ABSTRACT

Aim. This paper reports a study to develop a grounded theory to explain the experience of recovery following surgery for colorectal cancer.

Background. Studies have adopted a biomedical framework to measure quality of life and symptom distress following surgery for colorectal cancer. These studies suggest that symptoms of pain, insomnia and fatigue may persist for many months following treatment. Fewer studies have considered the individual’s experiences and perspective of the emotional, social and cultural aspects of recovery.

Methods. A longitudinal study using grounded theory was conducted with 12 individuals, who had received surgery for colorectal cancer. Semi-structured interviews were conducted at four time points over 1 year following surgery, between 2007 and 2009. Grounded theory analysis was undertaken using Strauss and Corbin’s framework.

Findings. Recovery is described in three phases: disrupting the self; repairing the self; restoring the self. The core category is Restoring a sense of wellness; fostered through awareness and enjoyment of the physical, emotional, spiritual and social aspects of life. A sense of wellness exists as a duality with a sense of illness, where both perspectives may co-exist but one usually takes precedence. A sense of illness pervades when the individual is preoccupied with illness and the illness continues to disrupt their daily life.

Conclusion. Recovery takes time and energy, particularly when the individual is at home and in relative isolation from health professionals. Opportunities exist for nurses to provide information and support to facilitate the individual in their progress towards achieving a sense of wellness.
INTRODUCTION

Colorectal cancer represents a significant disease burden worldwide, with 1.23 million new cases diagnosed in 2008 (International Agency for Research on Cancer (IARC) 2010). Almost 60% of new cases occur in developed regions, and colorectal cancer is the third most prevalent cancer in the UK (Office for National Statistics 2010). Around two thirds of disease occurs in the colon and one third in the rectum (Cancer Research UK 2010). The most accurate predictor of prognosis is the extent of invasion of tumour through the bowel wall, referred to as Tumour node metastasis (TNM) (Treanor & Quirke 2007). Five year survival rates for those diagnosed with early stage disease (TNM stage 1 and 11a) are over 93%, compared to only 7% of those diagnosed with advanced disease (Gatta et al 1998). Surgery remains the definitive treatment for localised colorectal cancer (Leslie & Steele 2002).

BACKGROUND

Common symptoms following surgery include pain, fatigue and insomnia (Hodgson & Given 2004, Esbensen et al 2006). Bowel symptoms are common including flatus, diarrhoea and constipation (Whynes & Neilson 1997, Pan et al 2010). Although the research indicates a trend towards improved quality of life scores 6 months following surgery (Ulander 1997; Bailey et al 2006), symptoms of fatigue, insomnia and diarrhoea may persist (Ulander et al 1997). Research suggests the impact of colorectal cancer on quality of life is greatest and most variable within 1-3 years following diagnosis (Ramsey et al 2000). Three years following treatment, symptoms of insomnia, fatigue, altered bowel habits were worse for colorectal cancer patients compared to the general population (Arndt et al 2006).

Qualitative studies illustrate how symptoms can influence emotional and social functioning. Patients newly diagnosed with colorectal cancer describe experiences
dominated by their physical condition as they pass through a stage of complete
dependence and loss of control and dignity (Worster & Holmes 2009. The cancer
diagnosis overwhelms the individual as they experience a loss of control and the
how 16 individuals experience a loss of body control and disconnection with their
body; and recovery requires re-establishment of a relationship with the body.
Emotions of fear, anxiety and vulnerability arise from frequency and urgency of bowel
symptoms, particularly faecal incontinence (DeSnoo & Faithfull 2006). Tiredness and
weakness impact upon social identity by reducing physical functioning and causing
social isolation (Dunn et al 2006). Rozmovits and Ziebland (2004) identify how an
individual becomes socially isolated as persistent problems with dietary intake and
bowel habits lead to a loss of social confidence. The distress experienced by
patients causes the removal of adult identity and "Loss of Adulthood" (Rozmovits and
Ziebland 2004).

Frank (1995) describes a shift in the cultural context in which people now experience
illness: a time he labels "post-modern". This postmodern experience is characterised
by technical expertise, demonstrated by the health professional in a complex
organisation. Advances in diagnostics and treatment have led to many patients
experiencing colorectal cancer as an acute episode, where illness is relatively short
lasting and resolves through recovery or death (Rosenfeld 2006). Patients highly rate
specialist colorectal nurses as information providers (Mills & Davidson 2002) and
pilot work suggests a nurse led model of follow up systemtaically assesses
symptoms and provides appropriate advice (Knowles et al 2007). However, the
emotional impact of a cancer diagnosis may be associated with mortality (Shaha &
Cox 2003) and those newly diagnosed will feel they have been given a death
sentence (Corner 2008). Existing research has often adopted a biomedical
framework where recovery is measured through sequelaes of treatment. There is a
relative lack of conceptual consideration of social and cultural meanings associated with colorectal cancer which create an illness experience beyond the immediacy of curative surgery.

THE STUDY
Aim
The aim of this study was to develop a grounded theory to explain the experience of recovery following surgery for early stage colorectal cancer.

DESIGN
An interpretive approach was chosen to explore participant's experiences as the topic area was relatively unexplored and theoretically under developed (Glaser & Strauss 1967). Grounded theory incorporates a symbolic interactionism perspective, where the emphasis is upon the natural world of human behaviour (Chenitz 1986). Grounded theory was chosen to facilitate a longitudinal exploratory study of the social processes and actions of the individual as they recover following surgery.

Setting and sample
The study was conducted at a district general hospital in South East England, UK. Theoretical sampling was employed, where data collection and analysis occur simultaneously, and analysis informs what data to collect next to inform the emerging theory (Glaser & Strauss 1967). The initial sample was determined by the subject area (Chenitz & Swanson 1986), and included those who had completed surgery for tumour of the sigmoid bowel or rectum, and required no chemotherapy or radiotherapy. Further sampling was determined by the emerging concepts (Goulding 1999), and ensured equal representation of gender and age. Recruitment stopped once theoretical saturation was achieved and no new insights emerge from the data.
The final sample included 12 participants (Table 2).

Data collection
A longitudinal design was adopted with a semi-structured interview at 2 weeks; 3 months; 6 months and 1 year following surgery. Interviews were conducted in the participant's home, between 2007 and 2009. The prompt for the first interview asked the participant to describe their experiences to date. Subsequent interviews were directed to elicit information about emerging themes and categories (Glaser & Strauss 1967).

Ethical considerations
The Local Research Ethics Committee approval was obtained. Eligible participants were initially approached by the clinical nurse specialist and given an information sheet. Written consent was completed at the first interview, and process consent adopted for the duration of the study by confirming participant agreement at each contact (see Munhall 1991; 2007). Interviews were conducted at the participant's convenience and they were able to have a relative present if they wished. Participants were advised of their right to confidentiality and anonymity, and to withdraw at any time.

Data analysis
Interviews were conducted and transcribed by the same researcher (NB) to aid recall; to ensure consistency and accuracy of reporting thus strengthening the rigour of the study; and to adhere to ethical principles of confidentiality of the data. NB is an experienced cancer nurse, with experience of conducting qualitative research interviews. A “denaturalized” approach was adopted for transcription, where idiosyncratic elements of pauses and non verbal cues were removed (Oliver et al
2005). Data analysis was conducted according to the steps described by Strauss and Corbin (1990; 1998). Firstly, in open coding each line of text was examined and codes were attributed to individual words or sentences to categorise the data according to their meaning and actions. The code would often directly arise from the data, known as an in vivo code (Charmaz 2006). Emerging codes were compared to existing codes using constant comparative analysis, to examine similarities or differences. Similar codes were grouped together to form categories. Descriptions were given to codes to ensure reliability in the coding strategy, and assist the audit trail. As data analysis progressed, relationships between the categories and subcategories were developed through axial coding (Strauss & Corbin 1990). Finally, the core category was identified as restoring a sense of wellness, which had analytic power and pulled the other categories together to form an explanatory whole (Strauss and Corbin 1998). Constant comparative analysis and theoretical sampling continued until each category was refined and saturated and no new properties emerged (Strauss & Corbin 1998).

**Rigour**

Koch and Harrington (1998) contend the entire research process is reflexive and evaluation criteria may be generated within the project itself, through detailed and contextual writing. Strategies to attend to rigour included one researcher conducting the interviews (NB), regular supervision from an experienced grounded theorist (AA), the keeping a reflective researcher's log and field notes, and wide reading of the literature. The researcher NB did not have a clinical role in the acute trust where the study was conducted. Memos were used to record reflections on theoretical aspects, data analysis, and the researcher's impressions. Participants own words were used to illustrate the research processes of data analysis and theory development.
FINDINGS

Participants describe recovery in three phases: disrupting the self; repairing the self; and restoring the self. Participants moved consecutively through the phases. Phase 1 began prediagnosis and ended on discharge following surgery. Length of time in phase 2 varied for each individual, but commonly lasted 3-6 months. Between 6 and 12 months after surgery, participants entered phase 3 and fluctuated between a sense of wellness or illness. Through inductive analysis, *Restoring a sense of wellness* has emerged as the core category to describe participant's experiences of recovery following surgery for colorectal cancer.

Phase One - Disrupting the self

The conceptual phase *Disrupting the Self* illustrates how personal identity is threatened as the physical body is disrupted by the symptom experience and medical procedures; and hospital practices undermine a sense of autonomy and confidence.

Body disruption

Body disruption often begins with the first sign of symptoms, which may be acute and specific such as rectal bleeding. In a context of apparent health and no forewarning, these symptoms are abnormal and emphasise body failure from within. More commonly, participants experience insidious symptoms which are non-specific, subtle, and harder to quantify:

“I was incredibly tired. I had had a hip replacement the year before and you know how you kind of blame things like that.” (4/1)
Alternative explanations are plausible and make it difficult to recognise the seriousness of symptoms. This undermines trust and confidence in body awareness skills.

Pre-operative investigations cause body disruption by inducing intense and uncontrollable bowel evacuation. Nil by mouth protocols disrupt dietary routines, and body disruption is induced by anaesthesia as described by this gentleman:

"I don’t know what it did but it almost sent me out of my mind to be honest with you. I didn’t know what time of day it was, I couldn’t see clearly, I was speaking a load of rubbish, I was vomiting." (12/1)

Altered consciousness and the loss of primary body functions disable this gentleman and place him in a position of vulnerability. He becomes reliant upon health professionals for safety and support. Body disruption highlights the loss of a predictable and trustworthy body, undermining feelings of personal control.

Medicalisation within secondary health care

Medicalisation within secondary health care is directed by a prevailing concept of the biomedical model, and interactions are focused around the disease process and treatment. The treatment pathway involves rapid progression through a structured system of technical procedures, which emphasise the urgency and seriousness of their situation. There is "no time to waste" (10/1).

"Literally it was, I think I must have been fast tracked, it was so quick". (9/1)
Access to treatment is expedited, and at times the transition between procedures seems impersonal and automated. Participants hand over responsibility for their self management to the health professionals, conceptualised as body handover. Experiences are characterised by immediacy with the physical body and continue up to the point of discharge:

"Well it all happened so fast I didn't even realise I had been in hospital and out again, things were happening so quickly." (4/1)

Rapid transition through treatment and lack of attention to individual needs can weaken the individual's sense of autonomy. Discharge decisions are determined by service demands and participants rarely feel involved, which confirms a focus upon the medicalisation of the illness experience.

**Emotional disruption**

Receiving their diagnosis of cancer creates mixed emotions and some participants experience a moment of time standing still as they attempt to make sense of the news: "It stops everything" (3/1). Many have suspected cancer, but confirmation is still a shock: "It really hasn't sunk in yet". (7/1); whereas others experience relief that they finally have confirmation of what they suspect: "It was simply a relief to know what was wrong" (6/1). Thoughts about cancer can raise fears of a lingering death, filled with disability and pain. Treatments are perceived as unpleasant, uncertain and causing as much disruption as the cancer itself. Cultural and personal views of cancer exert an influence and some participants recall the experiences of their relatives:
"When I knew what I had got, it probably actually was even more frightening because all I could remember was the absolute terrible experience that my mother and myself had gone through". (3/1)

Reviewing past experiences or lay knowledge can trigger negative thoughts and arouse fear. The previous life, which may have been taken for granted, is now gone and the future is now uncertain.

6.2 Phase Two - Repairing the Self

Following discharge, the individual begins *Repairing the self* through actions and interactions to restore the physical body; regain a sense of confidence and autonomy; and re-establish a sense of personal identity.

**Body repair**

Restoring physical integrity and body function takes time. Participants develop skills of body monitoring by which to assess their progress. The body is "watched" for a period of time to elicit details of how it is functioning and attention is given to the frequency and intensity of experiences and sensations:

"A pain in my stomach which isn't really a pain, it's a sensation which when I bend over or sit down on a chair, in and out of the car, I really get this stabbing feeling." (9/1)

By comparing experiences, the individual appraises symptoms and interactions. When certain activities appear to exacerbate symptoms and undermine body repair, the individual has opportunity to manipulate future actions to prevent a recurrence of
the symptom. Individuals are keen to restore independence in physical activities as soon as possible to regain autonomy. Actions to accommodate depleted energy include small increments in activity and regular rest periods. These strategies promote attainment of a positive outcome which bolsters feelings of control and confidence.

**Follow up**

Participants describe a follow up schedule based upon a biomedical framework with a priority to monitor for disease recurrence:

"I went back three days after and then 2 weeks after and they didn’t want to see me again after that. There was no cancer so there was no reason to go back." (3/4)

When recovery is not as expected, the individual can experience conflict and has to rely on their own interpretation and make decisions accordingly:

"Only wind really and painful wind, and some excruciating wind and I was on the point of ringing and I though no, I’ll just leave it a bit longer and it went. I have been on that point on several occasions, perhaps when this is a bit more than just wind." (3/1)

Regular episodes of abdominal discomfort were at odds with this lady’s expectations as the surgeon had informed her: "I would make a quick recovery because it was only keyhole" (3/1). Even when the pain is very severe she feels it is inappropriate to contact the team outside of the prescheduled appointments. Ambiguity and uncertainty regarding what action to take, hinders participants as they begin reclaiming personal authority. Initiating contact requires proactive behaviour which is
difficult if the individual doubts the validity of their concern because of a lack of experience or knowledge.

Information

In retrospect, participants feel they have few opportunities in hospital to ask questions and absorb information. Discharge within 48 hours of surgery, whilst recovering from general anaesthetic, adversely affects ability to retain information. At home, participants feel isolated and spend time reviewing questions to decide if they are important enough to warrant contacting someone.

“So I suppose to have reassurance from someone who’s been dealing with telling you, that is perhaps more reassuring than going to the GP who’s never seen you before and hasn’t had anything to do with the operation.” (3/4)

Many information needs are specialised and not perceived as the domain of the GP. Participants highlight that familiarity with a health professional offers reassurance that attention will be given to their personal circumstances. Participants identify areas of unmet need relating to the impact of symptoms on daily life:

“That is one of the things I would have liked some advice on and nobody ever really said. Some sort of diet information, even if it was just a sheet of what you should and shouldn’t have.” (3/2)
RESTORING THE SELF

The final phase of Restoring the self is an enduring process in relation to two perspectives: a sense of wellness, or a sense of illness (Figure 1). One perspective usually takes precedence, however participants can oscillate between the two; or demonstrate aspects of both perspectives simultaneously. A successful recovery is described as one where a sense of wellness prevails, and illness is relegated to the background.

A sense of wellness

A sense of wellness is demonstrated through an awareness and enjoyment of the emotional, spiritual and social aspects of life. Participants demonstrate increasing appreciation and knowledge of their body. Physical recovery is an ongoing process where the past and present are interwoven:

“Physically I have picked up very well. I have bounced back very quickly. I was in a car accident many years ago and remember when I recovered from that. The more you do, the quicker you recover… I went back to work part time. I told the head of department what I had had done and he was very understanding.” (10/4)

Advanced body listening skills and introspection are utilised to inform decisions. This gentleman has knowledge and familiarity with his body, illustrated by his ability to predict how his body may react when he returns to work.

Participants with a sense of wellness do not necessarily have complete restoration of physical health but demonstrate body confidence by engaging in meaningful activities. Failure to progress in the activity is viewed as a positive opportunity to moderate or vary the activity. Expertise is demonstrated when the individual uses this new knowledge to adopt strategies to minimise or avoid risk activities in the future. Participants gain a sense of acceptance of how things are, and of normality.
They may adjust their expectations of normality, perhaps by modifying their activity levels or adjusting certain aspects of their diet, but these modifications are not viewed as disruptive. These participants may also express a heightened sense of being alive and an appreciation of the present and future, by acknowledging the past and what they could have lost:

“I make the most of my life while I’ve got it. I reflect that this time now might not have been mine. I could have been decaying. When you really consider that you might not have a life, you come back and get on with your life. It’s made me spend more time with the family and doing things I want to do. In the past I always did what I had to, what I thought I had to do.” (10/4)

This gentleman reflects on his past, and that he is fortunate to have the opportunity for a future of personal growth and meaningful activities, rather than simply passing through life. Before illness, his future life would have been one of routine and obligation. With a sense of wellness, participants begin to view the passage of time in relation to their personal calendar, in preference to a treatment calendar. Whilst reaching the first year post surgery is an important milestone, a sense of wellness enables the participant to act as and when they choose as they are not restricted in time by their illness; the illness is predominantly viewed as a past event.

**A sense of illness**

A sense of illness is noted for participants who focus upon the sickness and burden caused by their disease. This sense of illness may be a transient episode in response to a symptom or outpatient appointment; or it may be an overwhelming and all absorbing experience which preoccupies their emotional and physical self. Preoccupation with illness may be in response to persistent symptoms. Symptoms vary in intensity and duration, and defy attempts to exert control over their
manifestation. As such, the individual suffers a lack of confidence and becomes preoccupied with habitual body monitoring and comparing:

"Experimentation. See if anything works and some things did and some things didn't. Sometimes I thought it did and then it didn't. It is something I am constantly thinking about it now which I must admit I didn't before." (3/4)

Measures of success are small as this lady attempts to manage her symptoms but repeatedly experiences a relapse. Her failure to break the cycle of dietary intake and nocturnal pain creates feelings of despondency and emphasises her lack of control. Persistent lethargy is also burdensome and several participants complain of being "tired a lot of the time" (11/4); or "just feel sort of weak all over really" (12/4). This causes frustration and dismay as it negatively impacts on other areas of life, and forces the individual to dwell on their illness. Altered bowel habits are another significant symptom and participants attempt to restore control by adjusting their dietary intake. They conduct detailed and lengthy observations of diet, noting when consumption of certain foods is associated with socially unacceptable behaviours such as passing flatus. Bowel symptoms cause emotional distress and embarrassment, and the individual is tempted to withdraw from activities and social interactions which previously gave pleasure.

Preoccupation with symptoms is enhanced if the symptoms mimic pre diagnosis experiences:

*They have cured me because they have given me another 20 or 30 years of life and whatever niggles and pains, it can't be that, it must be just the settling down so I did hang on to that conversation whenever I felt worried. But at the same time when
you’ve got quite a bit of pain going on you can’t help but think oh perhaps they were wrong." (3/4)

This lady explains how her symptom experience impacts upon her emotional health and forces her to adopt a sense of illness. Her pain is the focus of attention which impacts upon her psychosocial health, creating fear and vulnerability, and perpetuating a sense of illness. Regular monitoring of symptoms and adoption of a treatment focused calendar is encouraged by a health system which routinely books consecutive outpatient appointments before the individual has been seen by a doctor. Anticipation of future colonoscopies leads to participants dwelling on a sense of illness as it serves as a regular reminder of their cancer and the potential for recurrence.

DISCUSSION

Limitations of the study

This study recruited a small sample from one geographical location, and the grounded theory may therefore reflect the experiences of this specific population. It is feasible that experiences would be different in alternative treatment centres, geographical and socioeconomic locations. A grounded theory emerges as an ever evolving process, rather than a finished product (Glaser & Strauss 1967) and this study requires refinement with other colorectal cancer populations.

The study advances nursing knowledge by illustrating how recovery from surgery is more than simply physical repair. The social and cultural meanings associated with colorectal cancer imbue the recovery process. Participants describe recovery as a process of *Restoring a sense of wellness*, demonstrated through an awareness and enjoyment of the physical, emotional, spiritual and social aspects of life. Having a sense of wellness exists as a duality with a sense of illness, with movement between
the two perspectives, and has conceptual links to the Shifting Perspectives Model of Chronic Illness (Paterson 2001). This duality of perspective is discussed by Doyle (2008) where positive aspects of survivorship including feelings of self improvement, personal growth and an appreciation of life. In contrast, survivorship can present negative consequences with ongoing physical symptoms resulting from treatment and adverse emotions such as depression. Participants who restore a sense of wellness experience more positive aspects of recovery and either have less, or are more able to manage negative consequences.

Survivorship as a concept has evolved to reflect scientific, social and cultural change (Leigh 2001), and is no longer simply defined in terms of disease free intervals. Survivorship is viewed as a dynamic continuum from diagnosis until death (Feuerstein 2007). The literature on survivorship has conceptual similarities to restoring a sense of wellness. Little et al (1998) describe cancer survivorship as a state of liminality; a space between two places. Survivors pass through the space of illness but do not return to the normal world, because this world is no longer the same as it was before the illness (Little et al 2000). This sense of transition is evident for participants who moved through a stage of acute illness, and returned home as an individual recovering from colorectal cancer. Their life at home is different as a consequence of their illness. The diagnosis of cancer challenges prior plans for the future, which have to be temporarily halted, modified or discarded. The transitory nature of life leads them to question their beliefs and attitudes towards life (Shaha & Cox 2003). In restoring a sense of wellness, participants adapt expectations and behaviours to their new life situation. Focusing on the future provides forward movement, and restores a sense of purpose and meaning to life. Their sense of arrested temporality experienced at the point of diagnosis does not last and plans for the future began to re-merge (Breaden 1997). Little et al (2000) call this reorientation, where the individual comes to terms with the illness by
understanding the limitations imposed, and reconstructing their life to give meaning beyond the facts of the illness. Restoring a sense of wellness involves participants assessing and accepting limitations within recovery. This is noted with regards to fatigue and altered bowel habits as some participants become adept at assessing and monitoring these symptoms. They appreciate factors which exacerbated their experiences, and develop strategies which enabled them to manage the symptoms and continue with desirable activities. Having less complex expectations for recovery may also be beneficial as those with a "take for granted attitude" have a smoother recover (Winterling et al 2009). Studies suggest that between 20 and 30% of survivors have ongoing health problems, resulting in substantial negative social and economic effects on individuals (Corner 2008). Restoring a sense of wellness includes an element of hope: participants are optimistic that symptoms will subside, or that they will gain confidence and mastery in managing the symptoms. Ramfelt et al (2002) suggests a sense of hope offers some protection against despair. The experience of survivorship is one that deals with "the body as a house of suspicion" (Breaden 1997). Participants work to put symptoms into perspective and categorise tiredness or pain as side effects of surgery, rather than an indicator of disease recurrence.

By contrast, persistent symptoms cause some individuals to remain focused upon their illness, in a sense of illness. Symptoms may be viewed as threatening and indicative of disease recurrence, particularly if they mimic pre diagnosis experiences. Fatigue is described as a physical, social and emotional experience; associated with the curtailment of activity, reduced feelings of control and a sense of illness. Fatigue challenges the ability to perform activities with ease or spontaneity (Leidy & Haase 1999). Unpredictable bowel actions are also common, and cause a degree of uncertainty and emphasise a loss of control; as noted by Galloway and Graydon (1996). Participants engage in self care strategies of monitoring and modifying
dietary intake to ascertain association between food produces and symptoms (also noted by Pan et al 2010). Participants believe that high fibre foods are culpable in causing diarrhoea or flatus and so are avoided. Smaller meal portions and eating at regular intervals are other strategies tried by participants; also reported by Campbell et al (2001) and Kidd et al (2008). The loss of control of the body is unfamiliar to some and creates concern and anxiety, as found by MacDonald (1988). Bodily repair has to be attended to as it limits or interferes with other physical and social activities (Kelly and Field 1996). Participants engage in body monitoring and comparing to evaluate physical recovery. Achieving control over physical symptoms and the body is important for several reasons. Firstly, physical suffering will lead to emotional suffering because personal identity becomes what it is through the body, and the self is affected by what happens to the body (Corbin 2003). Secondly, failure to control the body causes uncertainty and a sense of unpredictability.

Health professionals may underestimate either the prevalence or the impact of physical symptoms (Volgelzang 1997). Kozachik and Bandeen-Roche (2008) question whether cancer and treatment related symptoms in older people are sufficiently managed. The findings of this study would suggest that on occasion, participants dismiss their needs as a normative experience of ageing and therefore do not seek assistance. This finding is also supported by Pound et al (1998). Kralik et al (2004) describes self management as a dynamic, active process where the individual learns, trials, and explores the boundaries caused by their illness. For participants in this study, self management becomes a focus for time and energy to review, reflect, monitor, and experiment with various actions.
CONCLUSION

The grounded theory has emerged from the data and illustrates how colorectal cancer and treatment disrupt a sense of self-identity. Recovery is an ongoing process where the individual is concerned with restoring a sense of wellness. Recovery takes time and energy, particularly when the individual is at home and in relative isolation from health professionals. Nursing practice must incorporate a role in providing information and support to facilitate the individual in their progress towards achieving a sense of wellness. Further research should consider how type of surgery and length of admission can influence the provision, understanding and recall of information provision. the individual in their progress towards achieving a sense of wellness.

ACKNOWLEDGEMENTS

The authors would like to thank the research participants for contributing to this study and the clinicians at the study site for their assistance and support.

FUNDING

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

CONFLICT OF INTEREST

No conflict of interest has been declared.

AUTHOR CONTRIBUTIONS

NB was responsible for the study conception and design. NB performed data collection. NB, AA and SF performed the data analysis. NB was responsible for the drafting of the manuscript. NB, AA and SF made critical revisions to the paper for important intellectual content. NB provided administrative, technical or material support. AA and SF supervised the study.
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Table 1: Characteristics of study participants

*Participant withdrew after interview 2 due to poor health