Original
ISSN 2413-0516

Lived Experiences of Iraqi Patients with Permanent Colostomy: A Phenomenological Study

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(Submitted: 20 January 2025 – Revised version received: 05 February 2025 – Accepted: 23 February 2025 – Published online: 26 April 2025)

Abstract

Objectives: This qualitative research examines the diverse implications of having a lifelong colostomy on the quality of life of patients with a view to developing an understanding of their lives and problems on a daily basis.

Methods: The study employed a phenomenological approach, whereby eight purposefully sampled permanent colostomy patients were interviewed from August to October 2023 via semi-structured interviews. Thematic content analysis was utilized to systematically analyze and interpret the data, providing rich insight into the physical, psychological, and social experiences of the patients.

Results: Six core themes to quality of life were found through the analysis: physical functioning, psychological well-being, sexual and marital relationships, social relationships, religious practices, and issues related to stoma care. All of these themes have some subthemes, including stoma odor, changes in eating habits, depression, isolation from society, and the intricacies of performing religious duties.

Conclusion: The results conclude the wide and profound impact of permanent colostomies on patients' lives. Having identified these issues, the research recommends better support systems within healthcare facilities, such as the inclusion of specialist stoma care nurses and personalized psychological counseling to enable a better quality of life among such patients. Moreover, the research emphasizes patient education and community sensitization to overcome stigma and promote more supportive environments for colostomy patients.

Keywords: Colostomy, quality of life, patient experience, qualitative research, phenomenological study

Introduction

The term "ostomy" is taken from the Greek word "stoma," or "mouth," and is utilized to define an opening created surgically in a hollow organ to allow for the egress of waste products from the body.[1] It is needed in those patients in whom their natural pathways of waste expulsion are dysfunctional, something that occurs in millions of individuals worldwide for a variety of health conditions.

A colostomy, which is an ostomy, establishes a fistula artificially between the colon and the outside to allow the expulsion of waste. It can be temporary or definitive and is usually needed as a result of a range of diseases, including neoplasias—morbid and fatal cause all over the world—and benign lesions such as congenital anomalies, trauma, obstruction, ischemia, or inflammatory disorders.[2,3] Colorectal cancer specifically frequently requires a colostomy, particularly if tumors are more than 5 cm from the anal sphincter, and removal of the normal segments of the gastrointestinal tract to provide oncologically safe margins.[4]

Though colostomies are life-saving, they significantly affect patients' physical and psychological health.[5] Recipients also endure problems of decreased self-concept, change in bowel function, and significant psychological distress.[6] As there is an increase in the incidence of colorectal cancer, especially in low- and middle-income regions, it becomes an absolute requirement to ensure control over postoperative outcomes and quality care without inequality.

This research is unique in offering an in-depth qualitative examination of the lives of permanent colostomy patients in Iraq's Kurdistan region—a region with very limited specialized information. It seeks to shed light on the intricate, long-term impact of colostomies on patients and make a worthwhile contribution to the international literature on enhancing surgery care and postoperative quality of life.[5]

With the colossal worldwide disease burden of gastrointestinal disease needing surgery, this study not only records individuals' experiences but also situates them in the context of wider health system issues. It aims to guide clinical practice and improve outcomes in various healthcare environments by promoting a model of care that addresses the physical and psychosocial needs of patients. The findings are meant to encourage policy reforms and improved comprehension of patient-centered care in postoperative recovery, particularly for patients who undergo life-altering procedures like colostomies.

Methods

Study Design and Setting

This research used qualitative phenomenological research to investigate the lived experience of patients with permanent colostomy so that extensive and comprehensive insights into their feelings, emotions, and coping mechanisms could be attained. Descriptive phenomenological design was used to document and examine systematically how individuals live through and make sense of their condition. This research approach was warranted by its capacity to grasp the multidimensional and holistic nature of the patient experiences and improve the understanding of their challenges, coping mechanisms, and temporal dynamics.

Data were collected in Rania Teaching Hospital in the Kurdistan Region of Iraq, in consultation clinics where colostomied patients visit on a regular follow-up and receive medical equipment. It was a good location to select because it was convenient to access a diverse population of colostomy patients with socio-economic and cultural differences, and it would be possible for the study to produce complete and relevant information to the setting. Additionally, conducting the study

within a healthcare setting where patients daily come into contact with medical doctors made the patients not shy one bit when discussing their experiences, which is vital in phenomenological studies. Homogeneity of the sample from such a setting permitted the study to cover a larger scope of ideas, and consequently more reliable and generalizable outcomes.

Participant Selection Process

A purposive sampling method was used to invite participants who were able to provide rich reflective information regarding individuals with permanent colostomies.[7] Participants had to meet inclusion criteria of age ≥18 years old with permanent colostomy and one year back having undergone the surgery before they joined the study. This period was selected to provide participants with sufficient time for psychological and physical adaptation, whereupon complete and efficient data collection can be done. The participants must also be psychologically healthy and physically healthy so that they can effectively use verbal communication in order to explain their experiences clearly and consistently. The recruitment was done at Rania Teaching Hospital, outpatient department pharmacy, where colostomy patients regularly came to pick up medical equipment and for follow-up visits. This setting provided access to a diverse patient population, enhancing the generalizability of the study's findings.

To guarantee a dense and theoretically rich dataset, data saturation was the driving force for sample size determination.[8–11] Recruitment iteratively accompanied with data collection and initial analysis to enable continued monitoring of thematic saturation.[8] Each tale contributed to elaborating emerging themes in order to have a responsive and flexible methodology instead of adhering to a predetermined sample size.[8] Methodological consistency was maintained by continuously cross-referencing new data with already established themes to identify any areas that were not thoroughly explored.[8] This iterative and concurrent process enabled the researcher to probe the data in depth so that the final analysis captured the lived experiences of the colostomy patients in depth.

Data Collection Process

Data were collected between August 1, 2023, and October 1, 2023, through semi-structured in-depth interviews as the main method (Table 1). The qualitative method enabled the experiences of participants to be probed in a comprehensive manner to allow them to provide their opinions in an open-ended and unstructured way. The interview schedule was also constructed with meticulous attention from an extensive literature review, expert opinion, and initial informal interviews with patients having colostomy to ensure that the questions were sensitive, contextually appropriate, and holistic.[12] The schedule touched on a wide variety of issues, such as physical, psychological, social, religious, and economic problems, coping strategies, and perceived shortcomings in health care services.

The interviews were carried out by surgeon with more than 20 years of experience in surgery and stoma care. This background facilitated rapport-building with participants and contributed to a compassionate and informed interview process. The interviews were conducted in Kurdish (Sornai dialectic), the native language of all participants, to ensure linguistic comfort and depth of expression. The use of the participants' mother tongue allowed for the exploration of nuanced emotional and cultural dimensions that might have been lost in translation.

The interviews were conducted in a quiet and comfortable room in the outpatient department so that they were in private and an atmosphere promoting free and frank disclosures. The interviewing process was loose and permissive, and subjects were enabled to explain their answers and pose questions of personal importance. The interviewer employed active listening, probing skill, and reflection questioning to conduct rich telling in a manner that was sensitive to non-verbal responses like tone change, facial expression, and body posture. The strategies allowed for enhanced comprehension of patients' everyday lives, making the richness and authenticity of findings more profound.

Each interview lasted 30–45 minutes to allow participants sufficient time to give information on their experiences, emotions, and coping mechanisms. The semi-structured approach allowed for in-depth exploration of the topics arising without loss of consistency across interviews. All interviews were tape-recorded with explicit participant consent to guarantee data collected had reliability and validity. Detailed field notes were also taken to document non-verbal responses, emotional indicators, and contextual information that could add depth to analysis.

The cyclical process of data collection permitted an adaptive strategy where results from previous interviews were used to inform the next, thereby enabling evolving themes to be explored.[8] The researcher gradually honed questioning strategies through preliminary data analysis to elicit rich and informative responses.

Data collection was stopped when data saturation was achieved, the stage at which nothing new was emerging and the salient themes were clearly established and replicated.[8] The process guaranteed the strength and comprehensiveness of the study results to increase their credibility and transferability.[13]

Data Analysis Process

The audio recordings were transcribed verbatim and subsequently translated into English by the principal investigator, who is a bilingual healthcare professional with proficiency in both languages. To ensure the accuracy of translation and preserve the contextual integrity of participant narratives, a back-translation process was employed and reviewed independently. This methodological rigor strengthens the validity of cross-language qualitative research.[8]

Data were transcribed verbatim and examined through thematic content analysis, following Braun and Clarke's (2006) six-step approach, which is celebrated for its systematic and transparent qualitative data analysis process.[14] The procedure began with familiarization, whereby the researcher read the transcripts repeatedly to familiarize themselves with the data.

Table 1. **Interview guide questions**

No	Questions
1	Do your eating habits get affected by colostomy surgery?
2	Does colostomy impact your social life?
3	Does colostomy affect sex life with your partner?
4	Does colostomy impact your worship?

This allowed for greater examination of participant accounts and helped to distinguish early trends. Manual initial coding was then carried out to preserve close contact with data. In this phase, outstanding words and concepts were selected systematically, documented, and classified into meaningful units of analysis. Due to the single-researcher set-up, special attention was given to strengthening the reliability of coding through iterative improvements and self-regulation.[8] The new codes were then aggregated into possible themes, which represented more general and longer-lasting patterns in participant stories. These themes were then scrutinized and refined in an iterative process to ensure that they were distinct from one another, consistent within themselves, and coherent.[8] This was done by returning to the data to make sure that the themes did indeed capture the content of participant experience. The last phase of analysis was to place the results within the current literature, locating the findings in the wider scholarly community on colostomy adaptation and quality of life. The comparative strategy made the academic validity of the research stronger, guaranteeing theoretical richness while maintaining firm participant voice connections.[8]

Trustworthiness

To provide for credibility and trustworthiness, the data underwent several iterations of coding verification with close cross-examination of emerging themes to preclude researcher bias and enhance interpretative precision.[8,13] Due to the single-researcher approach, specific techniques were utilized to ensure optimum trustworthiness and methodological rigor.[8,13] A reflexive journal was kept throughout research, acting as a self-checking device for recording methodological decisions, theory development, and potential biases impacting data interpretation. This reflexivity enabled openness and enabled critical self-reflection during the research process.[13,15] Furthermore, extensive exposure to data promoted deeper understanding of participant accounts, enhancing the depth and validity of the findings. Member checking involved disclosing condensed findings to participants to ensure that interpretations accurately reflected their lived experiences.[13] In addition to possessing methodological transparency, an audit trail was systematically maintained by outlining all important decisions regarding data collection, thematic coding, and analytic development.[13] Additionally, triangulation was utilized by cross-validation of themes with the previous literature and feedback from participants, thus enhancing the validity of the study and attaining a balanced, multi-perspective description of the colostomy patient experience.[13]

Ethical Approval and Inform Consent

The present research obtained the ethical approval from the University of Raparin, College of Nursing's Scientific and Ethical Committee (reference number: N-2023-01) and, thus, achieved the commonly agreed ethics of human-subject studies. Ethical consideration was employed at all levels of the research to secure the dignity, autonomy, and welfare of the study participants. Before data collection, all the participants were informed in full about the aim of the study, procedure, possible risks, and their complete right of withdrawal at any moment without penalty. The process was carried out both verbally and in writing through informed consent mechanisms and participants were given sufficient time to ask questions, clarify matters, and provide voluntary consent without coercion. Ethical transparency was given precedence to establish trust, respect for one another, and open communication between the research participant and researcher. Confidentiality and data protection were maintained by anonymizing all identifiable information of the participant in the transcripts and keeping them in password-protected databases with the authorized research staff being the only individuals having access. The inquiry was carried out while adhering to data protection measures stringently, ensuring that individual identifiers were never linked with qualitative data. In addition, the respondents were guaranteed that their answers would be used solely for research purposes and that confidentiality would be carefully maintained during the research process. Other ethical safeguards included using secure methods in data handling, participant confidentiality agreements, and systematic anonymization procedures to enhance compliance with qualitative research ethics standards, in addition to meeting study compliance with qualitative research ethics standards. These steps ensured that the study was carried out with the best ethical practices, in line with international human subjects research guidelines, and protected the rights, well-being, and privacy of all the participants.

Results

Demographic Participants

Table 2 illustrates the sociodemographic characteristics of the participants. There were five females and three males

Table 2. **Sociodemographic features of the research participants**

Participant's code no.	Gender	Age/years	Marital state	Job	Years living with colostomy	Diagnosis
P1	Female	33	Single	Housewife	20	Rectal ca.
P2	Male	57	Married	Teacher	3	Rectal ca.
P3	Female	52	Widow	Employee	8	Colonic ca.
P4	Male	70	Married	Retired	27	Rectal ca.
P5	Female	72	Widow	Housewife	2	Colonic ca.
P6	Female	54	Married	Housewife	1	Colon ca.
P7	Female	38	Married	Housewife	18	Rectal ca.
P8	Male	31	Single	Barber	3	Colonic ca.

ca: Cancer.

aged between 31 and 72 years. The mean age was 50.8 years. The colostomy duration ranged from 1 year to 27 years, with a mean of 10.2 years. All of them underwent permanent end colostomy for low rectal carcinoma following abdominoperineal resection or incurable metastatic colonic cancer (Table 2).

Key Themes and Subthemes were Elicited from Interview Data

Qualitative characterization of the interview data identified some prominent themes associated with the experience of individuals who have a colostomy. These were physical functioning, psychological issues, marital and sexual relationship, social activity, religious activity, and stoma care. I describe each theme and the respective subthemes below as illustrated in Table 3.

Physical Functioning

Members mentioned a range of bowel symptoms following colostomy, such as increased gas, flatus, and stoma odor, that had a significant effect on both daily life and social self-esteem. Three out of the eight members were on bowel-stabilizing medication—using laxatives to produce a bowel movement in advance of going out socially and the other two taking anti-diarrheal medication in order to manage constant loose stools. One of the patients utilized dietary adjustments to control bowel movements, and the remaining four patients did not get pharmacological management. Two of them suffered from chronic constipation, and the others had abnormal bowel habits without medicative therapy.

Dietary practices differed among participants. Half of the patients had consumed a normal diet with their families, but three had dietary restrictions imposed on them, excluding certain foods like beans, fruits, and vegetables on the grounds that they produced too much gas or caused diarrhea.

"*I usually eat a normal diet with my family but do not eat beans and vegetables because they disturb me with bloating and excessive gases*" (P 1)

One of the patients with metastatic colonic cancer advanced was following a fluid diet because the disease had progressed. Abnormal sounds from the stoma were a common complaint and resulted in discomfort and distress to social interaction. Redness and excoriations at the stoma site were observed in one of the patients, and this is why proper skin-care and appliance management are important. The frequency of bowel ranged from every two days to two to three times a day, showing considerable difference among patients.

"I was suffering a lot from redness of the surrounding skin of the stoma due to leakage of loose stools from the flange, especially when I eat fruits, that is why I used anti-diarrhea medication many times in order to manage it" (P 6)

The physical symptoms experienced by participants were diverse and persistent, often requiring ongoing management and lifestyle adjustments. These challenges formed the foundation of their lived experience with a colostomy, directly influencing emotional well-being and social interaction.

Table 3. **Summary of themes and subthemes of the study interview**

Themes	Subthemes
Physical functioning	Bowel problems Flatus/gas leakage Stoma-related Odour problems Use of bowel stabilising drugs Diet, Normal or Changed. Restrictions of some foods? Abnormal sounds Skin redness and excoriation Bowel movement per day (how many times)
Psychological issues	General: depression, loneliness, feeling of stigma and low self-esteem, Anxiety, feeling discomfort, hopelessness Specific form of distress: Distress and concern with appearance and change of body image
Marital and Sexual relationship	Men: Erectile dysfunction, Loss of desire, Diminished activity Women: less frequent intercourse, diminished orgasm
Social Activities	Return to work Contacts and visiting with friends and relatives Specific social activities and travel General social activities and leaving the house Relationship with partner and family members
Religious activities	Praying at home alone Praying in mosque Fasting in Ramadan
Stoma care and access to the appliance	By Patient himself By Health care professional Adequacy of appliance Frequency of Changing the appliance

Psychological Issues

The majority of the participants indicated severe emotional distress, including depression and anxiety, particularly in the postoperative period. The radical shift in lifestyle and physical changes caused by colostomy had a tendency to cause hopelessness and powerlessness. One of the participants indicated suicidal thoughts initially, demonstrating the immense psychological impact of adapting to a permanent colostomy. However, with time, most of the participants showed psychological resilience, ultimately adapting to their situation and gaining a sense of normalcy.

Religious, family, and personal coping mechanisms helped to reduce psychological distress and enhance well-being. Some participants applied religion as relief since they believed that their condition was a test of endurance. The healing process, according to others, was strongly enhanced by motivational support from family members and spouses who formed an active component that assisted them in coping emotionally.

Body image issues were also common, with two of the participants freely admitting that they experienced distress over their changed body shape, which made them feel embarrassed and socially isolated. Stigma regarding colostomy also heightened their emotional distress, causing them to avoid social activities.

One patient, female (P7), preferred total confidentiality in discussing her colostomy and said: *"Only my husband knows I have a colostomy; nobody else knows that,"* indicating strongly significant influence of close relationships in adjusting to feelings. They conclude that psychologic support guidelines specifically targeting patients undergoing colostomies would help remove suffering from hurtful feelings, enhance self-esteem, and return to social acceptability.

Psychological distress was a prominent feature of participants' experiences, particularly in the early stages. However, adaptive responses such as faith-based coping and familial encouragement gradually helped participants reclaim a sense of emotional stability.

Marital and sexual relationship

Colostomy had impact on sexual and marital relationships in a deep and compounded way, involving not only physical closeness but emotional and psychological bond between spouses. Body image, self-concept, and changes in sexual functioning created issues in relationships to be accommodated by partners as well as individuals. Two of the three men reported erectile dysfunction after colostomy, a happening that radically impacted their confidence and masculinity.

"Colostomy had completely transformed my life, but slowly I accommodated the new scenario with respect to food culture and social life, but my erectile dysfunction did not resolve and impacted 100% my intimate life with my wife" (P 2).

In spite of these physiological accommodations, they were able to experience sexual desire, demonstrating the psychological dissociation of libido from erectile function. The third male patient had normal erectile function and an active sex life, emphasizing variability in individual experience and physiological accommodation to colostomy. How well men accommodated these changes depended on support from their partner, psychological hardiness, and availability of counseling or medical attention to correct sexual health issues.

Three of the five female interviewees were widows and therefore, did not experience sexual contact after colostomy. The remaining two women were not sexed during the interview but one described a satisfying sexual life and ascribed her good experience to extensive spouse support and bonding. This shows the need for reassurance by the partner and communication in maintaining intimacy regardless of the existence of the stoma. The last person to be interviewed was a female who wasn't married and was neutral regarding sexual issues and consented to the fact that personal experience, emotional well-being, and social pressure influence individuals' attitudes toward colostomy and sex.

Sexual and marital intimacy was deeply affected by both physical and psychological consequences of colostomy. However, emotional support from spouses emerged as a key factor in maintaining relationship satisfaction.

Social Functioning

After surgery, the majority of the participants at first struggled with participation in social activities and their interaction with their social network. Social withdrawal was in most cases promoted by embarrassment, self-consciousness, and stigmatization concerns in the first few months after surgery. In a few months, however, most gradually adapted to their social sphere through the development of growing self-confidence and adaptation to their condition. Close relatives, friends, and relatives were also central to this exercise and provided both material and emotional support, which helped to introduce the participants at least with some sense of normality in social interaction.

P4 expressed embarrassment in front of others and said, *"I had never slept in any other house except in my son's house because it's an embarrassing situation"* Likewise, P5 further added, *"I would not go to anybody since my operation except my daughter and sister, because it is shameful for me, and even I did not go to my nephew's wedding a few months ago"*

Economic stability and work status were also important determinants in reintegration socially. The majority of the participants could return to work after one year on sick leave, indicating resilience and adjustment to the disease. Self-employed people had greater possibilities in altering their working hours and could therefore resume their professional activities more easily. But one advanced metastatic cancer patient was unemployed and socially inactive, emphasizing the heightened difficulties for those who have experienced extreme health decline. The results reaffirm the necessities of work accommodations and social support groups in the successful reintegration of colostomy patients into society.

Social functioning was restricted by avoidance of public humiliation, and hence most of the patients stayed away from crowded, enclosed areas but were comfortable in open environments like family picnics. Travel at night was restricted, with two participants avoiding home for ordinary purposes, and the rest going out only for unavoidable reasons like medical consultations to big cities. Despite such limitations, all respondents were content with the manner in which the family members attended to them and the important position that family care took in rehabilitation.

One participant stated, "*My husband supports me too much and even does not let any of the relatives know about my condition*." (P 7).

The impact of colostomy extended into social life, reducing public engagement and community participation. Supportive family dynamics were crucial in facilitating gradual reintegration into social environments.

Religious Activity

Religious practice was greatly affected by the difficulties that came with colostomy, most notably involuntary passing of gas and the preservation of ritual purity. Most of the participants were worried about going to communal prayers at the mosque for fear of embarrassment and disruption by out-of-control body functions. Thus, most opted to offer their prayers at home, where they were more comfortable and in control of their situation.

"When I pray, at times I felt some gases and stool entering the bag, but I did not stop my prayer because it was not my will. May Allah accept our obedience" (P 4).

In a bid to justify these religious concerns, religious experts (Mulla) were often consulted by the participants since they ensured them that their prayers were still effective even if the sickness was beyond their control. Religious validation provided relief against spiritual pain and affirming a sense of belongingness among their religious community.

Ramadan fasting was also another test since it might result in dehydration, tiredness, and stoma care complications. Fifty percent of participants could fast, adapting their diets normally to their medical conditions. Some others, mostly those with chronic illnesses, opted to make Fedia (charitable offerings) as a valid religious substitute for fasting, showing devotion to religious practice without jeopardizing their health.

In spite of these physical constraints, religious practice continued to be a vital component of participants' life. Two participants had undertaken the pilgrimage to Makkah for Umrah, an experience that they considered a deep spiritual cleansing and time of introspection. Such experiences

illustrate the resilience and versatility of colostomy patients in upholding religious practice, and the requirement of individualized religious counseling and social support in facilitating individuals with analogous medical complications.

Religious devotion remained central to participants' identity, and spiritual adaptation was facilitated by flexibility in practice and reassurance from clergy. This allowed individuals to maintain spiritual well-being despite physical constraints.

Stoma care and access to appliances

A majority of the respondents took care of their stoma by themselves or with the assistance of family members, as professional health advice was considerably restricted. The unavailability of specialist stoma care services compelled individuals to utilize self-care behaviors through peer support and informal learning. A participant who was a teacher revealed learning stoma care techniques from YouTube videos, indicating the increasing application of online resources because of an absence of formal medical training. The availability of Internet-based systems made learning possible but also pointed to places where proper structured patient education and professional input were not present.

"I learned from viewing YouTube videos how to manage my stoma" (P 2).

"Because they didn't have stoma bags, I saved the disposable ones made of nylon inside the stoma bag, and got rid of them" (P 1 and P 2)

"Because of repeated loose bowel movements, I am forced to drain the bag 5 times a day and wash and rinse them using water and recycle them, every 2 weeks I replace the flange" (P 3).

Another volunteer, a chemotherapy patient, was also engaged in patient education by instructing more than twenty individuals on how to deal with a stoma discreetly without hiding it herself.

"I taught over 20 patients to take care of their stoma when she was staying in an oncology Hospital for chemotherapy without disclosing these patients the fact that she also had a stoma". (P 7)

Others managed to hide their condition from their work.

For instance, P7 stated, *"I am self-employed, I am tailor, nobody is aware that I have stoma, even coworkers at work."*

This illustrates the interdependent nature of patient-led learning, where those with first-hand knowledge become de facto teachers, filling gaps in the healthcare system. The use of peer education and self-taught education highlights, however, the necessity for formal structured stoma care training programs to be incorporated into healthcare environments. Increased access to professional support services, such as stoma care nurses and education workshops, would increase confidence levels for the patient significantly, minimize complications, and improve overall quality of life for individuals who reside with colostomies.

Availability of colostomy appliances was a serious problem. Most of the respondents complained about unavailability in public hospitals and had to buy extra appliances to use from private pharmacies. With limited financial resources, some patients reused and cleaned appliances, highlighting better healthcare care and resource utilization. The frequency of appliance change was erratic, depending on the consistency of stool and stoma output, from once daily to three times daily.

Stoma care was marked by resource scarcity and knowledge gaps. In the absence of professional support, participants relied on personal experience and peer education to manage daily care and avoid complications.

Discussion

From findings in the study, the most common indication for permanent colostomy operation was colorectal cancer.

The findings of this research found that therapeutic permanent end colostomy patients are confronted with a lot of individual and social issues that negatively influence the quality of their lives. Patients attempt, with the cooperation of their relatives, to overcome these issues and adapt to the new situation. While a colostomy is a surgical procedure that is used to alleviate symptomatology involving the gastrointestinal tract and stop the development of the disease, the unavoidable physical alterations create abnormal physiological functions and disrupt most aspects of the patients' personal lives.[16] In terms of relationships with their family and friends, respondents indicated that they were supported by those around them, asserting that during all their time of need, family and friends supported them financially, psychologically, and physically. This highlights the significance of family members in supporting colostomy patients.

The lived experiences of colostomy patients can be interpreted through the lens of several psychosocial theories. Maslow's hierarchy of needs offers a foundational framework: participants consistently described unmet physiological and safety needs, such as difficulties managing stoma hygiene and fear of public embarrassment due to odor or leakage. These unmet lower-tier needs obstructed fulfillment of higher-order psychosocial goals such as social belonging, esteem, and self-actualization.[17] Furthermore, participants' narratives of social withdrawal and secrecy resonate with Goffman's stigma theory, which posits that individuals with visible bodily differences often anticipate social rejection and engage in self-isolation to manage identity threats.[18] Adaptation theory also proves useful in interpreting participants' coping strategies, especially the reliance on religious beliefs and familial support systems.[19] Such adaptive mechanisms illustrate the dynamic process through which patients negotiate identity, normalcy, and acceptance in the aftermath of life-altering surgery.

The present research considered the ostomy effect on quality of life in patients on several grounds. Other researchers have already reported physical problems with ostomies like redness, peristomal skin irritation, noise of appliance, and odour, as reported by the participants.[20] The psychological issues presented by these patients in the present research are also reported in the literature by other researchers.[21,22]

Following colostomy operation, the physical sexual health issues will vary for men and women. The key components of sexual well-being are the ability to enjoy and control sex, absence of fear, shame, guilt, and misconception, and absence of organic disorders.[23] In this present research, the aetiology of sexual issues owing to both organic reasons resulting from nerve damage and psychological reasons owing to changed physical form.[24] practitioners and patients may find it difficult to discuss sexual intimacy and relationships but there must be support and guidance, and patients that require additional support may have to be redirected to a professional counsellor.[20]

The stoma patients limit social contacts, engage in leisure activities less often, and travel by public transport less often

compared to other people.[21] The same result was also noted in the present study, particularly during the first postoperative time. However, some slowly became normal in terms of daily social activities, whereas some did not engage in any particular or fixed social activity even after a few years. The ostomy-imposed limitations on travel by the participants. In order to prevent changes of bags during the duration of the trip, some participants traveled short distances, and others traveled short distances. Pouch change is embarrassing to participants since it entails offensive-smelling and noxious effluents.[2] The majority of participants thus do not wish to have instances where a pouch change in public may be required. This result was also observed among the participants of this study.

For an individual to adequately adapt to colostomy life, time is the most important factor.[16] The level of adaptation to colostomy increased in proportion to the duration since stoma surgery, and it was discovered that the two variables were related.[22]

I believed the former social and cultural status of the patient would be an important determinant of quality of life after permanent colostomy. In the current study, because of the close and tight family and social relationships, the patients are adapted easily to the new condition, and the support of the family played an important role in this regard. Similar evidence has been confirmed by other former studies.[25]

Looking for a solution to his/her problem is an extremely important aspect of religion, specifically from the patient's point of view. Generally, increasing age and disease evoke a stronger desire for God's interference.[26] In the majority of the patients in the present study, most of them followed Islamic religious practices, such as praying, fasting during Ramadhan, and performing Umrah if they could afford it. For men patients, the combination of loneliness and physical inactivity was most probably the primary reason why men patients in this research ceased going to perform ritual prayers at mosques and doing them individually at home alone. This has been verified by other research that was conducted in other Muslim nations[26] but contrary to other research that was conducted among European nations where Muslim patients ceased praying on a daily basis and fasting during Ramadan.[25] Since they do not wish to leak and what they perceive as worse hygiene, Muslim patients with stomas try to avoid or reduce their involvement in congregational prayers.[27] The data revealed both culturally specific and universally shared experiences. Participants' struggles with religious practices, modesty in discussing bodily functions, and gender-based role expectations were deeply influenced by sociocultural norms prevalent in Iraqi Kurdistan. These findings align with literature documenting the spiritual and cultural complexities faced by Muslim patients undergoing stoma surgery.[28] Conversely, experiences such as diminished sexual intimacy, body image dissatisfaction, and fear of stigma transcended cultural boundaries and mirrored findings reported in Western literature.[22] This convergence suggests that while the expression and management of colostomy-related challenges are mediated by culture, the fundamental psychological and social disruptions are widely shared.

This research has endorsed the fact that no stoma patient care exists in nursing after discharge from hospital. This contrasts with other nations where patients receive a visit from the community nurse or stoma specialist nurse at home and are taught how to take care of and manage the stoma. The stoma patient is sustained throughout this period of transition (early postoperative period) by the community nurse until he/she is assessed to be self-managing.[29]

There are a number of skin conditions that must be addressed by a Stoma Specialist nurse or a trained doctor, some of which are due to underlying illness and others due to direct issues with stoma care.[30] Such patients, who are receiving standardised care in the hospital and in the home and normal counselling from properly trained stoma care specialists on a routine basis, will be much better able to handle normal issues occurring as a consequence of their colostomy than are those patients who have to take care of themselves in this regard.[25] The patients in this present study have no specialist stoma nurses, which gives them additional barriers to quality of life. All health care professionals who deal with colostomy patients should aim to enhance their quality of life; nurses specifically should know how their education and experience can enhance patient's quality of life pre- and post-ostomy surgery.[16]

Lastly, expert stoma nurses and stoma therapy units in the concerned hospitals where gastrointestinal surgery takes place should be present to provide group education of the stoma patients and their families to enhance the quality of life of permanent colostomy patients.[31]

This research is enlightening regarding the patients' life under permanent colostomy; however, one has to be aware of some limitations that may interfere with the generalizability as well as findings' interpretation. The research has been carried out on a low number of merely eight participants recruited from the same hospital environment. This small sample and homogeneity of the environment limit the generalizability of findings to other populations, which can be faced with varying socio-cultural and healthcare environments.[8] In addition, while reflexivity methods were employed to reduce bias, the researcher's professional experience in surgical colostomy care may still bias the process of interpreting data towards highlighting some thematic findings over others. Future studies should be a mixed-methods study design with the quantitative measurements used to cross-validate the qualitative data. Increasing the participant base from more centers would bring strength and diversity to the data.

Conclusion

Quality of life is increasingly being recognized as an important outcome measure in surgical evaluations. The establishment of a permanent colostomy has the potential to drastically curtail a patient's social and personal life, and is of high risk to their psychological and emotional stability. Prevention of most peristomal skin problems can be achieved through adequate skin care and pouching system management. Studies indicate that it takes a while for patients to adapt to stoma life, and thus supportive care by healthcare professionals is essential, particularly in the first months to a year following surgery. Thus, healthcare professionals have an important role to play in helping ostomy patients during the transition period until they are self-sufficient. Such support is rendered in the guise of educational resources like pamphlets, peer visitation programs, teaching tapes, and individual counseling by means of individual consultation with the help of ostomy nurse specialists. Detailed evaluation may foster better understanding of the needs of each patient, their relatives, and the community at

large and promote better psychological adjustment and effective rehabilitation following surgery.

Acknowledgement

None.

Conflict of Interest

No conflict of interest to declare.

Ethical Approval

Ethical approval was obtained from the Directorate of Research Center and the scientific committee of College of Nursing / University of Raparin (reference number: N-2023-01)

Funding

This research did not receive any specific grant from funding agencies in the public, commercial or not-for-profit sectors.

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