders experienced by stroke survivors^{83,92}. Although, there is yet no consensus, it has been shown in reports that PSEI, PSAP and PSD share similar pathogenic serotonergic mechanisms and lesion distribution^{7,83}. Thus, these factors suggest that indices alike sleep disturbances that are associated with depression, anxiety, cognition and fatigue may show similar traits as PSEI. This was also indicated in the findings of this study. However, as stated earlier, sleep disorders were not associated with PSAP in this study, which may warrant further inquiries on the mechanisms between sleep disorders and emotional post-stroke disorders. Nonetheless, these discrepancies may also be a result of different factors (genetic, social, environmental and neurologic) that are uniquely related to PSAP and PSEI^{15,16}. In addition, despite the fact that PSD, PSAP, PSEI and other emotional disorders in stroke are associated with neurochemical derangement secondary to brain injury, there are subtle differences in their manifestations and correlates¹⁵. According to the literature on the subject, some of these differences include varying anatomic locations for each of these emotional disorders^{4,17,93}, as well as varying factors associated with these emotional disorders at different stages of stroke^{15,94}.

This study has a few potential limitations. First of all, this is a cross-sectional observational study, which precludes us from inferring causality. Secondly, although we employed

validated tools in assessing sleep disorders, pain, emotional incontinence and anger proneness, their self-reporting nature may have introduced reporting bias. Thirdly, due to the methodology, we excluded patients with cognitive impairments, severe communication problems and those living alone, while including a relatively small sample from just two centres. Due to this, our findings may not be generalisable to all stroke survivors. Therefore, prospective studies with larger samples drawn from multiple centres may be needed to consolidate the findings of this study.

CONCLUSION

The rates of PSSD, PSP, PSAP and PSEI among Nigerian stroke survivors are 36.8%, 63.3%, 23.2% and 44.9%, respectively. Several factors including PSP, stroke duration, body mass, number of co-morbidities and social support were associated with PSSD. Furthermore, gender, marital status, income, employment status, education, stroke duration, stroke severity and functional independence were significantly correlated with PSP. The presence of post-stroke headache was associated with PSAP, while sleep disturbances and PSH were connected with PSEI. Specific, other than composite sleep disorders, and type, rather than presence or severity of pain after stroke, appear to be associated with PSAP and PSEI. Adequate screening and treatment of pain and sleep disorders among stroke survivors may lessen the prevalence and burden of PSAP and PSEI.

Ethics Committee

The Ethics Review Committee of the Osun State University Teaching Hospital, Osogbo, Nigeria gave approval for the study (LTH/EC/2021/01/496).

List of abbreviations

PSAP – Post-stroke anger proneness; PSEI – Post-stroke emotional incontinence; PSP – Post-stroke pain; PSSD – Post-stroke sleep disorders; CPSP – Central post-stroke pain; PPSP – Peripheral post-stroke pain; PSH – Post-stroke headache; PSD – Post-stroke depression; PSA – Post-stroke anxiety; PSF –

Post-stroke fatigue; STAS – Spielberger Trait Anger Scale; PSQI – Pittsburgh Sleep Quality Index; VAS – Visual Analogue Scale; DUFSS – Duke University of North Carolina Functional Social Support Questionnaire; MBI – Modified Barthel Index; NIHSS – National Institutes of Health Stroke Scale; aOR – Adjusted odds ratio; CI – Confidence interval

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