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Nursing Care for a Patient with Colorectal Cancer Based on Madeleine Leininger's Cultural Care Theory

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ABSTRACT

In the management and treatment of colorectal cancer, nursing care is considered one of the most important key elements in the path of treatment and recovery of patients. Culture-based care is an inseparable part of today's care. The aim of the present study was to present a case report of nursing care of a patient with colorectal cancer based on Madeleine Leininger's theory of cultural care. The patient is a 57-year-old woman with colon cancer who received the care process over a six-month period based on Madeline Leininger's cultural care model, in the form of four stages: the first stage was collecting cultural, social, and individual information; the second stage was analyzing data and identifying the patient's needs and understanding of care; the third stage was the patient's core beliefs and values about health and illness; and the fourth stage was based on the findings of the previous three stages of nursing interventions in the three axes of maintaining, adapting, and reconstructing cultural care; designed and implemented to provide meaningful, effective, and culturally appropriate care to the patient. Implementing culture-based care using Madeleine Leininger's Sunrise Model significantly improved the quality of care and increased patient satisfaction. Madeleine Leininger's cultural care model plays a decisive role not only as an ethical and humane approach, but also as a fundamental component in modern nursing, in improving the quality of care, patient satisfaction, strengthening the therapeutic relationship, and providing fair, comprehensive, and evidence-based care.

Keywords: Colorectal Neoplasms; Culturally Competent Care; Nursing Care

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Introduction

Colorectal cancer is the third most common cancer worldwide and the second leading cause of death from malignancies, with approximately 1.9 million new cases and 935,000 deaths reported worldwide each year [1]. Despite significant advances in diagnosis, surgery, and pre- and postoperative care, approximately 50% of patients still die from colorectal cancer, even in developed countries [2]. Estimates indicate that the prevalence of this disease will double by 2035 [3]. This cancer primarily occurs in individuals over the age of 55, but recent years have seen an increase in its incidence among younger age groups as well

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[4, 5]. The diagnosis of colorectal cancer can be made based on history, physical examination, and ancillary tests. Clinical symptoms may include blood in the stool, nausea, vomiting, a palpable abdominal mass, abdominal pain, change in bowel habit, bloating, decreased energy, weight loss, fever, and fatigue [6, 7]. The main treatments for colorectal cancer include surgery to completely remove the tumor and adjuvant chemotherapy. Surgery improves survival in the early stages, while chemotherapy can extend patients' lifespan by improving quality of life in advanced stages [8].

In the management and treatment of colorectal cancer, alongside therapeutic interventions, nursing care is considered one of the most important and key factors in the patient's treatment and recovery process. Nursing care is based on a deep understanding of the concept of care and caring actions. Care for cancer patients typically relies on therapeutic techniques and specialized knowledge and plays a vital role in supporting the patient, alleviating pain and suffering, and addressing their physical, emotional, and spiritual needs.

Despite the significance of this role, caring for cancer patients is accompanied by numerous challenges due to cultural and social differences. To provide comprehensive and holistic care, nurses must be able to identify and respond to the spiritual needs of patients, as these needs vary according to patients' perceptions, which are influenced by individual, cultural, and social differences. Furthermore, an accurate understanding of nursing care in practice can only be achieved by examining patients' real-life experiences and perspectives in actual conditions. Therefore, nurses must be able to recognize and respond to the cultural needs of patients to enhance the effectiveness of care during the treatment process. In this regard, culture-based care is considered an inseparable part of contemporary nursing care [9-11]. Therefore, the application of nursing theories in this field to support care interventions is essential [12].

Among the prominent theories that have proposed the basic structures and concepts of nursing care, Leininger's theory of cultural diversity and universality of care, also known as the theory of cross-cultural care, is considered one of the most fundamental perspectives on the concept and nature of care (12-14). Leininger defines care as a supportive or facilitating process that helps patients or groups with obvious and hidden needs to improve living conditions and human functioning [15]. This theory is based on accepting the cultural diversity of humans with the aim of discovering different care patterns through the analysis of cultural contexts, social structures, and human dimensions, relying on knowledge such as anthropology, sociology, and psychology, to ultimately design effective and culturally compatible care for patients to promote health, cope with illness, or face death [16-19]. Leininger's theory of cultural care, by presenting its conceptual model called the Sunrise Model, helps nurses and other health care providers explain the meanings of care by considering patients' values, beliefs, and lifestyles as accurate and reliable bases for culturally specific care decisions and actions [14]. The Sunrise Model encompasses four levels of abstraction:

At the first level, the individual's sociocultural structure is examined, including factors such as technology, economic status, education, religious and philosophical beliefs, kinship and social structures, values and lifestyle, as well as political and legal systems. These factors play a significant role in shaping the individual's worldview and care patterns.

At the second level, the nurse uses the collected information to analyze the care needs and meanings at the individual or group level.

The third level involves understanding the patient's care systems, beliefs, and values to accurately comprehend their perspective and arrive at an appropriate nursing diagnosis.

Finally, at the fourth level, Leininger proposed three key strategies to guide nursing decisions and actions: cultural care preservation, cultural care accommodation/adaptation, and cultural care restructuring. This innovative approach assists nurses in providing effective care that is congruent with the cultural backgrounds of patients [12,14,20].

Given Leininger's emphasis on cultural diversity and the necessity to tailor care according to patients' values, beliefs, and lifestyles, the use of this theoretical framework enables a more comprehensive analysis and provision of more effective and culturally congruent care. Furthermore, despite the importance of cultural care in improving the quality of treatment for cancer patients, case reports based on the practical application of Leininger's Sunrise Model in cancer patients in Iran, particularly in Lorestan province, are very limited, highlighting the knowledge gap that necessitates this study. This study aimed to present a case report on the nursing care of a patient with colorectal cancer based on Madeleine Leininger's theory of cultural care. This study examined the process of conducting a comprehensive cultural assessment, designing and implementing nursing interventions aligned with the patient's cultural background, and evaluating the impact of these interventions on clinical outcomes and patient satisfaction.

Materials and Methods

The present study is a case report conducted with the aim of providing culture-based care based on Madeleine Leininger's Theory of Culture Care. It was conducted on a 57-year-old female patient diagnosed with colorectal cancer who was hospitalized in the oncology department of Rahimi Hospital in Khorramabad, Iran, in 2025 to receive chemotherapy.

After obtaining informed written consent and coordinating with the treatment team, a six-month care process was designed and implemented. This process was organized according to Leininger's Sunrise Model, which provides a comprehensive framework for collecting and analyzing cultural data and enables the identification of patient care needs while considering cultural, social, religious, familial, linguistic, and personal factors.

In the first phase, cultural data related to the patient were collected using components of the Sunrise Model through semi-structured interviews with the patient and her family members. Direct observation of the patient's interactions and a thorough review of her medical records also played a role in data collection. Additionally, standardized tools were used to assess the patient's psychological and physical dimensions, including the health literacy questionnaire (HLQ), brief illness perception questionnaire(BIPQ), patient satisfaction questionnaire (PSQ), state-trait anxiety inventory (STAI), communication assessment tool (CAT), comprehensive score for financial toxicity patient-reported outcome measure (COST), treatment self-regulation questionnaire (TSRQ) functional assessment of chronic illness therapy – spiritual well-being scale (FACIT-Sp), and multidimensional scale of perceived social support (MSPSS).

In the second phase, the collected data were analyzed using thematic analysis. In this qualitative approach, the data were carefully read and initially coded. Key concepts and meaningful patterns were then identified, and finally, the main themes were extracted. This analysis provided the basis for identifying the patient's needs, preferences, and cultural perceptions of care and paved the way for formulating culturally oriented nursing diagnoses.

In the third phase, the patient's fundamental beliefs and values regarding health, illness, and treatment were carefully examined to develop nursing diagnoses aligned with her views. Furthermore, key indicators such as pain intensity, quality of life, treatment acceptance, attendance at chemotherapy sessions, and psychological status (anxiety and depression) were evaluated as they were considered clinical markers related to the patient's cultural needs.

Finally, in the fourth phase, nursing interventions were designed and implemented based on Leininger's three core modes of cultural care: preservation, accommodation, and restructuring. These interventions were planned in such a way that the positive aspects of the patient's culture were preserved, care was aligned with her cultural practices, and any limiting or harmful beliefs were gradually modified or corrected. This approach allowed for meaningful, effective, and culturally congruent care.

All ethical considerations in this study were observed according to the ethical guidelines for research in medical sciences. After fully explaining the objectives, research process, and intended interventions, written informed consent was obtained from the patient and her family. The confidentiality of the patient's personal information was strictly maintained throughout all stages of the study.

Results

The patient was a 57-year-old woman from the Lur ethnic group residing in a village near Khorramabad. She is a housewife with a basic literacy level and can read and write. Following her husband's death two years ago, she has been solely responsible for raising her two young children, an 11-year-old boy and a 6-year-old girl. The family's only source of income is a small pension from the deceased husband, and the patient lacks supplementary insurance or substantial financial support to cover her medical expenses. In this process, the patient's elder sister, who lives in Khorramabad city, actively accompanied and supported her throughout the treatment.

The patient initially presented to a gastroenterology specialist with symptoms including chronic constipation, bloating, abdominal pain, and changes in bowel habits. In the initial evaluations, she reported no family history of cancer, including colorectal cancer. Her weight was 80 kg, height was 165 cm, and body mass index (BMI) was 29.4. She had no history of chronic diseases such as diabetes or hypertension but complained of chronic musculoskeletal pain.

Colonoscopy revealed a suspicious lesion in the colon, and a biopsy was performed for pathological evaluation. Pathological results confirmed a definitive diagnosis of colorectal cancer. Subsequently, staging was performed using abdominal and pelvic CT scans, which indicated stage IIIB disease, which was considered treatable. The patient underwent surgery for tumor resection and was hospitalized to receive her first adjuvant chemotherapy session post-surgery.

Continuation of treatment to reduce the risk of cancer recurrence is planned.

During the treatment course, the patient faced multiple psychological, social, and cultural challenges. Lack of awareness regarding the nature of the disease and treatment process led to anxiety, fear, and distrust toward the healthcare system. She held a negative attitude toward modern treatments, especially chemotherapy, and in the early stages of the disease, preferred traditional and local remedies, which resulted in reduced cooperation with the treatment team.

Socially, separation from their young children, particularly due to limited visiting hours, caused feelings of loneliness, sadness, and emotional distress during hospitalization. Additionally, religious beliefs played a significant role in her life; she considered regular prayers and supplications to be a source of psychological comfort. However, due to personal convictions, she felt uncomfortable receiving nursing care from male nurses, which occasionally disrupted effective interactions with the nursing team.

From a linguistic and cultural perspective, limited proficiency in Persian and the predominant use of a local dialect posed communication challenges with the healthcare staff, sometimes leading to misunderstandings or inability to accurately express her needs and concerns.

Finally, economic difficulties and lack of awareness about insurance support led the patient to consider discontinuing treatment. However, with the intervention of the social work team and the provision of psychological, educational, and financial support, she was persuaded to continue treatment and demonstrated improved cooperation with the medical team. Table (1) shows nursing interventions based on Sunrise Model factors within the framework of Leininger's cultural care theory for the patient under study.

Table 1. Nursing interventions based on Sunrise Model factors within the framework of Leininger's cultural care theory

Factors	Status	Nursing diagnosis	Strategy	Goal	Nursing intervention	Evaluation
Religious and philosophical factors	The need to respect the patient's religious beliefs and continue to pray and supplicate during hospitalization	Readiness to promote spiritual health indicates the patient's desire to maintain and strengthen spiritual beliefs and activities.	Preserve	Maintaining and promoting spiritual health and satisfaction from religious activities	The patient's religious needs were carefully assessed.Worship items such as prayer beads, seals, and qibla markers were provided to the patient. The care time was coordinated as much as possible, taking into account prayer times, so that the patient had the opportunity to perform worship and that a calm and appropriate atmosphere was maintained at that time. Religious language and terms were used in interaction with the patient to create a sense of peace and empathy. The family was also taught to provide appropriate spiritual support to the patient and reduce her concerns in this regard	The patient's spiritual health was assessed using the FACIT-Sp scale before the intervention, during its implementation, and after completion. Results indicated that support for religious activities led to increased satisfaction and reduced anxiety, with a significant improvement in spiritual well-being. This positive trend continued in subsequent follow-ups, confirming the effectiveness of the cultural-religious interventions.
Social kinship factors	Strong therapeutic motivation due to a sense of maternal responsibility and the hope of playing a supportive role for the child	Preparing for increased self-care	Preserve	Maintaining and strengthening intrinsic motivation and effective behaviors to manage the treatment process	Initially, the patient's maternal motivation was recognized and strengthened as a source of hope and healing power. In daily conversations, her concerns about the future of her children were listened to, and her role as a supportive and caring mother was acknowledged and praised. Regular contact with the children was provided via voice or video call, and if possible, a face-to-face meeting was arranged in coordination with the social worker. The family was advised to emphasize the children's need for their presence and health in their contacts and conversations with the patient. Finally, the psychologist was asked to intervene to strengthen the patient's motivational resources and psychological resilience	The mother's treatment motivation, measured by the TSRQ scale, and perceived social support, assessed using the MSPSS, were evaluated before the intervention, during psychological support sessions, and after the intervention. These interventions strengthened self-care behaviors and alleviated the mother's concerns, with improvements maintained throughout the follow-up period.

Educational factors	Insufficient knowledge about the disease and related medical concepts	Limited patient understanding of the disease and treatment process due to low literacy level	Matching	Improving the patient's knowledge about the disease, treatment methods, and required care	The patient's level of knowledge and health literacy was assessed. Then, the concepts of the disease and the treatment process were explained in simple language and local dialect, along with images and concrete examples. He was provided with visual brochures. The patient was accompanied by a participant in the educational sessions and sufficient time was provided for questions and answers. The teach-back technique was used to ensure correct understanding of the material, and at the end of the explanation, all the patient's questions and ambiguities were answered. The patient's family was also given the necessary training about the disease and how to psychologically support the patient. Discussions with a social worker and psychologist were also provided to reduce stress, eliminate fear, and increase motivation for treatment	The patient's health literacy was evaluated using the HLQ scale before the intervention, during education sessions conducted in simple language, with visual aids and local dialect, and after the intervention. Family education and psychological support contributed to stress reduction and increased treatment motivation. This positive effect was sustained until the end of the follow-up period.
Religious and philosophical factors	The patient's desire to receive care from a nurse of the same sex and feelings of dissatisfaction if this preference is ignored	Anxiety related to care by a male nurse due to religious/cultural beliefs, with evidence of patient dissatisfaction and insecurity	Matching	Creating a sense of comfort, security, and satisfaction in the patient while receiving care, while respecting the patient's gender preference	The patient's desire to be cared for by a same-sex nurse was recorded in the initial assessment and communicated to the nursing team in the debriefing session. Then, with the coordination of the supervisor, an attempt was made to allocate critical care times to same-sex nurses and this was taken into account in the shift schedule. In emergencies where care by a same-sex nurse was not possible, the reason for the situation was explained to the patient before taking action and her tacit consent was obtained. The treatment team was made aware of the cultural-religious importance of this issue in order to maintain an effective and respectful therapeutic relationship while preserving the patient's dignity	Patient satisfaction, measured by the PSQ questionnaire, was assessed before the intervention, during accommodation of the patient's gender preference for nursing care, and after the intervention. Satisfaction levels improved significantly and remained elevated throughout the follow-up period, contributing to the maintenance of an effective and respectful therapeutic relationship.
Legal-political factors	Longing and restlessness due to restrictions on visiting your children due to hospital regulations	Restlessness (anxiety) related to being away from family and visitation restrictions	Matching	Reducing anxiety levels and increasing patient comfort	The patient's mental state was assessed upon observing symptoms of homesickness and restlessness. With the coordination of the shift manager and compliance with hospital regulations, the patient was allowed to have daily phone calls with her child. Video call conditions were also set at specific times using the patient's or nurse's mobile phone. The family was asked to send loving photos and writings of their children or family members to the patient to strengthen the emotional connection, and the children's pictures were placed next to the patient's bed. Coordination was carried out with the hospital's social work unit and psychologist to strengthen psychological support. If possible, the face-to-face meeting time was slightly increased while respecting the restrictions or was organized in an open space and for a short period. During shifts, the nurse provided the patient with a sincere and empathetic approach, providing the patient with the opportunity to talk about feelings in order to relieve her emotional tensions and increase the sense of understanding	Anxiety levels, evaluated using the STAI scale, were measured before the intervention, during efforts to reduce visitation restrictions and enhance emotional connections, and after the intervention. Anxiety significantly decreased, and feelings of comfort and satisfaction increased. These improvements persisted through the follow-up period, leading to better psychological well-being and quality of care

Values and lifestyle	Impaired therapeutic communication due to the patient's limited command of Persian and use of local dialect	Impaired verbal communication	Matching	Improving the patient's ability to express needs and understand treatment needs	Initially, the patient's language and dialect level was assessed. To facilitate communication, staff or companions fluent in the local dialect were used as much as possible. Treatment instructions and explanations were provided in simple and understandable terms. Images and visual aids were used if necessary to better understand concepts. Nonverbal communication such as gestures, facial expressions, and body language were used consciously. Given the patient's concerns in this regard, more time was given to listen to and answer the patient's questions, and an intimate and supportive communication space was created so that the patient felt confident and secure and could express her concerns. For greater assurance, the patient's family was once again informed of the treatment process using the local dialect to achieve common understanding and effective support	The patient's ability to express needs and understand the treatment process was assessed using the CAT scale before the intervention, during adaptive communication interventions with local dialect and supportive methods, and after the intervention. These advancements created a supportive environment and effective communication, which were maintained until the end of the follow-up period, resulting in increased satisfaction and active participation in treatment.
Technology factors	Fear and distrust of modern treatments and medical equipment, resulting from limited familiarity with this field and belief in traditional methods and local treatments	Ineffective health maintenance related to fear and belief in traditional treatments and unfamiliarity with modern treatments.	Reconstruction	Increasing effective health-seeking behaviors and acceptance of modern medical treatments	In the first step, the patient's beliefs and attitudes towards medical and traditional treatments were assessed through open and non-judgmental discussion. Then, concepts related to chemotherapy, surgery, and how the devices work were explained to the patient in simple language and using everyday analogies. The benefits, stages, and possible complications of the treatment methods were explained clearly and understandably, along with answers to the patient's questions. A respectful comparison between traditional and modern medicine was used to remove misconceptions. The experiences of successful patients were expressed in the form of short and positive narratives to increase hope. The possibility of a conversation with the treating physician was provided to directly respond to the patient's concerns. Due to the patient's interest in traditional medicine, safe non-interventional solutions such as the use of permitted sedative teas were introduced in consultation with the physician alongside the main treatment process to reduce the conflict between his beliefs and medical treatment.	Fear of modern treatments and trust in the treatment process were evaluated using the BIPQ scale before the intervention, during educational and supportive measures, and after the intervention. Fear was reduced, and active patient participation increased, leading to improved treatment quality and more effective communication with the medical team.
Economic factors	Concerns about treatment costs and lack of awareness of support resources	Anxiety related to financial concerns and lack of awareness of available support resources	Reconstruction	Patient awareness of support resources and ability to use them effectively to reduce financial concerns	After assessing the patient's financial situation and identifying financial concerns, he was referred to the hospital social worker. Information regarding insurance coverage, government support services, and charitable institutions was provided to the patient and her family in a simple and understandable manner. A joint meeting was held with the social worker and one of the patient's relatives to review the patient's financial situation, ways to receive financial assistance, and planning for continued treatment. The possibility of benefiting from local charitable assistance and discount schemes was examined. Finally, the necessary follow-up was carried out to register a request for financial support through the social worker. The patient was also provided with ways to contact support units to answer further questions in order to increase the feeling of comfort and support during the treatment process	Financial distress was assessed using the COST scale before the intervention, during referral to a social worker and provision of supportive information, and after the intervention. Financial burden decreased significantly, and concerns regarding treatment costs were alleviated, contributing to improved treatment adherence.

Discussion

In the present study, a female patient with colorectal cancer was treated to implement nursing care based on Madeleine Leininger's cultural care theory. The results of the present study showed that implementing culture-based care using Leininger's Sunrise model significantly improved the quality of care and increased patient satisfaction. The initial fear and distrust of the chemotherapy process, which was due to unfamiliarity with modern medicine and low literacy level, was transformed into acceptance and active cooperation through simple, step-by-step explanations tailored to the patient's understanding. In addition, hope for treatment was maintained and strengthened in the patient by strengthening maternal motivation as a psychological driving force. By consciously using the local dialect and establishing face-to-face communication, communication barriers were reduced and a safer space was provided for expressing feelings and treatment needs. Respect for the patient's religious beliefs, through respecting the patient's beliefs and entrusting care to female nurses, promoted a sense of peace and psychological security. Responding to the patient's emotional concerns about their children through psychological support and facilitating regular contact and flexibility in visitation times helped reduce anxiety. In addition, by introducing support organizations, insurance, and referral to a social worker, the patient's financial concerns were managed, and the possibility of continuing treatment was provided. Ultimately, comprehensive attention to the various dimensions of the Sunrise model of care led to the provision of targeted, effective care that was tailored to the patient's real needs.

Previous studies on the application of Madeleine Leininger's theory of cultural care in different population groups have strongly emphasized the role of culture in shaping effective health care. For example, the results of Putri et al. (2024) study on the incidence of short stature in toddlers, Nascimento et al. (2019) study on the care of infants admitted to the NICU and their families, and Henry et al. (2010) study on the status of breastfeeding based on Leininger's theory of care are in line with the present study and show that recognizing and understanding cultural contexts can improve the quality of care and promote health outcomes [21-23].

In critical situations, Almeida et al. study on cultural care to deal with the COVID-19 pandemic and Pereira et al. (2024) study on the experience of childbirth and afterwards in transgender men based on Leininger's theory of cultural care have proven the importance of using cultural frameworks to provide empathetic and effective care, such as the present study [21,27]. This evidence clearly shows that using the theory of culturally-based care can make the care process more consistent with the value, belief, and social model [28]. This evidence clearly shows that using the theory of culturally-based care can make the care process more consistent with the value, belief, and social contexts of patients. Although Leininger's theory of cultural care has been able to occupy an important place in modern nursing approaches, its implementation in clinical settings is accompanied by challenges, including communication barriers resulting from language and cultural differences, conflicts between patients' values and beliefs and institutional policies, cultural conflicts and ethical issues, and the inattention of some members of the treatment team to the importance of cultural concepts in care. Such barriers may affect the quality of care and make it difficult to interact effectively with the patient. Therefore, the accurate identification of these challenges and adoption of practical solutions to face them play an important role in achieving humane, effective, and culturally appropriate care for patients [18,29].

Despite the valuable findings of this case report, some limitations of this study should be noted. First, the study focused on a 57-year-old female patient, and this small sample size limits the generalizability of the results to larger and more diverse populations. In addition, the data collected were mainly based on interviews and observations, which may be affected by researcher or respondent biases. The intervention and follow-up periods were also short, which limits the ability to assess the long-term effects of cultural care. Implementing cultural care requires time, resources, and specialized training, which is difficult to achieve in some healthcare settings due to structural constraints and staffing shortages. In addition, cultural complexities and their multifaceted nature may not be fully reflected within the framework of a single theoretical model.

Given these limitations, future studies should conduct larger quantitative and qualitative studies with more diverse samples to comprehensively examine the different dimensions of cultural care and its impact on clinical outcomes and patient satisfaction. Nursing interventions should be designed and implemented with a personalized approach tailored to the needs, beliefs, and preferences of each patient to enhance the effectiveness of cultural care. In addition, specialized training in cultural care for nurses and treatment teams at different clinical levels should be included in educational programs and health system policymaking

to sustainably provide care appropriate to cultural contexts.

Conclusion

The results of this case study showed that cultural care, as a fundamental component of modern nursing, plays a decisive role in improving the quality of care, patient satisfaction, and strengthening the therapeutic relationship. Conscious and sensitive exposure to patients' cultural differences, especially in conditions such as cancer, which has a high psychological and social burden, can create trust, reduce patient resistance, and facilitate their participation in the treatment process. In this experience, it was observed that not paying attention to the patient's cultural background leads to communication barriers, reduced acceptance of treatment, and weakened cooperation between the patient and the nurse. In contrast, utilizing the principles of cultural care, including recognizing the patient's beliefs, values, communication style, and cultural background, improves professional communication, increases the patient's sense of psychological security, and enhances the patient's experience of care. The present study emphasizes the necessity of training and empowering nurses in the field of cultural competence, especially in societies that face ethnic, linguistic, and religious diversity. Ultimately, providing Madeline Leininger's culture-based care is considered not only an ethical and humane approach, but also a professional necessity to achieve equitable, comprehensive, and evidence-based care in the health system.

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