

Conceptual Issues Surrounding Body Image for Oncology Nurses

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Cancer and its treatment can uniquely influence survivors' body image. Oncology nurses should understand how this quality-of-life issue can affect patients. To better understand the body image experiences of patients with cancer, this article will present a historic overview of body image conceptualization, as well as a more contemporary, cancer-specific approach to understanding how this population of patients may be particularly affected.

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Body image is an important quality-of-life issue for patients with cancer that must be acknowledged by oncology nurses and other healthcare professionals. Cancer and its treatment can uniquely influence body image in several ways. The physical and emotional experience of cancer and its treatment can contribute to short- and long-term body image disturbance. During treatment, appearance changes, such as hair and weight loss, can be disturbing. However, they are most often thought to be temporary. After individuals complete cancer treatment, they often are left with other changes in their appearance or function that may contribute to prolonged body image disturbance. The way people think about body image has changed significantly during the past century; it is no longer only a matter of one's appearance. In addition, body image of a cancer survivor cannot be conflated with which type of surgery he or she experienced.

Historic Overview

Body image was first conceptualized in the context of clinical neurology. Some of the first known body image–related inquiries concerned individuals who had brain damage, resulting in distorted body perception. The brain was thought to be central in maintaining a normal pattern of body experience, and contextual and psychological factors

were thought to play a negligible role in patients' distortion (Fisher, 1990). Therefore, an individual's perception of his or her body was not expected to be a coping response to stress as opposed to the result of actual brain damage or other neuropathology (Fisher, 1990). Schilder (1950) first used the phrase *body image* to mean the picture of our own body that we form in our mind, or the way in which the body appears to oneself. Schilder was influenced by a psychoanalytic perspective and was particularly interested in the manifestations of body image distortions (Fisher, 1990). Schilder's (1950) conceptualization of body image centered on an individual's perception of his or her body—the way it appeared, in addition to the presence of body sensations. The psychoanalytic approach of Schilder (1950) emphasized the role of unconscious psychological conflicts in shaping an individual's body image. Pruzinski and Cash (1990) expanded body image conceptualization from a primarily neurologic focus. With their influence, the study of body image began to include not only a perceptual component but also an individualized attitudinal component. An individual's interaction with the world around him or her influences his or her body image. The study of body image has progressed from viewing body image as a static trait to an experiential state that could change during a person's life (Pruzinski & Cash, 1990).

Conceptual Models

Body image has been studied as a contextual and multidimensional experience. Individuals with cancer may not experience a disturbance of body image linked to a misperception of body size or shape. Rather, they must adjust to varying degrees of disfigurement, as well as physical disability that affects their day-to-day activities, interaction with others, and psychological health. Body image in patients with cancer is a focused phenomenon to which specific attention must be paid.

A conceptual framework of body image was developed that focused specifically on individuals diagnosed with head and neck cancer, who have a high potential for disfigurement and dysfunction as a result of treatment (Rhoten, Murphy, & Ridner, 2013). This framework proposed that head and neck cancer and its treatment result in two main tumor-/treatment-related physical effects: disfigurement and alterations in function (dysfunction). The framework demonstrates that patients may have dysfunction and/or disfigurement at any point along the trajectory of their diagnostic and treatment course. Personal, social, and environmental factors may moderate the effect of dysfunction and disfigurement on body image in a positive or negative direction. Over time, some patients may accept changes in physical appearance and function, leading to reintegration or acceptance of their changes, and others may not. Therefore, in this framework, body image was not considered static but rather an evolving phenomenon during the course of a patient's life. This framework suggested that body image reintegration was important for patients with head and neck cancer to maximize self-image, social reintegration, and psychological well-being (Rhoten et al., 2013).

This work was based on a review of the literature and was influenced

by Dropkin (1989). Her model was developed in response to the need for guidance of nurses at the bedside. Dropkin's (1989) model focused on the immediate postoperative period and allowed nurses to predict behaviors indicating body image reintegration. Body image reintegration was thought to occur as an individual learned to cope with body alteration after head and neck cancer surgery through optimizing the use of residual structure and function, restoration of self-expression, and reestablishment of sociality. Dropkin's (1989) model was based on the transactional model of stress and coping theory, in which stress was viewed as a dynamic unfolding process rather than a static unitary event (Lazarus, 1966; Lazarus & Folkman, 1984). Stress was defined as an event that exceeds an individual's resources, and the stressor in Dropkin's (1989) model was the surgical procedure that resulted in body alteration. Dropkin (1989) focused on postoperative days 4–6 as the pivotal period in terms of body image reintegration. Performance of self-care tasks, social interaction, and self-report during that time indicated that a person was confronting body alteration, adequately coping during the postoperative period, and, therefore, progressing toward adaptation or body image reintegration (Dropkin, 1989). This reintegration was considered a necessary characteristic of growth during the immediate postoperative time after head and neck cancer surgery (Dropkin, 1989).

Examining the conceptualization of body image across oncology populations, White (2000) and Fingeret (2010) have been influential in describing the experience of body image in the context of oncology. White (2000) felt that a cognitive behavioral model of body image was particularly appropriate for studying body image in the context of oncology, because those types of models were based on the premise that

individuals are constantly processing information and that the nature and results of this processing can be used to understand psychological dimensions of human experience. He noted that, although body image was a multidimensional experience, researchers did not often clearly distinguish the specific dimensions they were interested in understanding (White, 2000). He proposed that patients with cancer who have a perceived or actual appearance change, accompanied by the presence of a threat to their ideal selves (resulting from the content of their self and body image schemata), experienced negative appearance-related assumptions, thoughts, images, emotions, and behaviors if this ideal self-discrepancy related to a physical attribute in which they had significant personal investment (White, 2000). He advocated for the use of cancer-specific body image models to influence how clinicians and clinical staff referred to patients. White (2000) argued that, by delineating the multidimensional aspects of body image in the context of cancer, researchers would be better able to conduct research studies.

Fingeret (2010) expanded the conceptualization of body image concerns in the context of cancer by describing them as existing on a continuum. The center represented patients who experienced an average or normative amount of body image concerns. These individuals may have experienced some difficulties in adjusting to body image changes; however, they had realistic expectations for cosmetic and functional outcomes. On one end of the continuum were patients who were completely unconcerned about bodily changes and, conversely, on the other end were patients with severe levels of body image concerns. This model suggested that those who placed more importance on physical appearance would experience more struggles related to perceived or real body

alterations postprocedure (Fingeret, 2010). In addition, those who valued certain parts of their body's integrity would be more affected than those who put less emphasis on the functional aspects of their body. Many patients with cancer undergo substantial changes to their bodily aesthetic and functioning; therefore, body image disturbance in this population should not be considered pathological (Fingeret, 2010). Fingeret's (2010) analysis emphasized the limitations of previous oncologic research that used simplistic and inconsistent definitions to describe body image. She maintained that body image was a multifaceted construct that entailed perceptions, thoughts, and feelings about the entire body. Therefore, it could not be evaluated in its entirety with a single-handed approach. She suggested a method for healthcare providers to address body image changes with patients. This approach centered on viewing body image changes as common, addressing concerns, and recognizing the consequences of body image changes (Fingeret, 2010). Healthcare providers must ensure that patients know that potential difficulties adjusting to their new body image are common and typical. They also must ensure that their questions are open-ended and maximize patients' ability to elaborate if they choose. Healthcare providers must recognize the effects on daily life activities and functional life skills that are being affected by body image changes.

Although many theories of body image focused on positive and negative influencing factors, the negative experience of body image disturbance in adults with cancer required clarification to provide a standardized language surrounding body image disturbance in the context of adults with cancer.

The concept analysis of body image disturbance in adults treated for cancer identified three defining attributes: a self-perception of change

in appearance and displeasure with the change or perceived change in appearance; a decline in an area of function; and psychological distress regarding changes in appearance and/or function. Body image disturbance could manifest itself via depressive symptoms, social anxiety, social avoidance, and social isolation (Rhoten, 2016). The presence of one or more of these referents could indicate that an individual needed further body image assessment.

A goal of the concept analysis, according to Walker and Avant's (2011) method, was to reduce conflation of body image disturbance with disfigurement; not all who experienced disfigurement would experience body image disturbance (Rhoten, 2016). Body image disturbance in patients treated for cancer was a multidimensional experience that did not hinge solely on changed appearance but rather on the individual's reaction to perception of a changed appearance and decline in function (Rhoten, 2016). Because of the way they felt about their appearance and changed level of function, individuals in this population who experienced body image disturbance could become socially isolated from peers and family members, making employment and normal socialization impossible (Rhoten, 2016).

Conclusion

Today, body image is generally recognized as a fluid, multidimensional construct. Although Merriam-Webster defines body image as "a subjective picture of one's own physical appearance established both by self-observation and by noting the reactions of others" (Body image, 2017), this description cannot encompass the evolved complexity of its meaning. Particularly in the context of cancer, one's perception of functioning must be included. Although Rhoten's (2016) concept analysis of body image disturbance

in the context of cancer presents clear defining attributes, a definition of neutral or positive body image in the context of cancer has not been described. This presents an important opportunity for nurse researchers to engage in further body image conceptualization, as well as research to support specific recommendations for clinicians in response to patients who experience disfigurement and dysfunction and are, therefore, at an increased risk for body image disturbance.

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