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Research Article

Coping and Perceived Quality of Life After Breast Reconstruction: Experiences of Filipina Breast Cancer Survivors

Anna Jovan D. Santos

Author Information:

Graduate School, University of Baguio, Baguio City, Philippines

Corresponding Author:

Anna Jovan D. Santos
Email: 20152755@s.ubaguio.edu

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Abstract. Qualitative evidence on how Filipina breast cancer survivors experience breast reconstruction is scarce. This qualitative descriptive study aimed to describe survivors' coping strategies and their perceptions of reconstruction in relation to body image, daily life, and well-being. Six Filipina survivors who underwent or attempted reconstruction after mastectomy took part. The researcher conducted individual video-call interviews from April 2025 to March 2026 and analyzed them thematically. Five themes were developed. Participants described coping through faith, family, peers, and activity, alongside financial strain, limited information, and long waits in public care. Decisions involved body image, physician advice, and emotional well-being. Four participants described greater confidence or comfort after reconstruction; four reported pain, sleep difficulty, movement limitation, or costs; and one described unsuccessful reconstruction. These retrospective perceptions, not measured outcomes, may inform balanced, individualized counseling and attention to participant-identified support needs.

Keywords: *Breast cancer; Breast reconstruction; Coping strategies; Filipino women; Quality of life.*

Breast cancer brings physical, emotional, social, and practical demands that can continue well beyond diagnosis and active treatment. For women who undergo mastectomy, breast reconstruction is one option within post-mastectomy care, and the decision to pursue it is shaped by body image, self-esteem, emotional readiness, fear of recurrence, and clinical and health system factors (Bochtsou *et al.*, 2025). Reconstruction can be immediate or delayed and can involve different procedures, so women's experiences cannot be assumed to be uniform. Previous research addresses four related but distinct questions: who gains access to reconstruction (uptake), how surgical technique relates to satisfaction, how reconstruction relates to broader quality of life, and how women make decisions and are supported. These are considered in turn before the research gap is presented. Studies of reconstruction uptake identify patient, provider, and health system barriers. A systematic review of 15 studies from 11 low- and middle-income countries identified financial barriers, particularly self-payment, alongside low patient awareness and limited referral (Giwa et al., 2026). These population-level findings contextualize access but do not explain how individual survivors experience care.

Technique and satisfaction have been studied mainly with BREAST-Q. In an Italian sample, autologous (DIEP flap) reconstruction was associated with the highest satisfaction scores relative to implant-based reconstruction

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(Persichetti *et al.*, 2022). Evidence on broader quality of life is separate from satisfaction with the breast. A recent systematic review and meta-analysis found that mastectomy with immediate reconstruction was associated with better and faster recovery of global quality of life than mastectomy alone, but only a small, borderline advantage over breast-conserving surgery, with all groups plateauing modestly over the long term (Makhnevych *et al.*, 2025). These findings come from standardized instruments, and the direction and size of the differences depend on the comparison group and follow-up period. They cannot show how an individual woman perceives her own recovery, and they do not capture women whose reconstruction was unsuccessful.

Reconstruction decisions involve subjective as well as clinical considerations. A systematic review identified body image, self-esteem, fear of recurrence, and emotional readiness as important influences (Bochtsou et al., 2025). Young women considering implant-based reconstruction described informational, emotional, family-related, and peer-network needs (Gao et al., 2026). Korean qualitative research described the challenge of accepting a reconstructed breast as part of the body (Han et al., 2022). Decision tools may support consultation preparation, although usability and workflow require attention (Foraker et al., 2023). Outside reconstruction research, a randomized trial found benefits of one-to-one survivor support for resilience among newly diagnosed women (Aizpurua-Perez et al., 2024).

A qualitative systematic review of non-Caucasian women's surgical decision-making identified fear, trust in physicians, psychological well-being, external influences, and cultural expectations (Murray et al., 2023). These findings support examining variation rather than attributing decisions to a fixed cultural pattern. In the Philippines, linguistic validation and psychometric testing of the Filipino BREAST-Q Reconstruction Module supports standardized assessment (Arcilla et al., 2022); qualitative interviews can complement such measures by examining the meanings attached to recovery.

The literature reviewed here includes systematic reviews, standardized patient-reported assessments, and qualitative accounts mainly from outside the Philippines. It offers limited insight into how Filipina survivors connect coping, care navigation, reconstruction decisions, and everyday well-being. This study provides a context-specific account, including experiences of unsuccessful reconstruction.

This study addresses that gap. It does not evaluate the clinical effectiveness of reconstruction or measure quality of life with a standardized instrument; it examines the meanings participants attached to their experiences. Two objectives guided the study: (1) to describe the coping strategies Filipina breast cancer survivors used during treatment and recovery, and (2) to describe how participants who underwent or attempted breast reconstruction perceived its relationship to body image, confidence, daily functioning, social experiences, and well-being. The study's intended contribution is context-specific, participant-grounded evidence that complements the largely quantitative and non-Philippine literature. The findings may be of use to surgeons, nurses, and counselors who discuss reconstruction with patients, to survivor-support groups, and to researchers designing larger studies in Philippine settings.

Methodology

Research Design

The study used a qualitative descriptive design to provide a close account of participants' experiences in their own terms. Retrospective interviews, without pre-reconstruction data or a comparison group, support descriptions of perceived experiences rather than causal claims about reconstruction and quality of life. Three frameworks informed the study as sensitizing lenses rather than as deductive coding schemes. Social Cognitive Theory describes reciprocal influences among personal factors, behavior, and the social environment, and it gives particular weight to self-efficacy, outcome expectations, and social facilitators and impediments to health-related behavior (Bandura, 1998). In this study, it informed interview questions about information, preparation, and support, and it directed attention in the analysis to accounts of confidence, expectations, and the people and structures that helped or hindered participants. The Wilson and Cleary (1995) model links biological and physiological variables, symptoms, functional status, general health perceptions, and overall quality of life, with individual and environmental characteristics shaping each link. It informed the interview domains on physical symptoms, daily functioning, emotional well-being, and social experience, and it supported the interpretation of Theme 4. Posttraumatic growth refers to positive psychological change that some people report after struggling with highly challenging circumstances; it coexists with distress and should not be presumed (Tedeschi & Calhoun,

2004). It was used only to remain open to accounts of reappraisal and acceptance. These frameworks did not predetermine the themes, which were developed inductively. Because self-efficacy, outcome expectations, and posttraumatic growth were not coded as constructs, they are returned to in the Results and Discussion as interpretive lenses only, and the data cannot confirm them.

Participants and Sampling Technique

Participants were recruited through Facebook-based channels from April 2025 to March 2026. The researcher, who was the sole investigator, shared recruitment information and communicated directly with women who expressed interest. Seven women were invited; six agreed and completed interviews, one declined, and none withdrew after consenting. Purposive sampling was used to recruit Filipina women aged 18 years or older who had been diagnosed with breast cancer, had undergone mastectomy, and had undergone or attempted breast reconstruction. Women who had not undergone mastectomy, or who had neither undergone nor attempted reconstruction, were not eligible.

Breast cancer stage was not used to select participants. Stages range from non-invasive disease to metastatic disease and involve markedly different treatment pathways, so stage may shape experiences. It was not systematically recorded and is discussed among the limitations in the Conclusion. One participant, BCRP2, underwent reconstructive procedures that were unsuccessful and expressed an intention to pursue reconstruction again; the sample is therefore described as women who underwent or attempted reconstruction, not as women who all completed it successfully.

The sample size was judged using information power (Malterud *et al.*, 2016): the aim was narrow and focused on specific experiences, participants had direct experience of reconstruction or attempted reconstruction, and the interviews yielded detailed accounts sufficient to develop and refine the reported themes. Six participants cannot support claims of saturation or generalization. To limit the risk of deductive disclosure in a small sample, participant characteristics are reported in aggregate in Table 1.

Table 1. *Aggregated Participant and Interview Characteristics (N = 6)*

Characteristic	Information reported
Recruitment	Facebook-based channels, April 2025 to March 2026; 7 invited, 6 participated, 1 declined, 0 withdrew
Interview	Individual Facebook Messenger video call, approximately 45 to 60 minutes; English, Filipino, or Taglish according to preference
Language of quoted excerpts	Mixed Filipino and English
Reconstruction experience	All 6 had undergone reconstructive procedures; 1 (BCRP2) described procedures as unsuccessful and intended future reconstruction
Device or expander mentioned	2 (BCRP2, BCRP4); procedure type not reported for the other participants
Health care pathway described	Employer HMO and private care: 1 (BCRP5); public hospital: 1 (BCRP6); mixed private and public: 1 (BCRP1); public financial assistance process: 1 (BCRP3); not described: 2 (BCRP2, BCRP4)
Age, cancer stage, years since treatment, timing (immediate or delayed)	Not systematically collected; withheld from individual reporting to reduce deductive-disclosure risk

Note. BCRP = breast cancer reconstruction participant. HMO = health maintenance organization. Characteristics are aggregated to reduce the risk of deductive disclosure.

Research Instrument

Data were collected with a researcher-made, semi-structured interview guide developed for this study around the two objectives and informed by the frameworks described under Research Design. The guide covered experiences of diagnosis, treatment, and recovery; coping; health care access; reconstruction decision-making; perceived changes after reconstruction or attempted reconstruction; continuing challenges; and advice for other survivors and providers. Open-ended questions were followed by probes that invited participants to elaborate in their own words. Before data collection, the guide was validated through the University of Baguio Research and Development Center, and a tool validation certification was issued on March 30, 2025. Because the guide is a qualitative interview protocol rather than a scale, statistical reliability testing does not apply; trustworthiness procedures are described under Data Analysis Procedure.

Data Gathering Procedure

The researcher conducted individual, semi-structured interviews through Facebook Messenger video calls from April 2025 to March 2026. Interviews lasted about 45 to 60 minutes and were conducted in English, Filipino,

Taglish, or a combination, according to participants' preference. With consent, interviews were audio-recorded and transcribed verbatim. Transcripts were checked against the recordings. Informal member checking took place during each interview, when the researcher paraphrased key points and invited corrections; transcripts were not returned to participants. The researcher kept analytic memos. No repeat interviews were conducted.

Filipino and Taglish passages were transcribed in the language spoken. The researcher translated the excerpts selected for reporting into English and checked each translation against the recording and transcript. No independent translator or back-translation was used; this is acknowledged as a limitation. Quotations that were originally in Filipino or Taglish are shown in quotation marks, followed by the English translation in square brackets. Square brackets also mark words added for clarity or to remove identifying details.

Data Analysis Procedure

Data were analyzed using thematic analysis as described by Braun and Clarke (2006). The analysis was inductive and primarily semantic: codes and themes stayed close to what participants said and were not derived from a codebook or from the sensitizing frameworks. The researcher read the transcripts repeatedly, generated initial codes across the whole data set, grouped codes into candidate themes, reviewed themes against coded extracts and the full data set, and defined and named final themes. Coding was done by the researcher alone and was organized manually, without qualitative data analysis software. Analytic memos served as the audit trail of coding decisions and theme revisions. Accounts that differed from the dominant pattern, including persistent pain and unsuccessful reconstruction, were treated as discrepant cases and retained in the findings. Data sufficiency was judged against the information-power criteria described above. No second coder was used. Trustworthiness was addressed through credibility (informal member checking during interviews and checking transcripts against recordings), dependability (an audit trail of analytic memos), confirmability (reflexive memos and the retention of discrepant cases), and transferability (a description of the sample and setting within the limits of confidentiality).

Researcher reflexivity was also addressed. The researcher is a doctoral student who designed the study, recruited participants, conducted all interviews, translated the reported excerpts, and carried out the analysis. She had no clinical or treatment role with participants. As a lone researcher working from the literature on reconstruction, she could have been inclined to look for benefits of reconstruction, or to look for barriers in the public system. Analytic memos were used to record assumptions and decisions, and the analysis deliberately sought accounts that complicated a positive narrative. Participants' knowledge that the researcher was a doctoral student conducting an academic study may have shaped what they chose to share.

Ethical Considerations

The University of Baguio Research Ethics Committee approved the study on April 25, 2025; no protocol number was assigned. Participants received information about the purpose, procedures, possible emotional discomfort, voluntary participation, and the right to decline questions or withdraw without penalty. The study adhered to the Philippine Data Privacy Act of 2012 (Republic Act No. 10173). Written informed consent was obtained, including consent to the publication of anonymized direct quotations.

Participants are identified only by codes (BCRP1 to BCRP6). Because six women with distinctive treatment histories could be recognized by people who know them, a deductive-disclosure review was carried out: names, facilities, and other identifying details in quotations were replaced with bracketed descriptors, and individual age, stage, and timing are not reported. Participants were told that Messenger is a third-party platform whose data retention and security are controlled by its provider, not by the researcher, and that privacy therefore could not be guaranteed completely; they were encouraged to join from a private setting. Recordings, transcripts, and consent forms were stored in password-protected files accessible only to the researcher and will be retained for five years before secure deletion.

Because the topics could be distressing, participants could pause, skip questions, or stop at any time. If a participant became upset, the researcher paused the interview, offered supportive listening, and reminded her of these options. When appropriate, participants were encouraged to seek support from their own health care providers, counselors, trusted family members, or survivor-support networks. Participants may receive a summary of the findings on request.

Results and Discussion

Five themes were developed (Table 2). Counts refer to the six participants and indicate how many participants made a statement of that kind, not how important it was. Excerpts are illustrative. Within each theme, participants' accounts are presented first and are followed by a discussion that relates them to previous studies. The accounts are retrospective and self-reported, and the design cannot establish that reconstruction changed anyone's quality of life.

Table 2. *Themes, Subthemes, and Supporting Participants*

Theme	Subtheme	Participants (*n*)
1. Coping through faith, support, and activity	Faith and prayer	BCRP1, BCRP3, BCRP6 (3)
	Family support	BCRP1, BCRP4, BCRP5 (3)
	Peer connection	BCRP1, BCRP5 (2)
	Staying active	BCRP2, BCRP5 (2)
2. Navigating financial, informational, and system barriers	Cost, assistance, and coverage	BCRP1, BCRP3, BCRP5, BCRP6 (4)
	Long queues and waits	BCRP1, BCRP3, BCRP6 (3)
	Limited information	BCRP6 (1)
3. Deciding about reconstruction	Self-image and femininity	BCRP2, BCRP3, BCRP6 (3)
	Following the physician's advice	BCRP1, BCRP6 (2)
	Mental health	BCRP5 (1)
4. Perceived changes and continuing challenges	Confidence and comfort in appearance	BCRP1, BCRP3, BCRP4, BCRP6 (4)
	Daily and social ease	BCRP1, BCRP5, BCRP6 (3)
	Pain, sleep, movement, and cost	BCRP1, BCRP2, BCRP4, BCRP6 (4)
	Unsuccessful reconstruction and acceptance	BCRP2 (1)
5. Reflections and recommendations	Satisfaction alongside difficulty	BCRP1, BCRP5, BCRP6 (3)
	Advice to future patients	BCRP1, BCRP2, BCRP3, BCRP4, BCRP6 (5)
	System-level suggestions	BCRP5 (1)

Note. BCRP = breast cancer reconstruction participant; *n* = number of participants whose accounts supported the subtheme (*N* = 6).

Theme 1: Coping Through Faith, Support, and Activity

Participants described four overlapping ways of coping with treatment and recovery: faith and prayer, family support, peer connection, and staying active.

Faith and Prayer

Three participants described faith or prayer as a source of strength. BCRP1 said, "To cope, I prayed a lot and relied on my family members, particularly my husband and siblings; when I got back home from [the] medical center, I focused on eating healthy food as well as continued my juicing, this helped to keep my body strong." BCRP6 said, "The courage to face challenges gave way for me to live on. Above all was prayer; I held on and trusted God that I would get through this as well." BCRP3 said, "I would say my relationship with Jesus has been my anchor throughout my journey. If it wasn't for my relationship with Jesus, there's no way I would respond the same."

Family Support

Three participants described practical or emotional support from spouses or siblings. BCRP5 recalled, "My family rallied for me during those times, my brother went home to the Philippines just in time for my surgery and gave me a support system." BCRP4 said, "I coped mostly through my husband, who drove me to appointments, waited with me for surgical calls, and tried making me laugh even when I didn't feel like it."

Peer Connection

Two participants described other survivors as reassuring or practically helpful. BCRP1 said, "I met other patients like [another patient], who was already done with chemo when I got in, and this kind of journey comforted me because it showed me that treatment is survivable and I didn't have to be so afraid." BCRP5 described being referred by a peer to another survivor who "guided and coached me on the questions that I need to ask my surgeons. This prepared me mentally, it is as if you are getting ready for a test, but since you reviewed intensively, you become confident."

Staying Active

Two participants described keeping busy. BCRP2 said, "I got into mindfulness and meditation. I was fortunate to have enough energy to run around work and travel during treatment, so I dove into that." BCRP5 said, "At this

stage I didn't cry, just concentrated all my energy on consultations, further diagnostics and preparation, and decided to undergo surgery as soon as possible."

Participants described faith, family, peers, and activity as resources, but not every participant named the same ones: three described faith and three described family support, while two each described peer connection and staying active. These accounts are consistent with the qualitative literature on young women's reconstruction decisions, in which informational, emotional, family, and peer-network needs recur (Gao *et al.*, 2026). The peer accounts, in which a survivor helped a participant prepare questions for surgeons or showed that treatment was survivable, resemble the resilience-building effect of one-to-one survivor support in a randomized trial of women with a new diagnosis (Aizpurua-Perez *et al.*, 2024), although that trial did not involve reconstruction. In terms of Social Cognitive Theory, BCRP5's preparation for consultations is compatible with building self-efficacy through a model (Bandura, 1998), but self-efficacy was not measured. The participants' references to faith and family do not justify describing Filipino survivors as uniformly religious or family-centered. One participant (BCRP2) mentioned neither, and the study did not ask participants to compare themselves with other groups.

Theme 2: Navigating Financial, Informational, and System Barriers

Cost, Assistance, and Coverage

Four participants described how money and coverage shaped their care, and their circumstances differed. BCRP1 moved between private and public care: "I received care through both private and public systems beginning with a private hospital, which then transferred me to [a public tertiary hospital], where surgery was delayed due to long waiting lists. I finally got surgery in October. I was thankful for support from SSS, PCSO, DSWD, and a few foreign charity assistance, but one did not have access to expensive medicine, and assurance letters were close to impossible." BCRP6 had been treated only in public hospitals. BCRP3 stopped seeking medical assistance because of the process required to obtain a schedule. BCRP5, in contrast, was covered by an employer HMO that included her surgery and medication: "I was luckily covered by an HMO through my company, and my surgery was a benefit, as well as my meds."

Long Queues and Waits

Three participants described queues or delays in public services. BCRP6 said, "My experience with the health care system in our country has been quite difficult and frustrating, and it really requires a lot of patience, because I only received treatment in public hospitals. It is very hard, since you really must endure the long lines every day." BCRP3 said, "Our system is so antiquated because they don't normalize the use of automation."

Limited Information

One participant, BCRP6, described limited understanding of cancer and of reconstruction. She said, "I'm thankful that I finished my treatment even though I did not really know much about cancer." About reconstruction, she said, "I had no idea about it at all," adding that all she knew was that the lump would be removed and that she would lose her left breast.

Participants described contrasting financial and care pathways: employer HMO coverage, public-only treatment, mixed private and public care, and difficulty obtaining assistance. These accounts are compatible with financial and informational barriers identified in low- and middle-income settings (Giwa et al., 2026), but cannot establish their prevalence in the Philippines. BCRP6's limited knowledge highlights a participant-identified information need. The Wilson and Cleary (1995) model provides a lens for considering how environmental conditions may shape perceived well-being; the present study does not test that model.

Theme 3: Deciding About Reconstruction

Self-image and Femininity

Three participants linked their decisions to appearance or femininity. BCRP3 said, "The number one factor that popped into my mind was that I am single at the time, well, until now I still am. I would say I felt insecure if I were to lose a part of my body that makes me feminine." BCRP2, diagnosed at a young age, said, "I knew I wanted to look 'normal' as much as possible." BCRP6's agreement to the procedure was also tied to the expectation that she would still appear to have a breast (see below).

Following the Physician's Advice
Two participants relied heavily on their doctors. BCRP1 said, "I did not do my own research, I trusted my doctor's recommendation and chose to follow through despite my concerns for pain, recurrence, and another major operation." BCRP6 said, "I only agreed to do this procedure because the doctor suggested it, saying it was better and that I would look like I still had a breast."

Mental Health
One participant, BCRP5, framed the decision as a mental health decision: "I did it for my mental health. I didn't want to wake up every day and be reminded every day by seeing my scars and flat chest."

Concerns about femininity, appearance, and emotional well-being featured in three participants' reasons for reconstruction, consistent with reviews that find subjective factors at least as influential as clinical ones (Bochtsou *et al.*, 2025; Gao *et al.*, 2026). The two participants who relied on their doctors' advice, one of whom had little prior knowledge of reconstruction, illustrate why decision support matters. Decision aids may help patients prepare, although workflow barriers have limited their uptake (Foraker *et al.*, 2023). The data do not show whether such tools would help in Philippine settings.

Theme 4: Perceived Changes and Continuing Challenges
Participants' accounts after reconstruction or attempted reconstruction were mixed. These are participants' own descriptions, not measured changes.

Confidence and Comfort in Appearance
Four participants described greater confidence or comfort with their appearance. BCRP1 said, "When I looked at myself in clothes, after reconstruction I almost felt like nothing happened and that helped restore my confidence." BCRP4 said, "Reconstruction improved my self-image tremendously. When I wear clothes with no upper neckline, most people cannot even tell anything happened, my chest looks symmetrical, and people often think that I was never sick." BCRP3 said reconstruction helped her gain back her confidence "because it looks normal when I dress up, like as if I did not go through mastectomy." BCRP6 said it helped restore part of the confidence and femininity she had felt she lost.

Daily and Social Ease
Three participants described feeling more at ease in everyday life. BCRP6 said, "I worry less now when I move, get dressed, or face work and household chores, because I am not as self-conscious about how my breast looks." BCRP1 said reconstruction "allows me to move more freely and feel comfortable in social situations, as people do not immediately know I had surgery." BCRP5 said it gave her "a semblance of normalcy" and the confidence to wear a swimsuit again.

Pain, Sleep, Movement, and Cost
Four participants described burdens. BCRP4 said, "In daily life, the biggest remaining problem is sleep. I had to sleep upright for months with the expander, and even years later, lying on my side hurt until just recently." BCRP6 described "intermittent pain, restriction in some movements, and cost of follow-ups or possible revision." BCRP1 named physical pain, financial strain, and fear of recurrence as her greatest challenges. BCRP2 described operations that were "painful as well as expensive." For some participants, benefit and burden were described together.

Unsuccessful Reconstruction and Acceptance
BCRP2's reconstruction was unsuccessful after multiple procedures. She said, "My failed reconstruction made me realize that I can still be beautiful and happy with my body even without it. I had to go through so many operations due to the problems occurring with my expanders and implants. They were painful as well as expensive." She also expressed an intention to pursue reconstruction in the future. Her account combines acceptance of her body as it is with continued interest in reconstruction.

Four participants described greater confidence or comfort with their appearance, and three described greater ease in daily or social life. These perceptions fit the finding that reconstruction is associated with better and faster global quality-of-life recovery than mastectomy alone (Makhnevych *et al.*, 2025) and with satisfaction with appearance

(Persichetti *et al.*, 2022). That literature also reports only a small advantage over breast-conserving surgery, and this study cannot add to it because it used no standardized measure, no pre-reconstruction assessment, and no comparison group.

Perceived benefits coexisted with pain, sleep disruption, restricted movement, follow-up costs, and repeated procedures. BCRP1, BCRP4, and BCRP6 described both benefits and burdens. BCRP2 reported feeling "beautiful and happy" despite unsuccessful reconstruction while also hoping to try again. This account is compatible with positive reappraisal alongside difficulty (Tedeschi & Calhoun, 2004), but does not establish posttraumatic growth or imply that unsuccessful reconstruction is benign. Together, these accounts may inform balanced counseling about expectations, recovery, repeat procedures, and costs.

Theme 5: Reflections and Recommendations

Satisfaction Alongside Difficulty

Three participants expressed satisfaction with their decision while acknowledging difficulty. BCRP1 said, "In retrospect, I think it was the right decision to choose reconstruction at that point in time. The greatest challenges were the physical pain, the financial strain, and the lingering fear that the cancer could return, but all in all, I'm thankful my breast was reconstructed." BCRP5 said, "Up to this present moment, I have no regrets." BCRP6 said, "Even though what happened to me was devastating, looking back, I am thankful that I decided to have a reconstruction." The other three participants did not state an overall evaluation in this form.

Advice to Future Patients

Five participants offered advice. BCRP1 advised, "Look honestly at your budget and health insurance." BCRP4 recommended "a really good support system" and learning about "surgical options, expander timelines, and what long-term sensations might be so that your expectations are realistic." BCRP6 advised, "do not rush, pray or reflect first, ask your doctor many questions, and to consider risks, costs, and recovery time." BCRP3 said that talking with survivors who had been through the same thing would help women weigh their decision. BCRP2 advised consulting a plastic surgeon who specializes in breast reconstruction and using online forums and groups to do one's own research.

System-level Suggestions

BCRP5 proposed broader insurance coverage for reconstruction and greater visibility and affordability of reconstructive plastic surgeons. Her description of Philippine coverage is a participant perception, not a verified account of all insurance arrangements. The study did not examine insurance contracts or legislation.

Participants suggested clearer information, survivor support, affordable specialist access, attention to insurance coverage, and more efficient assistance processes. Decision-tool research also emphasizes the importance of usability and clinical workflow (Foraker et al., 2023). These suggestions reflect participant-informed considerations, not interventions this study established as effective. Financing and policy recommendations require separate Philippine legal and health-system analysis; no international coverage comparison is asserted here.

Variation and Cultural Interpretation

A qualitative systematic review identified cultural expectations among influences on surgical decision-making across non-Caucasian populations (Murray et al., 2023). Here, three participants described faith and three described family support, while BCRP2 mentioned neither. None of the reported accounts explicitly attributed reconstruction decisions to cultural norms. These accounts therefore do not establish a shared Filipino pattern. Comparative research would be needed to examine variation across Philippine communities.

Conclusion

This study contributes participant-grounded evidence from Filipina breast cancer survivors, a group rarely represented in reconstruction research. In these six accounts, reconstruction was experienced neither as a uniform benefit nor as a purely cosmetic choice. Perceived gains in confidence and everyday ease coexisted with pain, cost, repeated procedures, and, in one case, unsuccessful reconstruction, and participants' experiences were shaped by uneven access to information and financing as well as by faith, family, and peer support. These accounts do not

establish system-wide barriers, a uniform cultural pattern, or causal effects of reconstruction on quality of life. For practice, these accounts may inform balanced counseling that presents reconstruction as one option and explains recovery, sensations, repeat procedures, and costs. Survivor connections may help patients prepare consultation questions. For education, materials in Filipino and other local languages may address participant-identified information needs. For policy, concerns about affordability and coverage suggest that financing and referral pathways merit examination using local evidence. These are participant-informed considerations, not interventions shown to be effective. The study has several limitations. First, the purposive sample of six women recruited through Facebook is small and may differ from survivors without social media access or who are outside online networks, and the findings have limited transferability. Second, only women who underwent or attempted reconstruction took part; the perspectives of women who declined, could not access, or chose not to have reconstruction are absent, as is any comparison with them. Third, participants' age, stage, years since treatment, reconstruction timing, and procedure type were not systematically collected, which limits interpretation of how clinical pathways shaped their accounts. Fourth, interviews were retrospective, so recall and later reinterpretation may have affected accounts, and interviews by video call may have limited observation of nonverbal cues. Fifth, interviews in English, Filipino, and Taglish were translated by the researcher alone, without independent verification, so some nuance may have been lost. Sixth, one researcher recruited participants, conducted interviews, and coded the data without a second coder, so her perspective may have influenced data generation and analysis. Finally, no quality-of-life instrument was used, and the design cannot establish causal effects of reconstruction or estimate outcomes for any wider population.

Future studies could include women who declined, could not access, or chose not to have reconstruction, and could collect clinical details such as stage and timing in a way that protects confidentiality. Longitudinal qualitative or mixed-methods designs could follow expectations and well-being over time, and the Filipino BREAST-Q Reconstruction Module (Arcilla *et al.*, 2022) could be used alongside interviews. Further work could examine financial navigation, referral pathways, and peer support in different regions and health care settings in the Philippines.

Contributions of Authors

Anna Jovan D. Santos: conceptualization, research design, proposal writing, data gathering, data analysis and interpretation, manuscript writing, and manuscript review and editing.

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Conflict of Interests

The author declares no competing interests.

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