THE ROLE OF THE NURSE IN THE REHABILITATION OF PATIENTS WITH RADICAL CHANGES IN BODY IMAGE DUE TO BURN INJURIES

Aacovou I.

Psychiatric Department, Makarios Hospital, Nicosia, Cyprus

SUMMARY. Burn injuries are among the most serious causes of radical changes in body image. The subject of body image and self-image is essential in rehabilitation, and the nurse must be aware of the issues related to these concepts and take them seriously into account in drafting out the nursing programme. This paper defines certain key words related to body image and discusses the social context of body image. Burn injuries are considered in relation to the way each of these affects the patient’s body image. The aim of nursing is defined and the nurse’s role in cases of severe changes in body image due to burn injuries is discussed.

Society places a great importance on a person’s having an attractive physique, and this is reinforced by the many advertisements for a healthy body, physical exercise, bodybuilding, gyms, beauty centres, etc. The selection of subjects presented on television, the way they are presented, and the presenter’s choices also build on this idea, while at the same time they exert pressure to conform to the image projected by the advertisements.

A person with an appearance that does not fall within what are considered socially acceptable limits may be stigmatized and isolated, and eventually develop psychological problems because of this social stigma. A similar fate may await a person who has suffered a radical change in appearance because of an accident. Loss of limbs or loss of their use, wounds, and disfigurement of the skin are all related to change in appearance. One of the gravest, most sudden, and most radical changes in appearance is caused by burn wounds.

A burns patient may have to stay in hospital for long periods of time, sometimes months, and undergo plastic surgery several times. The serious changes in the body appearance of a burns patient may create many problems beyond the person’s health, since these changes affect social life and seriously affect or even destroy the person’s self-image.

The subjects of self-image and body image are very important in the process of the rehabilitation of a patient, and a nurse must be aware of them and have them in mind when putting together a personalized nursing programme for the patient.

Body image is a basic ingredient of an individual’s personality and is part of a more general concept, which we call “self-image”. Price defined self-image as the evaluation of our social value. It is made up of ideas we have about who we are and ideas on how worthy we are to other people. Self-image is important for our confidence, our motivation, and our sense of achievement.

The term “body image” was coined in 1935 by Schilder, who defined it as the way we see ourselves, this involving not only the physicality of the body and the head and body alignment but also the psychological awareness of such things as body unity and integrity. Others have built on Schilder’s definition by pointing out that sensations and attitudes are neither static nor simple. Not everyone agrees on the definition of body image: some place an emphasis on the social dimension of the term, others emphasize the dynamism of the concept, and still others stress its relationship to the conscious understanding of the body.

Galagher made a definition of body image that refers to three dimensions:
1. the experiential understanding of the body;
2. the conceptual understanding of the body;
3. the emotional attitude toward the body.

It is important to realize that all definitions of body image suggest that this image is constantly changing and is therefore dynamic.

Price’s model of body image
Price defined body image as the way we understand our body and our appearance and the way we think about
them. He distinguished three basic factors or dimensions of body image:

1. Body reality, i.e. the way we understand our body and the way we sense it. This could be described as the actual situation of the body. Since the body constantly changes because of genetic factors, this dimension of body image is constantly being adapted to these gradual changes.

2. Body representation, i.e. the way we control our body and the way we present it to the outside world - how we dress, how we move or pose, and generally how we understand that others accept our appearance.

3. Body ideal, i.e. the image which we have of ideal bodily characteristics and which we use as an internal criterion to compare and judge both our body reality and our body representation. The body ideal begins to take shape at a very early age and is deeply influenced by the family and society. Western society has developed a body ideal based on youthfulness, health, splendour, and mobility.

Price pointed out that if at any given point one of the factors of body image changed, there were adjustments in the other factors so that there was a compromised new image. He also pointed out that the body ideal rarely coincided with body reality and that people were rarely content with their body image.

A person’s body image is considered successful if the three factors are in harmony. The fact that the three factors are constantly changing points to the constant adjustments that have to be made in order to preserve this harmony. It is important to note that although one’s body image changes constantly, the changes are usually small and gradual.

**The social dimension of body image**

Many researchers stress that body image is strongly influenced and reinforced by environmental factors and social behaviours and attitudes, and to a great extent it is dependent on the way a person has been brought up. If a person has been raised in an environment of acceptance and approval when needed, then the acceptance by others leads to self-acceptance.

McQuaid wrote that body image was not only due to our internal world, since we do not live as isolated beings. We live in a society and interact with family, friends, and strangers. Our external body image is affected by the way we understand that others are treating us and accepting or rejecting us.

McQuaid also stated that body image could be seriously affected by the way a person was teased by his or her peers. Such effects could lead to low self-esteem, depression, or general psychological dysfunction.

A person with apparent disfigurement or alterations in body appearance may be treated by the rest of society as a person who is physically stigmatized. Having a stigma is a situation in which a person has no social acceptance or is treated as a person set apart from society. And since the way we evaluate ourselves is strongly influenced by the way others evaluate us, the way we think about our appearance is not unrelated to the way others see and treat us. It is obvious that a disfigured person has a lot of social taboos and stereotypes to overcome.

**Changed body image**

Altered or disturbed body image means any significant change in body image apart from the changes that are due to normally expected human development. Pregnancy and old age involve expected body changes, while injuries and pathological changes are situations causing altered body image. A change in body image is always something very personal, since what is a great problem for one person may be insignificant for another.

The identification of an alteration in body image and the evaluation of its seriousness must always be accompanied by the assessment of person’s capacity to cope, within what is acceptable as “normal body image”. It has been pointed out that the more flexible one is, the easier it is to preserve one’s body representation and ignore problems of body image.

A change in body image needs to be evaluated so that we know the seriousness of the situation and take this into account when planning our next steps in our nursing programme. The evaluation of this change is not however a simple matter, and there are certain problems in the evaluation process that deserve mention.

The first problem has to do with the obscurity of the concept. In the light of the foregoing remarks, it is clear that body image is an abstract concept related to, among other things, personal attitudes, emotions, intelligence, and interpersonal relations. To a large extent, it is an obscure concept and certainly a very personal one. In the same way that people shape their body image and assign to it the importance they want in their value system, with regard to the sudden and radical change in body image, the understanding of the change and the reaction to it are not the same in all persons. Some of the factors that can determine the way people will react to changes in body image are their life experiences, their self-image, their value system, their beliefs and emotions, and the possible effects of the change on their life or career. Since several of these factors are difficult to measure, it is obvious that the concept of change in body image is difficult to evaluate. We are trying to evaluate the seriousness of a change in an idea that is not static but is based on the perceptions of real life events and can seriously affect a person’s life.

A second problem in the evaluation has to do with the aims of the evaluation. The question of the validity of the evaluation is even further complicated by the fact that the
aim of the evaluation may affect the result. Thus, the aim of evaluation by a sociologist may differ from that by a nurse or a physiotherapist or a medical doctor, and the result of the evaluation that each of these performs in the same situation may reflect different conclusions. The nurse is interested in the health of the patients, their coping, and their rehabilitation. It is very useful for the nurse to know what the patients’ perceptions are of a normal body, the importance they attribute to the changes in their appearance, and their usual coping strategies.

A third problem in the evaluation process has to do with the theoretical approach of the evaluator. A characteristic example is that of Price, who suggests a model of evaluation that conforms with his theory on the dimensions of body image. His model aims at pinpointing changes in body reality, body representation, and body ideal, discovering patients’ coping strategies and their way of reacting to grief, and finding out their social network of support.

Methods of evaluation of changes in body image.
The usual nursing evaluation of body image change is based on one of the theoretical nursing models. The nurse collects data and information using various methods, such as an interview, an observation, or a questionnaire. Such an evaluation may be sufficient for the nursing programme, as long as the evaluator is especially careful to collect enough information about subjects related to body image. It is also important to pay special attention to details like the patient’s nonverbal communication - which is related to actual body change - as also to avoidance behaviours, negation of the problem, or attempts to minimize it. Price pointed out that the evaluation of body change image was not a clear-cut step in a linear nursing procedure. Evaluation includes much information that begins to be collected at the time of the patient’s admission and continues to be gradually collected even after discharge.

Changes in body image because of burn injuries
Burn wounds cause some of the most radical changes in a patient’s body image. Some of the factors that determine the seriousness of the change are related to the wounds themselves: the type and the gravity of the wounds (whether they are superficial, partial-thickness, or full-thickness), the time needed for healing, and the appearance and permanency of the scars. Apart from their wounds, patients are affected by the reaction to their condition in the people around them. Even though patients may have to remain in bandages for a long time, they are still in a position to observe the reaction of the people who come to see them, and their self-confidence and self-image can be affected by this reaction. The radical nature of the change and the impossibility of foreseeing the accident mean that body image was lost at the time and place of the accident. Patients have to adapt to a new body image, whether the wounds are visible to other persons or not. Burn accidents are especially traumatic because they usually involve unprotected and uncovered parts of the body that are usually exposed and visible. But even if the lesions are in parts of the body usually covered by clothing, the patient can be under constant stress for fear of their being revealed. Other people tend to stare and make thoughtless remarks or ask offensive questions, or else they show embarrassment and difficulty in normal communication. Without meaning it, friends and strangers can make the burns patient feel constantly unnatural, unwelcome, and undesirable.

Bergamasco et al. pointed out that disfigurement of the face caused greater changes in body image and self-image than other changes, mainly because the face was the part of the body most involved in the communication of emotions and in identification by others.

The model of grief
The model of grief is often used in the literature to explain the way a patient reacts to a radical change in body appearance. This model describes a series of 4-6 stages, namely rejection, anger, depression, negotiation, and acceptance. Associated with each stage there are certain coping strategies that people use when they suffer a personal loss. These strategies are very personal and differ both in emphasis and in sequence from one person to another. The fact that the model of grief is used in association with changes in body appearance shows the importance of the change in body image, since this is considered a significant loss for the person that may cause the emotions of deprivation and grief. However, the use of the model has its disadvantages as it suggests that there is a normal sequence of events to be followed and that the nurse can programme the nursing at each successive stage. But every patient reacts in a very personal way to body changes and it may be that some of the stages do not appear at all, or else they may not come in the sequence we expect, or else there may be regression to a stage that the patient has already come out of.

According to Jessee, the lack of successful coping strategies in parents is related to the development of a dysfunctional body image in their children and to a difficulty in coping after a change in body image.

Nursing in cases of change in body image
In people with an altered body image, nursing has a triple aim. First, it aims at rehabilitation of their health and the restoration of the use of their body. The second aim is restoration of the patient’s good standing and reputation, while the third aim is psychological rehabilitation.
If nurses are to help patients effectively, they must be aware of the importance to patients of body image. In addition, they must have good counselling skills and good skills in interpersonal relations, since the way information is passed on is as important as the information itself.

The problems arising from changes in body image need to be solved through group work. The group includes the patient, his or her family and friends, nurses, psychologists, doctors, social workers, and anyone else that is likely to come into significant contact with the patient in the first stages of treatment. Each of these brings to the treatment something unique that may contribute toward successful coping. At different stages of the treatment, the main role is played by different persons. According to Salter, the nurse functions as the main observer in the coping process and plays the leading role during the admission stage and the immediate post-surgery stage.

**Nursing plan according to Price**

a) Nursing in relation to body reality. There is a programme of care aimed at satisfaction of the patient’s bodily needs. There is an attempt to limit diffusion of the wounds and to improve the body’s appearance and functional capacity. There is also an attempt to limit the side-effects of immobility and to promote good health.

b) Nursing in relation to body ideal. The aim here is to make patients recognize that body image is transient and that this is also true of body ideal. The action here respects their grief. Talking to patients on a personal level and encouraging them to voice their feelings help the adjustment of body ideal towards something that is more attainable.

c) Nursing in relation to body representation. In this action the nurse has a very important role to play that is critical for the success of the rehabilitation process. The nurse helps the patients to achieve a representation over which they have maximum possible control. Representation is linked to the sense of dignity of the person and failure in this aspect may lead to undesirable results. For example, effective camouflage of a wound or defect, either in appearance or in movement, can help patients in what they consider to be a socially acceptable body presentation.

**The nurse’s role in burn patient rehabilitation**

Burn patients are admitted to hospital unexpectedly after an accident or a suicide attempt. Usually they have all their senses, although their eyes may be closed owing to swelling of the brows. The hospital staff’s first concern is to prevent hypovolaemic shock due to loss of plasma and to evaluate the injuries. The seriousness of the wounds is usually clear from the start, but it is important to supply patients with liquids and keep them alive. Patients and relatives all need to be constantly informed about the patient’s condition, and in particular they need to be informed that many of the symptoms are temporary (e.g. swelling, temporary loss of sight, difficulty in eating). The relatives usually keep asking about the wounds and the need of skin grafts. Even though the patients themselves may not ask these questions, they are thinking about them and may be anxious about them, so the nurse must have them in mind. The nurse must also provide the patient’s family with information and explanations about treatment procedures.

The nurse needs to assure the patient that swelling is normal in burn injuries and that it will gradually recede. After the first reactions comes the stage of understanding the seriousness of the condition, during which patients realize that there has been a great change in their body and that their self-image must adapt to the new body.

Nurses must prepare a nursing programme for the care of the patients taking into account the instructions of the physicians and incorporating their knowledge of the patients’ special needs. The nursing of burns patients cannot be limited to just general nursing, physiotherapy, and social work. The role of nurses in such cases is much wider, for they contribute to the success of the patients’ coping as regards not only their acceptance of their new body image but also their integration into society.

Price proposed a special list of factors to be taken into account when preparing nursing for a burn patient who has undergone a radical change in body image. A list of the factors appears in the appendix to this paper.

Kubler-Ross (1969, cited in May) described five stages in the rehabilitation of a burn patient, stages that parallel those of the model of grief. The first three of these stages (rejection, anger, and negotiation) usually occur when the patient is still in hospital, while the last two (depression and acceptance) occur later in the process. Very often, we observe regression during these stages - usually from the stage of depression to that of rejection or anger. Negotiation is observed when the patient uses phrases like “everything will be fine when I stop wearing the bandages or the special pressure clothing.” Reaching the stage of acceptance may take a very long time, and even then some patients continue with the process of grief. It is very important that the rejection stage should be overcome during the patient’s stay in hospital.

Some of the patient’s reactions may be violent or difficult for the nurse, requiring the intervention of a clinical psychologist or psychiatrist. Bernstein (1976, cited in May) reported that many burn patients suffer what is called “social death”. Self-isolation is common, and it is usually adolescents and young adults who suffer most from these types of psychiatric symptoms. Bowden (1980, cited in McQuaid) says that adolescents prefer social support from their peers, something they may not have in the case of serious burn injuries. Also, when teenagers have...
burns in childhood, they may suffer because all the support they had from their parents and physicians was subsequently withdrawn.

After skin grafts and reconstructive surgery, the body image factor is strongly involved. It is not always possible to attain the body ideal or reconstruct the pre-accident body appearance, and thus there is always the problem of coping and adapting to the new body image that is achieved by surgery or other means. In this adaptation process, family and social support are both very important.

The help of the nursing staff in cases of serious changes in body image can be the key to success in this process of adaptation. It can enable the patient to find support and look for a meaning in life in things other than appearance. A girl who had sustained burns said, “The fact that I was loved for myself apart from my appearance helped me forget my self-pity and replace it with self-respect. The fact that I was an invalid was less important than the fact that I loved and was loved.” Related to this attitude are another patient’s words: “If life has a meaning and purpose, then a body image disorder can fade into insignificance,” (Shontz, cited in Jessee).


Appendix: Matters of special attention for nurses during the first stage of burn patient treatment (adapted from Price)

<table>
<thead>
<tr>
<th>Patient’s condition</th>
<th>Matters of special attention for the nurse</th>
<th>Body representation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First 3 days after the accident</strong></td>
<td>• critical condition, possible anaesthesia • swelling, hypovolaemic shock • stress, confusion, delirium, absence of feeling, disappointment • strong reactions of grief, feelings of guilt, incapacity, helplessness • shock therapy treatment</td>
<td>• supply of oxygen, protection of breathing tract • replacement of body liquids and ensuring the balance of electrolytes • care of wounds • protected environment • confinement of pain • observation of basic body functioning</td>
</tr>
<tr>
<td><strong>2-6 weeks after the accident</strong></td>
<td>• pain, swelling, patient regains control of most of body • patient leaves intensive care and stays in burns unit room • cataclysmic sensitivity outburst, anger, depression, withdrawal, enmity • problems of treatment of patient • partial help from family in care of patient • intensive physiotherapy • restoration of food intake</td>
<td>• care of wounds • first skin grafting operations • attempt to constrain skin contraction • control of pain • basic body functioning</td>
</tr>
<tr>
<td><strong>A few months after the accident</strong></td>
<td>• some persistent pain • probability of contamination • side-effects of anaesthesia and surgery • physiotherapy and social work • long-term trauma • low self-esteem • danger of suicide attempt • danger of withdrawal • need for family to develop skills for helping the patient • need for socialization and need to control patient’s contacts with other people</td>
<td>• surgery for reconstruction of parts of the skin • continuous physiotherapy • possible re-education for a new job • need for use of pressure bandages to contain scars • restoration of feeding habits • removal of medical equipment</td>
</tr>
</tbody>
</table>
BIBLIOGRAPHY


AWARD OF THE G. WHITAKER INTERNATIONAL BURNS PRIZE FOR 2005 PALERMO, ITALY

At a meeting held on April 11, 2005, at the seat of the G. Whitaker Foundation, Palermo, after examining the scientific activity in the fields of research, teaching, clinical organization, prevention and cooperation presented by various candidates and in consideration of the high level of the candidates, the Adjudicating Committee unanimously decided to award the prize for 2005 to Prof. MICHEL COSTAGLIOLA Director Chirurgie Plastique Reparatrice et Esthétique, Clinic du Parc, Toulouse France.

The prize is awarded with the following motivation:

“Prof. Michel Costagliola, immediately after graduating in 1958, began to take an interest in burn patients as an intern in Algiers Hospital under the guidance of Prof. Felix Lagrot, with whom he collaborated in the creation of the Algiers Burns Centre. His experience was consolidated during the war in Algeria. In 1962, he moved to France, where still under the guidance of Prof. Lagrot, who had been appointed Chief of the General Surgery Department, he became Senior Resident in Toulouse University Hospital, with specific responsibility for burn patients. In 1970, he was made Fully Tenured Lecturer and Assistant Head of the Surgical Emergency Department. In 1976, he was appointed Head of the Department of General Surgery, Plastic and Reconstructive Surgery and Burn Care. His interest in burns pathology has covered the study of all its aspects, as can be evinced from his professional activity, his scientific writings, and his national and international acknowledgements.

He was the creator of the Severe Burns Centre of Toulouse University Hospital, which was inaugurated in 1984 as the “Centre des Brûlés Felix Lagrot”. His chemical and scientific activity has been multiple, varied and, above all, uninterrupted in the fields of the aetiology, pathogenesis and treatment of burns and their sequelae, with the production of numerous publications also in international journals of considerable prestige. In particular, he has conducted in-depth studies of the physiopathological aspects of burns due to chemicals, electricity, X-rays, CO2 laser and ultrasounds. He has taken a particularly vigorous interest in the surgical treatment of extensive burns in the acute phase proposing both surgical and intensive care emergency treatment protocols that have become the object of international training courses. He has set up a Skin Bank and made exhaustive studies on autologous epithelial cultures and the use of dermo-epidermic constructs. He has proposed therapeutic solutions for acute burns in general and specifically for those of the auricle and face and for hand lesion due to rays in order to limit their invalidating consequences, dedicating his surgical activity to the recovery of the quality of life of patients with severe burns sequelae in the hands, face and feet. He has also made a fundamental contribution to the definition of burns treatment in France as an autonomous specialization, having proposed the term “Spécialité de Brûlologie”.

His interest in this pathology has extended to the sector of Fire Disasters, which has benefited from his commitment to various activities of research, study and participation in international projects in the field of burns disasters. His work to enhance the recovery of quality of life in persons suffering from serious invalidities has also seen him involved in the sector of Humanitarian missions in developing countries, such as Ivory Coast, Cambodia and Vietnam.

Prof. Costagliola’s extensive activity, which confirms his absolute commitment to the defence of the quality of life of persons suffering from burns, is manifested in his over 260 publication and scientific papers, in the high positions of authority he has held in various national and international scientific organisms, in the various teaching courses he has organized in which the numerous pupils of his school received their training, and in the high honours that France has thought fit to bestow on him, including those of Chevalier de l’Ordre National du Mérite (1990) and Chevalier de la Légion d’Honneur (1995).”