

Experiences of Japanese Patients With Colorectal Cancer During the First Six Months After Surgery

Michiyo Mizuno, RN, PhD, Miho Kakuta, RN, MSN, Yuriko Ono, RN, BN,
Akiko Kato, RN, MNsc, and Yumiko Inoue, RN

Purpose/Objectives: To investigate the dynamic experience of patients who recently experienced the stressful situation of being diagnosed with colorectal cancer and undergoing surgery.

Research Approach: A qualitative and inductive inquiry.

Setting: General hospitals in Japan.

Participants: 12 patients who had undergone colorectal cancer surgery and had been discharged in the previous six months.

Methodologic Approach: To inductively elicit the findings from patients' real experiences, interviews and qualitative analysis were used.

Main Research Variables: Experience of patients with colorectal cancer.

Findings: Three domains that symbolized experiences of patients with colorectal cancer during the first six months after surgery emerged: types of burdens, steps in accepting the cancer diagnosis, and way of living a normal life. Burdens included vulnerability, lack of control, asking for assistance or support, and a "why has this happened to me?" attitude. Way of living a normal life included resisting vulnerability, constructing a daily living routine, and asking for help.

Conclusions: Although patients faced many and varied burdens, they were able to take several actions to gradually accept their cancer diagnoses and resume normal lives.

Interpretation: Some of the patients were sincere and skillful in asking for help to live normal lives, but others found that difficult. The present findings are significant in helping nurses provide interventions to enable patients to make use of assistance or support.

who are vulnerable and unable to cope adequately with a diagnosis of colorectal cancer and the subsequent operation might experience a decline in quality of life. If the situation deteriorates further, a crisis could occur.

However, research findings verify that many patients with colorectal cancer make good recovery in terms of physical condition and quality of life at some point after surgery (Ramsey, Berry, Moinpour, Giedzinska, & Andersen, 2002; Ramsey et al., 2000; Ulander, Jeppsson, & Grahm, 1997). Nevertheless, the literature contains little qualitative research describing the experiences of such patients during those difficult times and how they ultimately cope with them and recover their health. The current study was performed to clarify those areas.

Literature Review

Adaptation to Life-Threatening Disease

Studies examining a sample of patients on two separate occasions during the clinical course of colorectal cancer (prior to surgery and after surgery) have found that most physical symptoms declined and psychological distress dissipated within three months (Whynes & Neilson, 1997) or five to eight months (Ulander et al., 1997). In contrast, other research has found that physical symptoms such as diarrhea and depressive symptoms persisted at a relatively high prevalence, even in those who had survived at least five years after diagnosis of colorectal cancer, although their quality of life had improved (Ramsey et al., 2002). In another study (Ramsey et al., 2000), respondents with stage I–III disease reported a relatively uniform and high quality of life at three years after

With the current trend toward Westernization of Japanese lifestyle, the incidence of colorectal cancer in Japan has been increasing annually. In 2004, the death rate for colorectal cancer per 100,000 in Japan was 35.4 for men and 28.2 for women, with mortality rankings of fourth and first, respectively (Health and Welfare Statistics Association, 2006). Although the leading cause of cancer deaths in Japan in the past decade was lung cancer among men and gastric cancer among women, colorectal cancer has overtaken gastric cancer as the leading cause of cancer deaths among women.

For patients who undergo surgical treatment of colorectal cancer, the five-year survival rate is relatively high in Japan—approximately 80% for colon cancer and 70% for rectal cancer (Takasu, Ogata, Yamaguchi, & Kitahara, 2001). However, the surgery is demanding on patients. Postoperatively, many have physical symptoms such as elimination disorders and fatigue, and they have to deal with changes in physical functioning and body image dictated by the surgery as well as the emotional distress related to a cancer diagnosis. Patients

Michiyo Mizuno, RN, PhD, is a professor in the Department of Nursing Science in the Graduate School of Comprehensive Human Sciences at the University of Tsukuba in Ibaragi, Japan; Miho Kakuta, RN, MSN, and Yuriko Ono, RN, BN, are instructors in the Department of Adult and Elderly Nursing, and Akiko Kato, RN, MNsc, is a doctoral candidate, all at Ishikawa Prefectural Nursing University in Japan; and Yumiko Inoue, RN, is a head nurse at Mitsui Memorial Hospital in Tokyo, Japan. This study was supported by a grant-in-aid for Scientific Research (C) from the Japan Society for the Promotion of Science (No. 18592376) and by a grant from the Community Care Center Foundation at the Ishikawa Prefectural Nursing University. (Submitted September 2006. Accepted for publication March 4, 2007.)

Digital Object Identifier: 10.1188/07.ONF.869-876

Quick Facts: Japan

- Japan is an Asian archipelago nation and has a total population of approximate 128.75 million as of 2006. Tokyo is the capital city. In the 1960s, Japan achieved remarkable economic growth.
- Remarkable economic and technologic advances have led to ongoing Westernization of traditional Japanese lifestyle, resulting in changes in frequency of various diseases. Cancer has been the leading cause of death in Japan since 1981 and accounts for more than 30% of national mortality.
- Even today, some patients with cancer are not informed of their diagnoses, particularly in provincial areas. In a national survey by a medical group, given the hypothetical situation of being told by doctors that a loved one had cancer, only 74% of respondents stated that they would inform their loved ones of the diagnosis, and most would do so only if they thought the patients would want to know.
- All health insurance coverage for the entire population is organized under the well-respected Japanese medical care system that was established in 1961. Under the system, all citizens can receive medical services with minimum financial burden. Surgical patients in Japan usually can stay in the hospital longer than patients in the United States.

diagnosis, although it was poorer in the first three years. In those studies, an instrument assessing health-related quality of life (HRQOL) in a variety of chronic health states or a HRQOL scale specific to disease were used.

Regarding the relevance of prognosis to emotional function, patients with colorectal cancer may have an advantage over those with other cancers considered to have poorer prognoses. Zabora, BrintzenhofeSzoc, Curbow, Hooker, and Piantadosi (2001) found that the prevalence of psychological distress as a consequence of cancer diagnosis was considerably lower among those affected by colorectal cancer when compared to those with other cancers, such as lung cancer and brain cancer, which are thought to be associated with poorer prognoses.

Research also has revealed gender- and age-related differences in emotional distress and demands of illness. In a study of older adult patients with colorectal cancer by Kurtz, Kurtz, Stommel, Given, and Given (2002), female patients exhibited more psychological distress and more depressive symptomatology than male patients did. In contrast, while postulating that a greater degree of spiritual well-being in people with colorectal cancer might help to mitigate the demands of the illness, Fernsler, Klemm, and Miller (1999) found that women reported significantly greater spiritual well-being than men. Concerning the relevance of age to demands of illness in people being treated for colorectal cancer, the youngest age group (younger than 45 years) reported significantly greater demands than the middle and older groups (Klemm, Miller, & Fernsler, 2000).

Nonetheless, such findings about the state of recovery of physical function and emotional function do not sufficiently elucidate what difficulties patients with colorectal cancer cope with in the process and how they adapt to the experience. Such adaptation consists of various interdependent factors; hence, healthcare providers cannot unconditionally conclude that patients will adapt to life-threatening disease just because their emotional functioning improves. For example, Northouse, Mood, Templin, Mellon, and George (2000) examined patterns of adjustment to colon cancer in patients and their

spouses one week after diagnosis and 60 days and one year after surgery. They found that patients and spouses reported decreases in emotional distress over time but that family functioning and social support also declined over time. If the latter continues to be reduced, the couples' coping resources also will be compromised and their adjustment will be even more disturbed despite improvement of both parties' emotional functions. Comprehensive assessment of the basis of patients' situations and their perceptions of why they became ill is necessary to adequately understand patients' perceptions of their emotional well-being and health.

Psychological Stress

In aiming to develop a nursing care plan that corresponds to patients' needs and demands and stimulates patients to adapt to their cancer experiences, nurses need to learn what the inevitable stressors are for patients and what enables them to manage the stressors. Packard, Haberman, Woods, and Yates (1991) stated, on the basis of findings from a study on the demands of illness, that adaptation to chronic illness, including cancer, may be a function of how well patients manage the inevitable stressors of personal disruption and environmental transactions associated with the illness experience rather than an ability to manage the direct effects of disease on their lives. The present study investigated the dynamic experience of patients who recently had experienced the stressful situation of receiving a diagnosis of colorectal cancer and undergone related surgery. It focused on environmental demands on patients and their psychological resources for dealing with them.

Experience After Surgery

Tumor stage and prognosis influence patients' perceptions of their cancer experiences. Weisman and Worden (1976) investigated patients with newly diagnosed cancers of various types and showed that mental state dominated by concern and high vulnerability were closely connected to high mortality, poor therapeutic response, and concurrent psychosocial disruption. Although that means that subjects who had poorer prognoses tended to experience predominant concern and high vulnerability, the researchers also found that the concern and vulnerability tended to abate during the first 100 days. The tendency was demonstrated even among patients who were strongly influenced by protracted treatment. Hence, that phase of the cancer experience might be the period of greatest optimism because the most effective treatment methods are applied first (Weisman, 1976).

"Cognition, or the subjective meaning, of a stressful event plays a major role in determining both the nature and degree of coping behaviors" (Aguilera, 1997, p. 35). The subjective meaning of illness also is affected by the internal standard of health. Some evidence shows that patients with chronic disease reframe their internal standards of health in the process of becoming and remaining ill (Bernhard, Hurny, Maibach, Herrmann, & Laffer, 1999; Oort, Visser, & Sprangers, 2005; Schwartz & Sprangers, 1999; Sprangers & Schwartz, 1999). That is, patients' perceptions of health-related quality of life change as a result of shifting their responses to health status. For example, patients with malignant colon tumors reported more optimistic assessment of their postoperative quality of life than those with benign colon tumors (Anthony, Jones, Antoine, Sivess-Franks, & Turnage, 2001). In that case, quality of life was assessed chiefly by the Medical Outcomes Study

Short Form-36, which measures eight health concepts. The findings suggest that the change in perception was not induced primarily by intervention (e.g., colon surgery, postoperative adjuvant chemotherapy) but by coping with the disease itself (Anthony et al., 1999; Bernhard, Lowy, Maibach, & Hurny, 2001).

Surgery is the most effective treatment method for most patients with colorectal cancer, and it has psychological as well as physical effects. In light of a study by Weisman and Worden (1976), although the surgical experience is demanding, it seems to mitigate existing concerns about life-threatening disease, thereby increasing psychological resources. In consideration of studies by Anthony et al. (2001) and Bernhard et al. (1999), reframing tends to be induced by coping with the disease. Hence, enhanced coping tends to promote reframing of internal standards of health. Given the active reframing period, effective nursing interventions might efficiently promote positive changes in health behavior. However, because the clinical phenomenon has complex and interdependent aspects, it has not been fully elucidated.

Therefore, the current study was designed to inductively elicit findings from patients' actual experiences. The researchers chose to focus on effects of cancer diagnosis and surgery on patients because they believed that the two stressors overlap and affect the actual experiences. The investigation aimed to ascertain the perceptions of patients with colorectal cancer with regard to their experiences in the first six months after surgery and the attitudes with which they chose to deal with their problems throughout that experience.

Methods

Participants

Among those who had undergone colorectal cancer surgery and had attended the outpatient department of a general hospital in Japan from September 25–December 25, 2003, all who had been discharged in the previous six months were asked by a nurse to participate in the study by consenting to an interview. Immediately before interviewing participants, the investigators explained the purpose of the interview, the way in which it would be conducted, and the participants' rights. Twelve subjects agreed to be interviewed.

Procedure

Prior to interviews, the study was approved by the research ethics committee of the institution with which the authors are affiliated, as well as the hospital in which the interviews were conducted.

Personal interviews were conducted by investigators in places and at times of the interviewees' choice, most often in an office at the outpatient department after patients had consulted their physicians. After obtaining written consent, the investigator interviewed a patient for approximately 60 minutes using an interview guide. The interview was designed to obtain information about the patients' experiences with colorectal cancer from the time of discharge onward. The focus was on difficulties experienced in recuperating from colorectal cancer, in conducting daily life activities, and in continuing treatment and follow-up; patients also were asked when difficulties occurred; what, if anything, kept them from being able to benefit from the events; and what perspectives they gained from the experience.

An average of 111.4 days (SD = 48.9; range = 49–183 days) had elapsed since surgery. Second interviews were conducted approximately one month after the first interview (i.e., within six months after discharge) with five patients who agreed to a follow-up interview. The second interview was designed to obtain information not ascertained in the first interview and to determine any changes in patients' experiences in the interim. All interviews were recorded on audiotape, and recordings were transcribed verbatim. Transcripts were not edited to alter any of the patients' statements.

Data Analysis Strategies

A multiphase process was used to analyze the transcribed interview data based on the analytic methods described by Lincoln and Guba (1985), McCracken (1988), and Spradley (1979, 1980). The interviews were read multiple times by a representative party of investigators. The data then were categorized while the units of analysis in the transcribed data were identified. Each unit was heuristic and the smallest piece of information that could stand by itself (Lincoln & Guba). Hence, the unit of analysis that was coded was the complete idea rather than the complete sentence. Whenever possible, it was coded with terms as they were expressed by the patients.

Each unit of analysis was reviewed and categorized on the basis of similarity among terms. In the process of determining categories, similarity was based on the denotative meaning rather than the connotative meaning of each unit. Each category, called a "domain," had three structural elements: cover terms, two or more included terms, and a single semantic relationship (Spradley, 1979, 1980). Cover terms are names for categories, included terms are terms that belong to a category of knowledge named by the cover terms, and the semantic relationship links a cover term to all of the included terms in its set.

Because many different domains were identified, a few key domains were selected based on the purpose of this study. Selection was based on trends in the raw data and the organization with and within each domain. The researchers identified the internal structure of the key domains by searching for possible subsets among the included terms. Simultaneously, the key domains were enlarged and made more inclusive by combining with other, similar domains. At that time, a domain and the taxonomy associated with it were always based on a single semantic relationship.

Decisions about selecting key domains, their internal structures, and the components of their meanings were based on consensus among the representative party conducting the analysis and an auditor who also was one of investigators. While the domains were under development, any disagreement about aspects of the analysis was resolved through discussion, which resulted in either refinement in the definition of a domain or new decision rules about the inclusion or exclusion of a unit in a domain.

Results

Subjects

Twelve subjects participated in the study; seven (58%) were men; 11 (92%) were accompanied by their spouses. Patients' average age was 66.2 years (SD = 11.1; range = 43–79 years); average age was 65 (SD = 9.2) for men and

67.8 (SD = 14.3) for women. In six patients, tumors had been staged at Dukes C, and Eastern Cooperative Oncology Group (ECOG) performance status (Oken et al., 1982) showed that ability to perform activities of daily living was basically satisfactory in the sample. Additional descriptive statistics for the study sample are summarized in Table 1.

From the interview data, three domains symbolizing the experiences of patients with colorectal cancer during the first six months were elicited. Cover terms of the domains were “burdens,” “accepting the cancer diagnosis,” and “living a normal life.” The cover terms were linked to include terms by each of the following semantic relationships: strict inclusion, sequence, and means-end. Taxonomy of three domains is shown in Table 2. Explained based on the meaning of three domains, the theme of the patients’ experience was that although they experienced many and varied burdens, they gradually accepted their cancer diagnoses and resumed normal lives by taking several actions.

Burdens

Patients’ burdens included problems associated with and demands from colorectal cancer diagnosis and surgery. Burdens first were classified as “vulnerability,” “lack of control,”

Table 1. Sample Characteristics

Characteristic	n	%
Age (years)		
\bar{X} = 66.2	—	—
SD = 11.1	—	—
Performance status score		
\bar{X} = 0.5	—	—
SD = 0.5	—	—
Gender		
Male	7	58
Female	5	42
Employment status		
Employed	5	42
Not employed	7	58
Marital status		
Married	11	92
Single	1	8
Key person		
Spouse	9	75
Other	2	17
None	1	8
Cancer site		
Colon	4	33
Rectum	8	67
Cancer stage (Duke)		
A	3	25
B	1	8
C	6	50
D	2	17
Treatment		
Supplementary chemotherapy	5	42
Chemotherapy	1	8
Radiation therapy	1	8
None	5	42
Stoma		
Stoma	2	17
Colonic resection	10	83

N = 12

“asking for assistance or support,” and a “why has this happened to me?” attitude.

Vulnerability was classified further as “hypersensitivity to the physical condition,” “awareness of death and dying,” “possible recurrence,” and “intrusion of thoughts related to self-image.” Patients with colorectal cancer experienced various combinations of those types of vulnerability as burdens after surgery.

The patients became hypersensitive to their physical conditions as illustrated by the following quotations. “I am concerned about the slightest symptom,” “I became conscious of my own body on occasions such as defecating, eating, or being on a crowded train,” and “I can’t help suspecting others’ hidden motives in assessing my own health through their speech and behavior.” The hypersensitivity must have a great deal to do with the uncertain and unpredictable course and life-threatening nature of the cancer and the awareness of death and dying and the possible recurrence of disease.

Most patients recounted becoming aware of death and dying after receiving their cancer diagnoses. Some patients spoke of feeling ready to die. When patients were aware of death and dying, however, most also realized that they were frightened at the possibility of their own deaths and the process of dying. Although the expression of that fear was highly individual, patients seemed to find it easier to express their fear in the context of the risk of recurrence than in the context of death and dying. For example, one patient said, “I tell myself that it really does not matter and I do not mind dying. And yet I fear a recurrence. If the cancer recurs, it of course appears hopeless. First of all, I don’t want another operation.” Various subjects inspired patients’ fear of recurrence. All patients voiced thoughts of recurrence, even though the awareness of possible recurrence tended to be deep-seated and latent; for example, “I do not think about [recurrence] when I am talking to my wife or watching television. Only when I am alone in bed do I slip into dark thoughts.”

Many patients also experienced a sense of vulnerability related to intrusive thoughts about self-image. In particular, those who had a colostomy appraised their changes after having surgery and expressed their altered self-images; for example, “When I first went into town after leaving hospital, I could feel myself having aged suddenly.” Altered self-image was not confined to those who had undergone colostomy. Even patients who did not have a colostomy experienced problems, such as soiling the perianal area at defecation and a sense of physical deterioration. Statements such as “I started to lack self-confidence,” “I felt pity for myself,” and “I felt damaged because of my poor esthetic condition” symbolized their experience of vulnerability as the intrusion of concerns related to self-image.

Lack of control: People feel burdened when they cannot control their own behaviors, conditions, or situations. Three issues—“fatigue,” “conflicts over health care,” and “too much concern paid by family”—could make patients feel that they were not in control, and the issues were burdensome.

Many patients reported that their physical strength had deteriorated considerably and that they became tired easily. Fatigue was a burden that almost all patients recognized. Even slight variations from routine tired them easily, particularly those that occurred soon after discharge. Some continuously felt like lying down or could not even walk as they used to.

Table 2. Taxonomy of the Three Domains

Domain	Terms	Examples
Kinds of burdens	Vulnerability	Hypersensitivity to physical condition Awareness of death and dying Possible recurrence Intrusion of thoughts related to self-image
	Lack of control	Fatigue Conflicts over health care Too much concern paid by family
	Asking for assistance or support	Asking about information and counseling service Delegating some duties to others Sharing feelings and thoughts about the illness
	“Why did this happen to me?” attitude	Attitude of resisting having cancer Attitude of “why has this happened to me?”
Steps in accepting the cancer diagnosis	Learning to be grateful	Recognizing the seriousness of one's own illness Actually feeling the family's or physician's concern Contemplating the meaning of suffering caused by one's illness Taking other's concern in a favorable light
	Developing the willpower to face the illness	Awakening to the responsibility of living Becoming conscious of the drive to live
	Actually feeling that one is getting better	Feeling a sense of well-being Getting one's physical strength and appetite back Starting to go out as before Gaining weight Returning to work
	Not being depressed	Having a naturally optimistic personality Recovering a normal life
Way of living a normal life	Resisting vulnerability	Being intentionally unconcerned about the illness Coping with apprehensions, worries, or fear
	Constructing a daily living routine	Recovering one's former lifestyle Making special times for oneself
	Asking for help	Giving one's own health condition priority Talking about the illness with family and friends

Note. The bolded portions represent semantic relationship. The second column shows cover terms.

The deterioration in physical strength made the patients very aware of their limitations in performing work, and many did not want to overwork during the recuperation period. On some occasions, however, they could not escape their roles at home and in workplaces, despite their physical conditions. For example, one patient, a breadwinner of the family, said,

I believe that my family is the most valuable thing to me. So irrespective of my condition, I think I owe my beloved family a great deal of work, although I know my health should be my first priority in everything I do.

Even though the illness experience inspired an interest in improvements in diet and lifestyle, some patients worried about not being able make the changes dictated by the disease despite their best wishes to do so. The concerns weighed

heavily on such patients. Too much concern paid by family sometimes prevented patients from freely performing their daily roles, and they then felt uncomfortable. An older patient who commented that he used to be bossy said, “I can no longer do much work. Even if I try, my wife insists that I rest. I feel like working though. My wife is against any heavy work. I do not like it, but I cannot help it.”

A female patient complained, “With my diet, I often feel that my behavior is being kept watch on by my family. With my condition, this can't be helped.” For patients who had a sense of vulnerability, family concern sometimes seemed uncontrollable.

Asking for assistance or support: Some patients wanted information and counseling services provided by healthcare professionals about devices related to elimination and their current situations, some wanted to delegate some of their

duties to others, and others wanted to share their feelings and thoughts about the illness with other people. If the patients lacked the skills or opportunities to meet the demands, however, the demands often weighed heavily on them, in some cases justifiably so.

One patient, a housewife, said, "My husband has never fallen sick and never does housework. So he can't understand my position. So I, myself, must do everything." She might have lacked the skills or opportunity to ask her family for assistance and, therefore, felt unable to delegate any of her duties to her family, even after surgery. If patients who said that asking for assistance or support was difficult for them had been enabled to talk candidly about their illness with significant others, things might have been different. However, some patients felt uncomfortable talking about the illness with family and friends. Some of them confided that "Nobody but the patient can understand the suffering associated with this illness" or "I do not want my family to know my worries or fears; it might upset them too much." Patients tended not to discuss death and dying and symptoms related to evacuation with their families.

The opportunity to talk was important. One woman who said at the first interview, "My husband does not appear to be thinking much about me; I got my illness, and, in a way, it is my own private fight," related a different experience during the second interview.

Talking about my illness with you reminded me all about it. I realized that it was really hard, and I wanted someone to listen to my account. It is no use talking to people who cannot understand it. I did tell my friends about my experience but got the impression that they did not understand it.

Why did this happen to me? A "why did this happen to me?" attitude weighed heavily on some patients. A female patient recounted, "I know that I have cancer, but part of me still resists accepting the fact. Somehow I believe that I am almost the same as other, normal people; part of me gives up and yet another part fights back."

She was troubled about whether she would be able to resolve the question of why this had happened to her. A male patient asked about a superstition that he had heard: "I wonder if my cancer is the type that recurs. If one of your parents, your mother, has died from cancer, is it true that her male children will get the same disease?"

Accepting the Cancer Diagnosis

Certain steps were apparent in accepting the cancer diagnosis: learning to be grateful, developing the willpower to face the illness, actually feeling that they were recovering, and not being depressed.

Learning to be grateful: Most patients who mentioned that they had accepted the cancer diagnosis had learned to be grateful for their experiences. They also recognized the seriousness of their illness, actually felt their families' or physicians' concern for them, reflected on the meaning of suffering caused by the illness, and saw others' concern for them in a favorable light. Through the positive accomplishments, they learned to be grateful. The following quotation seems to symbolize the sequence.

If I were unfortunate, I could have been dead. One cannot help being serious about it. The fact that I am still alive

has changed my approach to life. I should be grateful. I am simply grateful that I am now alive. I would never have attained this state of mind if I had not become ill.

Developing the willpower to face the illness: Some patients declared that they could accept the cancer diagnosis because they had awakened to the responsibility of living and had become conscious of the drive to live. At that time, they became resolved to recover from the illness, to fulfill the roles required of them, to return to normal society, to live their lives in full while withstanding the suffering, and to survive.

Actually feeling that they were recovering: When patients actually felt that they were getting better, many could be convinced that they had accepted the cancer diagnosis. Patients believed that recovery was real for various reasons: The food tasted good, disorders of evacuation improved, and they regained physical strength and appetite, gained weight, returned to work, and started to go out as before.

Not being depressed: Themes the patients most readily referred to as proof that they had accepted the cancer diagnosis were "no need for depression/not being depressed." Indeed, some patients said that they had come to appreciate their cancer experiences rather than being depressed. Some said that their depression had resolved because they had recovered normal lives, whereas others said that they did not get depressed because of their natural optimism. The fact that patients often used the word depression seemed to symbolize their latent consciousness that a cancer diagnosis naturally would make people depressed. The acceptance of the cancer diagnosis was the fruit of their efforts to deal with depression; hence, "not being depressed" might be a step toward acceptance.

Living Normal Lives

When the patients said that they could resume normal lives, they also mentioned the actions required to do so. These were classified as resisting vulnerability, constructing a daily living routine, and asking for help.

Resisting vulnerability: For the patients to live normal lives, they needed to deal with the burden of vulnerability. Many actually mentioned several attitudes that they adopted to resist vulnerability. One representative stance was the attitude of being intentionally unconcerned about the illness: not dwelling on the cancer diagnosis, accepting the illness as a fate that had been predetermined, and leaving the future to chance. Another theme that emerged was an attitude of coping with apprehensions, worries, or fear: adding positive meaning to the experience, focusing on the bright side of the present experience, finding something more precious than life, not regretting a life already lived, thinking deeply about life, managing to believe in recovery, and keeping the mind active. For example, a woman said that images of her body flashed across her mind whenever she went to the bathroom after surgery; however, apart from those occasions, she did not have time to worry too much about her bodily functions because of her hobby of composing Haiku (Japanese short poems) and using every little thing as a source of poetic creativeness.

Constructing a daily living routine: Although patients reported being able to live normal lives, they still experienced some substantial burdens in terms of their actual conditions. Hence, to resume normal lives, they took necessary actions such as "constructing" a daily living routine in addition to resisting vulnerability. The actions included recovering their

former lifestyles and making special time for themselves as well as using more concrete means, such as doing housework, going on trips with others, or taking daily walks for exercise.

Asking for help: In trying to live normal lives after being discharged, patients sometimes needed a breakthrough in asking for assistance or support. Indeed, some patients were assertive yet discerning in asking for help. They did not ask for help for everything, but they sought assistance in health matters they considered priorities. If such patients were able to talk about the illness with family, family members usually became aware of their conditions and helped them. For example, one woman said, "When I am very tired, I do not suffer in silence but truthfully tell my family of my condition so that I can take a rest."

Discussion

Clinical Implications

The burdens elicited in the study could be seen as expressions of tension and anxiety resulting from the stressful experience of being diagnosed with colorectal cancer and undergoing related surgery. Although patients experienced many varied burdens and were under considerable tension, they came to accept their cancer diagnoses through several steps, and they took several actions to resolve their problems and live normal lives. The process reflected the consequences of recuperating, learning from, and overcoming difficulties or tensions experienced from the time of cancer diagnosis to six months after surgery. The researchers found that patients reduced the tension by positively defining and understanding their experiences and coping with problems. This meant that they had the ability to productively expand their actions and develop their personalities to reduce tension.

Even patients who have well-developed coping abilities can require specific nursing services. The findings suggest that patients need careful nursing intervention, particularly to be able to ask for assistance or support. Although some patients were assertive yet discerning in asking for help, others found that asking for any assistance or support was difficult. Such reticence was a problem, as was inadequate provision of assistance or support. Depending on others for support when needed is a naturally difficult task for patients. Peplau (1991) explained that patients have difficulty communicating their wishes to others and feeling free to make use of assistance unless they are provided with appropriate nursing intervention.

The ability to express oneself is essential to communicating wishes to others. However, the ability can be impaired in patients who experience problems related to adult identity. In the current study, some patients experienced damaged self-images related to altered postoperative bowel control; therefore, they felt vulnerable. Moreover, based on narrative interviews with patients with colorectal cancer, Rozmovits and Ziebland (2004) stated that defective bowel control experienced by patients in adulthood caused them to lose dignity, privacy, independence, and sexual confidence and compromised their ability to work, travel, and socialize. In addition, a phenomenologic study of the experience of being diagnosed with colorectal cancer demonstrated the difficulties patients have in expressing themselves (Taylor, 2001). That study summarized one of the main themes experienced by patients: feeling "on your own." This was characterized by patients' perception

that no one else could appreciate the effects of the diagnosis on their bodies, their need to protect others, and the inherent personal and social difficulties in talking about cancer and associated issues.

Difficulty with self-expression is particularly evident for the Japanese, who do not tend to talk frankly about their feelings and thoughts, even with family. The Japanese identity is dependent on interpersonal relationships, and Japanese tend to appraise themselves through the context of relating to others. As pointed out by social anthropologist Nakane (1984), moral concepts such as "the husband leads and the wife obeys" embody the Japanese emphasis on the whole. According to Japanese psychologist Doi (1981), most Japanese consider it perfectly natural to vary their attitudes depending on whether they are dealing with their "inner circles" or with others. The inner circle is a group of people with whom a person feels at ease and generally includes family members. However, asking others, including family, for assistance or support imposed a burden on the patients in the present study. Hence, at least regarding illness experiences, Japanese patients with colorectal cancer do not regard their families as part of their inner circles.

Moreover, not only did patients have trouble communicating their wishes, but they also were unaware of their real state of mind. The "why has this happened to me?" attitude that was an expression of anguish related to attribution and that was one of the "burdens" elicited was not expressed by any of the participants until the second interviews. All of the interviewers were researchers or clinical nurses with more than 15 years of experience in oncology nursing. During interviews, they demonstrated and communicated acceptance of the patients as they were and tried to help them to talk freely about their experiences. The first interviews likely led patients to become aware of their feelings about current areas of confusion and problems, and they probably expressed that awareness and were better able to communicate their feelings in the second interviews because they knew that the interviewers accepted them. Therefore, nurses should allocate sufficient time to uncover Japanese patients' feelings about illness experiences and to enable patients to feel comfortable with them and at liberty to make use of assistance.

For any intervention to be helpful, nurses must develop some understanding of how patients perceive themselves and how they view the situations confronting them (Peplau, 1991). The authors believe that the findings involving patients after surgery for colorectal cancer are likely to help nurses understand such perceptions. The patients were able to take several actions to resolve their problems and live normal lives. The phenomenon is not likely to be limited to Japanese patients. The authors believe that, if nurses provide nursing interventions to help patients sustain and develop such actions further, they can maximize patients' resources.

Limitations of the Study and Future Tasks

The study recruited a comparatively small number of patients who had undergone surgery within the prior six months and included those with diverse tumor stages who had undergone various treatments. Although the diversity was intentional, a carefully constructed, prospective, longitudinal study will be necessary in the future. Moreover, the timing of second interviews should be considered further in future studies.

To further understand how care should be delivered to patients after colorectal cancer surgery, further analyses of their burdens and the relationships between them and patients' psychological resources for dealing with them will be necessary to identify operational components of nursing care that can be used to influence such factors.

The authors gratefully acknowledge all participants and the staff of the hospitals who made the study possible.

Author Contact: Michiyo Mizuno, RN, PhD, can be reached at michiyo0611@md.tsukuba.ac.jp, with copy to editor at ONFEditor@ons.org.

References

- Aguilera, D.C. (1997). *Crisis intervention: Theory and methodology* (8th ed.). St. Louis, MO: Mosby.
- Anthony, T., Jones, C., Antoine, J., Sivess-Franks, S., & Turnage, R. (2001). The effect of treatment for colorectal cancer on long-term health-related quality of life. *Annals of Surgical Oncology*, 8, 44–49.
- Bernhard, J., Hurny, C., Maibach, R., Herrmann, R., & Laffer, U. (1999). Quality of life as subjective experience: Reframing of perception in patients with colon cancer undergoing radical resection with or without adjuvant chemotherapy. Swiss Group for Clinical Cancer Research (SAKK). *Annals of Oncology*, 10, 775–782.
- Bernhard, J., Lowy, A., Maibach, R., & Hurny, C. (2001). Response shift in the perception of health for utility evaluation. An explorative investigation. *European Journal of Cancer*, 37, 1729–1735.
- Doi, T. (1981). *The anatomy of dependence*. Tokyo: Kodansha International.
- Fernsler, J.I., Klemm, P., & Miller, M.A. (1999). Spiritual well-being and demands of illness in people with colorectal cancer. *Cancer Nursing*, 22, 134–140.
- Health and Welfare Statistics Association. (2006). *Kokumin eisei no doukou 2006 [Health in Japan: Recent vital statistics 2006]*. Tokyo: Author.
- Klemm, P., Miller, M.A., & Fernsler, J. (2000). Demands of illness in people treated for colorectal cancer. *Oncology Nursing Forum*, 27, 633–639.
- Kurtz, M.E., Kurtz, J.C., Stommel, M., Given, C.W., & Given, B. (2002). Predictors of depressive symptomatology of geriatric patients with colorectal cancer: A longitudinal view. *Supportive Care in Cancer*, 10, 494–501.
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- McCracken, G.D. (1988). *The long interview* (Qualitative Research Methods Series 13). Newbury Park, CA: Sage.
- Nakane, C. (1984). *Japanese society*. Tokyo: C.E. Tuttle.
- Northouse, L.L., Mood, D., Templin, T., Mellon, S., & George, T. (2000). Couples' patterns of adjustment to colon cancer. *Social Science and Medicine*, 50, 271–284.
- Oken, M.M., Creech, R.H., Tormey, D.C., Horton, J., Davis, T.E., McFadden, E.T., et al. (1982). *American Journal of Clinical Oncology*, 5, 649–655. Retrieved September 8, 2006, from http://www.ecog.org/general/perf_stat.html
- Oort, F.J., Visser, M.R., & Sprangers, M.A. (2005). An application of structural equation modeling to detect response shifts and true change in quality of life data from cancer patients undergoing invasive surgery. *Quality of Life Research*, 14, 599–609.
- Packard, N.J., Haberman, M.R., Woods, N.F., & Yates, B.C. (1991). Demands of illness among chronically ill women. *Western Journal of Nursing Research*, 13, 434–454.
- Peplau, H.E. (1991). *Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing*. New York: Springer.
- Ramsey, S.D., Andersen, M.R., Etzioni, R., Moinpour, C., Peacock, S., Potosky, A., et al. (2000). Quality of life in survivors of colorectal carcinoma. *Cancer*, 88, 1294–1303.
- Ramsey, S.D., Berry, K., Moinpour, C., Giedzinska, A., & Andersen, M.R. (2002). Quality of life in long term survivors of colorectal cancer. *American Journal of Gastroenterology*, 97, 1228–1234.
- Rozmovits, L., & Zieband, S. (2004). Expressions of loss of adulthood in the narratives of people with colorectal cancer. *Qualitative Health Research*, 14, 187–203.
- Schwartz, C.E., & Sprangers, M.A. (1999). Methodological approaches for assessing response shift in longitudinal health-related quality-of-life research. *Social Science and Medicine*, 48, 1531–1548.
- Spradley, J.P. (1979). *The ethnographic interview*. New York: Holt, Rinehart, and Winston.
- Spradley, J.P. (1980). *Participant observation*. New York: Holt, Rinehart, and Winston.
- Sprangers, M.A., & Schwartz, C.E. (1999). Integrating response shift into health-related quality-of-life research: A theoretical model. *Social Science and Medicine*, 48, 1507–1515.
- Takasu, S., Ogata, E., Yamaguchi, T., Kitahara, M. (Eds.). (2001). *Konniti no tiryousisin 2001* (Vol. 43). [Today's therapy 2001 (Vol. 43)]. Tokyo, Japan: Igaku-Syoin.
- Taylor, C. (2001). Patients' experiences of "feeling on their own" following a diagnosis of colorectal cancer: A phenomenological approach. *International Journal of Nursing Studies*, 38, 651–661.
- Ulander, K., Jeppsson, B., & Grahn, G. (1997). Quality of life and independence in activities of daily living preoperatively and at follow-up in patients with colorectal cancer. *Supportive Care in Cancer*, 5, 402–409.
- Weisman, A.D. (1976). Early diagnosis of vulnerability in cancer patients. *American Journal of the Medical Sciences*, 271, 187–196.
- Weisman, A.D., & Worden, J.W. (1976). The existential plight in cancer: Significance of the first 100 days. *International Journal of Psychiatry in Medicine*, 7(1), 1–15.
- Whynes, D.K., & Neilson, A.R. (1997). Symptoms before and after surgery for colorectal cancer. *Quality of Life Research*, 6(1), 61–66.
- Zabora, J., BrintzenhofeSzoc, K., Curbow, B., Hooker, C., & Piantadosi, S. (2001). The prevalence of psychological distress by cancer site. *Psycho-Oncology*, 10(1), 19–28.