Psychological considerations in gastrointestinal nursing

Julia Williams

Abstract

Body image changes and psychological adaptation are often associated with patients who have gastrointestinal disease due to the potential alteration to physical appearance through the very nature of the disease process or treatment. This article describes some of the psychological issues highlighted by patients with gastrointestinal disease, including loss of bowel control, withdrawal and concealment. It highlights altered image difficulties and adaptation through the patients' journey and treatment with illustrations from patients' narratives. In doing so, it explores the nurse's role and stresses the necessity for nurses to seek training to become skillful in counselling this group of patients towards exploring and identifying their individual psychological problems.

Key words: Gastrointestinal disease ▪ Body image ▪ Psychological disturbance

Often patients with diseases of the gastrointestinal tract face anxiety and apprehension between the demands made by their illness and its treatment, and the demands made by their normal societal roles. In the main, patients do appear to adapt and cope with their disease trajectory, however, some find their illness a source of great anxiety that results in significant psychological difficulties. As one patient describes why she found her ileostomy disturbing (Interview 18 script, 2002):

> **'It was pretty grotesque really. It was just so weird to have this bit of your inside popping out and also to think that you've got "poo" on the outside of your body, you know sort of carried with you rather than just got rid. It was really hard to get my head around that'.**

The anxieties faced by this group of patients might include alteration in physical appearance as a result of medical or surgical treatment, change or loss to bowel function, as well as restrictions to lifestyle and daily activities. Change in physical appearance may make individuals feel less attractive, thus leading to feelings of insecurity, lack of confidence and loss of control which in turn can be a threat to existing relationships (Price, 1990).

This article discusses psychological problems faced by patients with gastrointestinal disease with a focus on body image, and how alteration in body image might well lead to feelings of anxiety, depression, low self-esteem, helplessness and hopelessness, obsession and ultimately withdrawal. There is evidence to suggest that little difference is noted in the psychological problems experienced by patients with inflammatory bowel disease and cancer (Thomas et al, 1998; Bekkers et al, 1995). Therefore, it is appropriate to explore psychological disturbances in relation to gastrointestinal disease as a whole. It is important to note, however, significant psychological difference between the diseases processes occur with the creation of a stoma (White and Unwin, 1998). This article will also explore ways in which nurses can assist the patient through this period of adaptation.

Body image

In general, humans are very critical of how they look or which part of their body they perceive to be their best, or worst, attributes. Society puts a great deal of attention on body image and physical attractiveness, youthfulness, sexuality and appearance. The way people see themselves is an important part of their everyday lives (Salter, 1997). If there is a sudden alteration in this picture it can have psychological implications for the way people behave (Price, 1990).

Defining body image is not a straightforward issue and in the main it is poorly defined; however, it does involve aspects of neurology, sociology and psychology (Newell, 1991). There are also several factors which can affect body image, including genetics, socialization, culture, race, fashion, the media and health education (Price, 1990). Body image involves people's perception, imagination, emotions, and physical sensations of, and about, their bodies (Salter, 1997). It is certainly not static, but ever-changing; it is sensitive to mood, environment and physical experience. Body image is,

> **'...the picture we form in our minds of how our body feels, behaves and conforms to commands we give it.. our thoughts are based upon the reality of our body as it changes and ages and we are influenced by social, cultural and personal norms' (Price, 1990).**

Julia Williams is Lecturer in Gastrointestinal Nursing, St Mark's Hospital, Watford Road, Harrow, Middlesex

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Body image is not based on fact, but is psychological in nature and much more influenced by self-esteem than by actual physical attractiveness as judged by others. It is not inborn, but learned. This learning occurs in the family and among peers, but these only reinforce what is learned and expected culturally (Newell, 1991).

It might be considered that body image dissatisfaction is such an epidemic in society that it's almost considered to be normal. For some people a daily activity might be to purchase a newspaper and/or magazine. The newsstand displays images of men and women alike, whose images are offered as nearly perfect in society's point of view. What is not shown is the fact that these images are often enhanced by computers and made to look perfect with airbrushing. In doing so, teeth can be made whiter, skin can be darkened or lightened, blemishes and moles covered, waists and thighs can be reduced and breasts can be enlarged. The average man or woman cannot compete with these images and what is so unfortunate about those who strive for the perfect body image is that society's ideals of what looks best are constantly changing. It guarantees that they will never be able to reach their goals and almost always ensures a sense of failure (Bekkers et al, 1995). It is refreshing to see the recent Dove™ promotion encouraging society to become involved in the great beauty debate by campaigning for real beauty.

Body image is recognized as being intrinsically linked to the notions of self-concept, self-esteem and self-worth from which a person functions (Price, 1990). Wassner (1982) accepts that if people are happy with their physical appearance they are more likely to experience positive feelings of self-esteem, whereas in contrast, Burnard and Morrison (1990) suggest that someone who is unhappy with their appearance will experience negative self feelings. When someone falls ill they are more likely to become aware of their body and its loss of function. If this illness also involves an alteration in body shape or function, then there is an increased likelihood that psychological disturbances will occur (Virgin-Elliston and Williams, 2004).

Body image disturbances for the patient with gastrointestinal disease

There may be a variety of reasons for changes in body perceptions of patients with gastrointestinal disease, including manifestations of the disease, loss of control of bowel function, side-effects of medication and surgery.

Although for many patients the inner workings of their body is not clearly understood, any disruption to it can cause concern and it is thought that loss of bowel function is one of the initial concerns and is obviously a major concern for this patient group (Williams, 2004). The skills of controlling elimination that are socially acquired are learned at an early stage. Western society has developed rules that are publicly acceptable for elimination behaviour. Parents teach children these rules, whereby children associate wetting or soiling their clothes and bad behaviour. These rules are then instilled into us through our lifetime so that when loss of control of elimination occurs through ill-health, public humiliation is evident, which in turn represents a major threat to self-esteem. As bodily waste is associated with disgust (Garria et al, 2005) and any loss of bowel control can relate to regression in behaviour and exposure of oneself (Holden and Littlewood, 1991).

When discrepancies occur in body image because of the differences in the way the patient has always perceived his/her body and how he/she now sees it as a result of the disease process, mental conflict can occur. This conflict can produce many anxieties which will manifest in various ways. Furthermore, the disease process not only alters the body's external physical appearance but also removes the ability to control elimination of body waste; a double assault on body image. As one patient recalls while adjusting to his stoma (Interview 35 Transcript, 2002):

> **'My social life was very bad, I had no social confidence. I was afraid of people smelling this stuff, obviously if it leaked you could smell it, but I was always concerned that there was a proper fixture and fitting on. I made sure it was well adhered and of course I kept myself very clean'.**

The concept a person has of themselves will influence his/her behaviour and opinion, as this is a part of his personality (Newell, 1991). Rogers (1959) offers a concept of self as consisting of 'all the ideas, values and perceptions that characterize the individual, what he/she is and what he/she can and can't do'. Self-concept has the ability to influence the behaviour of that person and is responsible for attitudes and well-being. The notion of loss of self-concept can be said to embrace body image, role performance, self-identity and self-esteem. The patient lives with the threat of loss of health, the inability to work, and the absence of self-determination. Anxiety is therefore often combined with guilt, anger or denial, and the patient may undergo the grieving process (Price, 1990). It is not only the patient who is affected by the disease's progress; immediate family and loved ones often have to learn to cope with the highs and lows of the disease process. The stress experienced by the patient can be mirrored by the family, so when quality-of-life issues are raised, the patient may not be the only one for whom there is concern (Fawcett and Smith, 2005).

Patients who are symptomatic from their gastrointestinal disease are more likely to withdraw from any possible situations where they feel vulnerable. Withdrawal is one strategy that may safeguard against potential negative interactions (Garcia et al, 2005). Fearing unexpected loss of faeces with subsequent odour, results in the patient curtailing activities relating to occupational, social, sexual and physical events as a means of avoiding shame and embarrassment (Garcia et al, 2005). Attempts are then made to conceal this shame and embarrassment, leading to increased psychological distress. Patients may fear the thought of being 'found out', resulting in constant worry which may lead to obsessive behaviour (Smart and Wegner, 1999). This concealment of shame forces the individual to choose between being true to himself and others, risking possible rejection, and hiding an aspect of himself as a means of avoiding rejection (Goumay and Rogers, 2000), which ultimately poses a threat to their self-esteem.

It would seem apparent that feelings of helplessness and hopelessness are more associated with long-term chronic disease as patients feel that recovery is highly unlikely (Junken and Beitz, 2005.

Sexual wellbeing

As described by Maslow (1974), within the hierarchy of needs, the basic human need of sexual expression is a necessity throughout life, despite disability or major illness. Sexuality has been described as a highly complex phenomenon as it encompasses much more than just the physical acts of sexual expression and involves the totality of being human. Hence, it has an influence upon self-image, feelings and interpersonal relationships (Junken and Beitz, 2005). Sexuality involves biological, psychological and social aspects, and a person's self-image, feelings and relationships with others affect sexual behaviours (Sprunk and Alteneder, 2000). The World Health Organization (1975) offers three basic elements of sexual well-being:

The capacity to enjoy and control sexual and reproductive behaviour in accordance with social and personal ethics

- Freedom from fear, shame, guilt, misconceptions and other psychological factors that inhibit the sexual response and impair sexual relationships
- Freedom from organic disorders, disease and deficiencies that may interfere with either sexual or reproductive function or both.

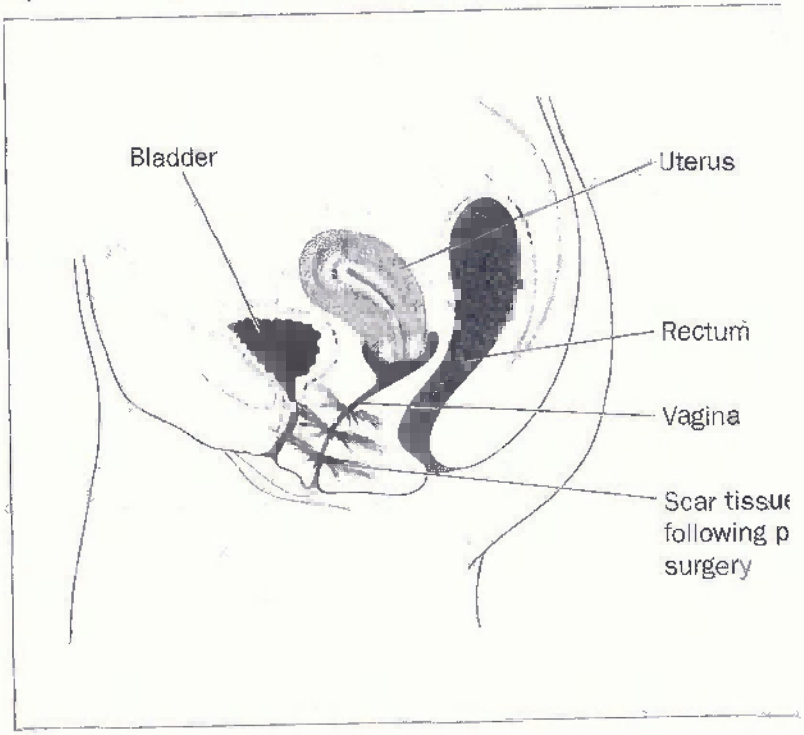
However, as previously mentioned, it must be remembered that expressing sexuality is much more than sexual intercourse, as ultimately it is the human contact, comfort and security, as a measure of self-worth providing cohesion in a relationship (Borwell, 1997).

Sexual dysfunction

Males and females may have different physical concerns regarding sexual health after surgery that includes the creation of a stoma. The most common sexual dysfunction reported by women with stomas is dyspareunia, or painful intercourse (Sprunk and Alteneder, 2000). Scar tissue from pelvic surgery may create bands around the vagina resulting in tightness (*Figure 1*). Pelvic surgery also results in the drying of the natural lubrication of the vagina and the consequence of both the tightness and vaginal dryness leads to friction and pain on sexual intercourse (Topping, 1990). Lack of lubrication may also be a result of the menopause or removal of ovaries resulting in decrease oestrogen production (Golis, 1996).

In the case of the male patient, surgery may result in damage to the nerves that control ejaculation and erection and cause altered sexual function. The amount of nerve damage depends on the location of ligation during surgery (*Figure 2*). For example, the risk of impotence is very high in men who undergo radical cystectomy (Filingham and Douglas, 2004). Studies show that approximately 90% of men have reported impotence following such surgery for bladder cancer (Anderson, 1993; Dorey, 2000). Sexual dysfunction also may take the form of retrograde ejaculation or dry orgasms. In this instance the bladder neck fails to close properly during orgasm resulting in semen

Figure 1. Scar tissue from pelvic surgery may create bands around the vagina resulting in tigh



entering the bladder rather than being forced out through the urethra. Sterility or an inability to produce sperm is also a complication of radical surgery (Young-McGaughan 1999) and for men who engage in anal intercourse the loss of the rectum, in the case of permanent stoma surgery, can remove a major source of pleasure (Salter, 2002).

Drug therapy also has significant implications for body image alterations and sexual dysfunction, as in some cases the side-effects of drug therapy can outweigh the benefits (Salter,

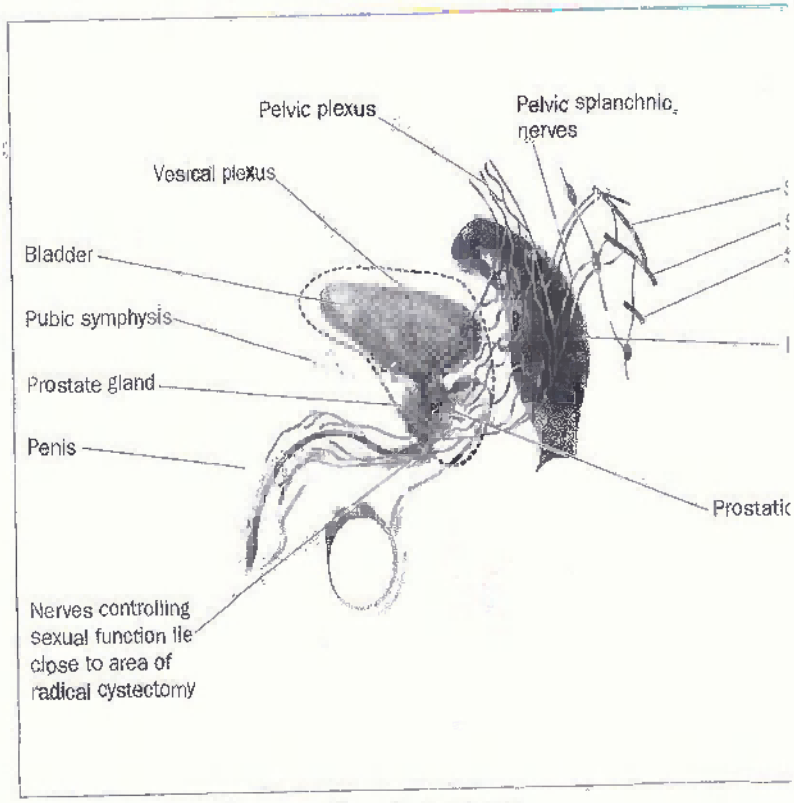


Figure 2. Sites of nerve damage caused by radical cystectomy.

1997). An example of this is the administration of steroids. Known for the side-effect of mood swings, steroids can induce a range of feelings from that of enhanced well-being to depression and with this comes suppressant effects on libido and on social and sexual activities (Giese and Terrell, 1995). Changes in physical appearance, such as weight gain, moon face, skin pigmentation, acne and purple striae on the abdomen can all cause anxiety and may cause the patient to question the benefits. Also, some cytotoxic drug therapies are linked to infertility problems, lethargy, nausea and vomiting and general feelings of being unwell (Giese and Terrell, 1995). All these factors will interrupt normal daily activities of living, including personal and intimate relationships as well as sexual desire (Webb, 1994).

Nursing strategies

Gamel et al (1993) suggest that there may be five factors that influence sexuality-related approaches to healthcare practice with regard to sexual wellbeing (*Table* 1). Some healthcare professionals believe that discussing sexuality will make patients feel uncomfortable. However a survey showed that the patients' need for such information and how its focus lacked in their rehabilitation and adaptation (Goodwin, 1992).

In nursing, perhaps the clearest and most comprehensive account of body image comes from Price (1990). At the core of this framework is a view of body image as consisting of three related components: body reality, body ideal and body presentation. Price (1990) views the elements as existing in a state of tension, or balance, which together make up a satisfactory body image which humans strive to maintain. Therefore it may be supposed that alterations to body reality, for example from surgery or the disease process, will lead to tension between the reality and body ideal. The individual may attempt to decrease this tension by altering the body presentation to compensate for the deficiency in body reality or may change their own attitudes as to what constitutes their body ideal, invoking particular coping strategies and social supports in order to help make these compensatory changes.

Table 1. Factors that influence sexuality-related approached to healthcare practice

- Knowledge of sexuality
- Attitudes about sexuality
- Opinions about professional responsibility to address sexuality
- Continuing education about sexuality
- Comfort in addressing sexuality

Source: Gamel et al (1993)

Nursing support of the patient as they adapt through the differing levels of coping may facilitate integration of body reality into body ideal and presentation. Kelly (1991) identifies four levels of coping: technical, intrasubjective, interpersonal and intersubjective. In the instance of the patient with gastrointestinal disease, the technical coping phase might allow the mastery of the new skills needed to manage body waste; the intrasubjective coping phase is important in relation to assessing the individual's ability to deal with anger, worry and anxiety. In the interpersonal phase of coping, anxieties relating to sexual issues might materialize. As the patient enters the final intersubjective phase, adaptation towards alteration in body image begins to stabilize.

Nursing management

During the period of adaptation, patients with gastrointestinal disease need to grow and learn to live with their condition. The way to do this is not to assume we know what they want to learn, but rather to offer a participative partnership that facilitates their control of what and how it is offered (Koch et al, 2004). Salter (1997) explores four stages of adaptation and acceptance as impact, retreat, acknowledgement and reconstruction. In the case of the patient with a gastrointestinal disorder, the initial two stages might be viewed as shock of diagnosis of disease and what impact this has upon the individual, thus leading to retreat. Acknowledgement is seen as a period of decision-making, for example exploring surgical options, and finally the patient begins to rebuild his/her life and enters the reconstruction stage by bringing all aspects of health together.

Nurses act as a professional mirror for patients trying to improve their damaged body image (Price, 1993). According to Webb (1985), simply being in hospital and needing assistance with the daily activities of living can influence body image, as personal hygiene, arranging hair and dressing all contribute to body image because people express their personalities through their appearance. Patients should be involved in their own care so that with the information offered they are in a position to make an informed choice as to their process of adaptation.

Bell (1989) identifies three challenges for nurses when promoting sexual wellbeing for patients:

- They must feel comfortable in addressing such issues and therefore examine feelings towards their own sexuality
- They must be knowledgeable in areas including anatomy and physiology, pathophysiology and psychosexual development and functioning
- They must be sensitive towards the cultural, religious and ethical implications of the patient's situation.

Conversations regarding sensitive matters, such as relationships, sexual matters and issues relating to body image, can be challenging and sometimes difficult. Cultural differences, the fear of upsetting patients, as well as underdeveloped counselling and interpersonal skills can inhibit an open and effective means of communication. Skills needed to assess patients with psychological disturbances evolve through interpersonal skills, including trust, empathy and touch. Verbal and non-verbal communication hold the same importance, as patients are often aware of healthcare professionals' facial expressions, tone of voice and touch.

These skills are not easily learned or indeed taught. The most effective method of developing interpersonal skills is through experiential learning (Kolb, 1984). Kolb's work integrates knowledge, thoughts, feelings and actions through reflective observation. Current curriculum development is

in progress at the authors' academic institute, exploring creative methods of teaching in the classroom. The more knowledge healthcare professionals have regarding psychological issues, the more positive their attitudes will be leading to more comfortable and competent interactions with patients (Taylor, 1994).

By establishing a rapport, nurses can help to alleviate the patient's anxiety and embarrassment by putting the issues expressed by the individual into context and teaching them techniques to move forward to adaptation. The most important thing nurses can do is create a feeling of safety for patients to talk about the real issues. This means creating a context in which people feel comfortable to take risks (Garcia et al, 2005). The nurse must feel comfortable to explore issues relating to the psychological problems expressed by patients as sensitive issues may be raised.

Conclusion

Psychological adjustment may be affected if patients feel they do not possess the coping skills needed to resolve their issues. Nurses are in an ideal position to help patients achieve a satisfactory body image and contribute to positive self-concept (Price, 1993). Psychological disturbances are not always disclosed by the patient as they may not have addressed the issue, it takes a skillful nurse with sensitivity to ensure appropriate questioning takes place in order to identify specific issues for the patient. BJN

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KEY POINTS

- Nurses should be aware of the psychological disturbances relating to gastrointestinal disease.
- Nurses should be skillful and sensitive in discussing psychological issues with patients.
- It is important to be aware that non-verbal communication is as importance as verbal.
- A framework of care should be identified in order to assist the patient through the period of adaptation.
- Educators need to explore creative methods of teaching in order to ensure nurses acquire sensitive interpersonal skills of communication.