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Confronting Embodiment

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Abstract

In this discussion of an aspect of body care which I find confronting I intend drawing on a personal experience. This experience relates to the issue of faecal incontinence and involved a patient who, for the purpose of this assignment, I shall refer to by the pseudonym John. I will examine the approach I took based on my training and experience at the time and then incorporate more recent learning to reflect on how the interaction could have been managed. I was working in the community at the time and John was living in a boarding house. Having trained to be a nurse in the 1970's, I felt I was an experienced nurse and yet found myself in an extremely confronting situation.

Although nursing is 'fundamentally and centrally concerned with the care of other peoples' bodies' (Lawler, 1991, p.29), as I recall it, the nursing curriculum on which my training was based in the 1970's did little other than stress the need for sensitivity and respect of the patient's privacy. It was heavily influenced by earlier models of nurse education dating back as far as Florence Nightingale who placed great importance on basic hygiene, however, did not even refer to the body but instead to cleaning "the skin" (Lawler, 1991). Education took more the form of instructions. Such as how to protect the embarrassment of the patient by the actions of minimizing nudity and covering bedpans, and to avoid showing reactions such as discomfort or disgust. There was an emphasis on procedure and mechanics but little discussion of the feelings of the people involved, nurses or patients (Lawler, 1991). This emotional control was considered being 'professional' and required an element of detachment.

Society then, as it still does, tends to privatise the body. Lawler claims that there has been a tendency to ignore or use sanitized language in reference to the body (Lawler, 1991). I recall referring to patients' genitals as "down below" when struggling for words as a nurse in training. In addition body care has been considered essential and basic, taken for granted as something women

and nurses do naturally and not requiring enquiry or research. While dealing with the body in nursing, social norms are inevitably broken and boundaries crossed. During my training such issues were not presented as of value or worthy of analysis. (Seed, 1995).

When I first met John another nurse had already completed an initial assessment of him and, using the nursing process, had given him the nursing diagnosis of “impaired skin integrity”. I recall being surprised that, when first assessed, the extent of this man’s health problems had been identified as simply one wound. I proceeded to identify more “problems” thinking at the time that I was being more precise and thorough when I added the nursing diagnoses of ‘self-care deficits’ related to his diabetes and faecal incontinence. Critique and nursing research in the 1970’s identified how the nursing process tended to scientise nursing (Lawler, 1991). Whilst I saw the nursing process as providing a framework on which to base practice, in doing so I was reducing the patient to a set of problems (Lawler, 1991).

Initially caring for John’s faecal incontinence was not a major issue though I was keen to deal with it quickly and effectively because I felt some discomfort. I had developed ways of coping with embarrassment and this was not an issue. I utilised coping mechanisms learned as a neophyte nurse to manage what I saw at that stage as the practicalities of the problem. I found myself drawing on procedures and methods to cope with the ‘dirty’ aspect. I experienced reactions such as concern about cross infection and feeling ‘dirty’ myself after cleaning up. Working in the community I took the steps I was familiar with to address the problem. This involved liaising with his GP, provision of incontinence pads, linen service and referral to incontinence advisor. In short, numerous actions to contain and manage what I perceived as a problem to the patient, his social network and those sharing the responsibility of his health and wellbeing.

As time went on I learned more about John. The complexity of his life grew and so did the attempts to unravel the issues he was experiencing. He was gradually reduced to a growing list of diagnoses during admissions to hospital and consultations with numerous specialist doctors including a psychiatrist for his depression. However, of all the emerging problems, speculations and attempts to treat John, of paramount importance to me was his intermittent problem of faecal incontinence. It was emerging as a persistent perhaps unsolvable problem. The smell entering his room was putrid, and his apparent apathy regarding the problem and his “non-compliance” with wearing pads I found exasperating. I sometimes might tread unwittingly in faeces or find it had run down his leg

onto wound dressings. Alarm bells rang in my brain about cross infection and deep down I found the situation quite repulsive. His security in the boarding house was threatened and I had no answer for the manager of the boarding house who wanted to evict John. He was too young for a nursing home and psychiatrically had been assessed as able to manage his problems but as being “passive aggressive”. All my coping mechanisms were failing me and to face faecal incontinence with no solution in sight was indeed confronting. Community mental health nurses visited John distancing the community nurses from his psychological problems and my focus became more his physical care. However I did not feel I was managing or solving the problem with procedures alone.

Ironically at about this time nursing academics were recognising that the reductionist approach had produced theories which did not fit all facets of nursing practice (Benner, 1989). Nursing research, in an attempt to establish a curriculum and a knowledge base on which to base clinical practice, emphasised the scientific paradigm. This was not teaching how to care about the patient as a whole human being. Capra had said that “By concentrating on smaller and smaller fragments of the body, modern medicine often loses sight of the patient as a human being” (Capra, 1982, p.118). To care for patients as whole human beings nurses need to know what being in the world means to people and how it feels to them. Benner asserts that theory must be “informed by real-world experience and experiments”, and needs to capture “embodied, relational, configurational, skilful, meaningful and contextual human issues” (Benner & Wrubel, 1989, p.5). So it has followed that research has begun to enquire into the phenomenon of embodiment and, of particular interest to nursing, the question of what it feels like to be ill.

Embodiment is a way of considering human beings that does not think of the mind and body as split (Wilde, 1999). This is in contrast to the “conceptual split between mind and body” known as Cartesian dualism developed long ago when the philosopher Descartes first identified the problem of both having and being a body (Lawler, 1991). On embodiment Madjar writes “From a phenomenological perspective, the body is our basic mode of being in the world; consciousness is embodied consciousness, and a person is an embodied being, not just a possessor of a body (Merleau-Ponty, 1962)” (Madjar in Lawler, 1997, p.55). When healthy we are unconsciously embodied, our lived bodies are our unique way of being in the world (Madjar, in Lawler, 1997). In illness the ability to be our bodies is disturbed (Wilde, 1999). Publications giving patients’ accounts of how it feels to be ill and deal with the health system can give nurses invaluable insight

into the illness experience. For example Fassett states that M.R. (a patient and her co-author) 'struggles to retain her identity, her despair and the harsh reality of the separation of her self into a mind and a body' (Fassett and Gallagher, 1998). In another text written from the patient's perspective Frank states that for him when his disease was discussed it was as if his body as an object had been measured and assessed (Frank, 1991). It becomes apparent that if nurses can try to stand in the patient's shoes then they are going to increase their understanding of what care is needed. Benner refers to this as the 'ability to presence oneself, to be with a patient in a way that acknowledges your shared humanity,' (Benner & Wrubel, 1989, p.13). Benner believes this is fundamental to the caring element of nursing practice. This ability to connect with the patient's embodied awareness requires nurses to be aware of their bodies and how it must feel for the patient (Wilde, 1999).

Unfortunately I didn't ever pose the question to John 'What does it feel like to be this way?'. Language is so crucial to unlocking understanding. Firstly, nurses will only increase their knowledge about how to care for the body when issues around the body are discussed, debated and written about. Secondly, the language they use with patients and their ability to listen holds a key to caring practice. It follows though that while language can bring about understanding so its limitations limit such understanding (Taylor in Benner, 1984). For John expression was denied him on many fronts. If the conversations John had with the multitude of health professionals he encountered were focussed on his diseases this may not have given him a sense that his illness experience was being understood and shared. Frank is very critical of the language doctors and nurses use. He describes feeling 'mute' when staff are not willing or able to assist him express himself, and that the very time when he is finding it difficult to find words is when he needs to express himself (Frank, 1991). As well John may well have suffered the isolation and devastation that so often is associated with mental illness (Pickens, 1999). When people experience a disturbance of thoughts, perceptions and emotions they will often keep this inside hoping it will go away (Horsfall in Lawler, 1997).

During an admission to hospital the boarding house seized the opportunity not to allow John to return. Socially his world continued in turmoil as accommodation establishments rejected him and the health system had no answer. I was aware of him moving to other areas of the city and heard the gradual despair of other nurses challenged by his seemingly unsolvable problems. I was struck

by the irony that a society which civilised and educated, struggled to cater for this human being. John's case could be seen as a good reason for nurses to be aware of economic and political policies and demonstrates the need for contrasting disciplines such as nursing and economics to be more closely related (Lawler, 1997). Mental health clients both lack a voice of their own and contend with issues of stigma. John's case supports the argument that there is 'a clear need for psychiatric/mental health nurses to become more mindful of the wider, socio-political environment in which their practice occurs' (Cutcliffe, 2001, p.319).

John was a well educated man who had been married but no longer had work nor family. He seemed to almost ignore his health problems, asking few questions regarding this and generally taking very little part in the care of himself. It was as if he didn't own his body. His inactivity was frequently interpreted in a negative way. When labels are put on patients it can influence how they are treated and he was the victim of such stereotyping. While caring for John I recall feelings of frustration and blame at the stage when I was finding his faecal incontinence very confronting. I can see now that my own feelings of repugnance regarding exposure to faeces played a major part in how I was coping as a nurse. For whilst I believed society would find him unacceptable functioning as he was, I can now see that I shared this view, that is, he was unacceptable the way he was to me. Now as I imagine standing in his shoes I am conscious of there being a totally different meaning to John's existence. Unfortunately because I didn't investigate just how it was for him I am unable to complete the transformation. By just getting to this stage I have moved completely away from the standpoint I had at the time. When I reflect on the encounter my memories are no longer coloured with the unpleasant, uncomfortable feelings that used to come up about the incontinence and the lack of closure I used to have about something not well done and not understood. Now I have some understanding for why it was how it was and feel better equipped to offer care to the next John.

In conclusion to reflect on my encounter with John with the knowledge I now have I can see the experience could have had different meaning. That his body was a physical expression of how he was in the world. Not an object he was consciously using at will but 'an expression of his way of being in the world' (Benner & Wrubel, 1989). Had I focussed more on understanding the meaning of his illness for himself and his life I'm confident that I would have approached his incontinence differently. He may well have had difficulty articulating this but to have a nurse wanting to

understand would in itself have overcome some of the alienation and lack of understanding which may have accompanied his experience of illness. Outcomes may not have been greatly different but the care along the way could have altered. John died in his forties.

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