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Psychological Adaptation, Body Image Distress, and Quality of Life Among Women After Mastectomy: An Interpretative Phenomenological Analysis

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ABSTRACT

Objective: This study aimed to explore the lived experiences of psychological adaptation, body image distress, and quality of life among women after mastectomy.

Methods and Materials: This qualitative study was conducted using Interpretative Phenomenological Analysis among 14 women in Canada who had undergone unilateral or bilateral mastectomy for breast cancer. Participants were selected through purposive sampling from oncology survivorship networks, breast cancer support organizations, and community-based patient advocacy groups. Data were collected using a demographic and clinical information form and individual semi-structured interviews. Interviews explored women's emotional responses to mastectomy, changes in body image, femininity, sexuality, relational experiences, coping strategies, and perceived quality of life. All interviews were audio-recorded, transcribed verbatim, and analyzed through repeated reading, exploratory noting, development of experiential statements, identification of personal experiential themes, and synthesis of group experiential themes.

Findings: Interpretative analysis inferred five interconnected experiential themes. First, mastectomy disrupted the embodied self by altering bodily familiarity, femininity, and self-continuity. Second, body image distress emerged through mirror avoidance, clothing-related anxiety, fear of social visibility, and concerns about sexuality and attractiveness. Third, psychological adaptation was inferred as a nonlinear process involving grief, acceptance of survival, bodily relearning, identity reconstruction, and regaining control. Fourth, relational experiences shaped adjustment, as supportive partners, family members, peers, and healthcare professionals facilitated emotional integration, whereas silence or insensitive responses intensified distress. Fifth, quality of life was reconstructed through the interaction of physical limitations, fear of recurrence, daily functioning, intimacy, social participation, and renewed life priorities.

Conclusion: The findings indicate that post-mastectomy adjustment is a complex embodied and relational process rather than a simple transition from illness to recovery. Women's quality of life after mastectomy is shaped by how they interpret bodily change, negotiate body image distress, receive social support, and reconstruct identity after breast cancer treatment. Survivorship care should therefore integrate psychological support, body image counseling, relational support, sexual health discussion, and rehabilitation services.

Keywords: *Mastectomy; Breast Cancer Survivors; Psychological Adaptation; Body Image Distress; Quality of Life; Interpretative Phenomenological Analysis*

1. Introduction

Breast cancer is not only a life-threatening disease but also a deeply embodied, psychological, relational, and social experience that can reshape how women understand themselves, their bodies, and their everyday lives. Although advances in screening, oncological treatment, surgical techniques, reconstruction, rehabilitation, and survivorship care have improved survival and clinical outcomes, the consequences of breast cancer treatment often continue long after the completion of surgery or adjuvant therapy. For many women, mastectomy represents a particularly disruptive event because it involves the removal or alteration of a body part that may be closely connected to femininity, sexuality, maternal identity, attractiveness, bodily symmetry, and self-recognition. As a result, post-mastectomy survivorship cannot be understood only through biomedical indicators such as disease stage, treatment completion, or absence of recurrence; it must also be examined through the subjective meanings women assign to bodily change, emotional vulnerability, adaptation, and quality of life. Recent studies across different cultural and healthcare settings have consistently shown that breast cancer treatment affects multiple dimensions of women's quality of life, including physical functioning, emotional well-being, social participation, body image, sexual life, and psychological adjustment (Gică et al., 2024; Lemmih et al., 2025; Narayanan et al., 2023; Yaneva et al., 2021).

Quality of life after breast cancer treatment is a multidimensional construct that includes physical, psychological, social, emotional, sexual, and spiritual domains. In women who have undergone mastectomy, these dimensions often intersect in complex ways because bodily change can influence emotional well-being, relational confidence, social visibility, and the ability to return to ordinary life. Studies of post-treatment quality of life among women with breast cancer have shown that survivors may experience ongoing physical symptoms, reduced vitality, pain, fatigue, emotional distress, fear of recurrence, and difficulties in social and intimate relationships (Aldaak et al., 2022; Jayasinghe et al., 2020; Seneviratne et al., 2022; Smail et al., 2022). These experiences may vary according to type of surgery, time since treatment, age, treatment burden, and social context. For example, research on breast cancer survivors has indicated that age, type of surgery, and length of time since treatment are associated with differences in quality of life, suggesting that survivorship is not a uniform condition but an evolving process shaped by both clinical and personal factors (Álvarez-Pardo et al., 2022). Similarly, studies examining women with non-metastatic breast cancer have shown that treatment-related changes may continue to affect quality of life even one year after surgery, emphasizing the need to understand survivorship as a prolonged and dynamic phase rather than as a simple return to pre-diagnosis functioning (Yfantis et al., 2020).

Mastectomy can be especially consequential because the surgery directly alters the visible and symbolic body. Unlike some other forms of cancer treatment whose effects may be less externally visible, mastectomy can produce scars, asymmetry, absence of breast contour, altered sensation, limitations in movement, and persistent awareness of bodily difference. Studies comparing women after mastectomy, breast-conserving surgery, and reconstruction have reported meaningful differences in satisfaction, psychosocial well-being, physical well-being, and quality of life (Hassan et al., 2024; Limantara & Djatmiko, 2021; Nsaful et al., 2024a, 2024b). However, the relationship between surgical type and quality of life is not simple. Breast reconstruction may support body confidence, clothing comfort, and satisfaction for some women, yet it may not fully resolve the emotional meaning of loss, altered sensation, pain, or changed self-perception. Evidence from studies on reconstruction and conservative breast surgery suggests that surgical approaches aimed at preserving or restoring breast appearance can improve quality of life and emotional outcomes, but they do not eliminate the need to understand women's subjective experiences of bodily change (Abuelnour et al., 2024; Zaher et al., 2024). Similarly, findings from prophylactic risk-reducing mastectomy indicate that women may report improved breast and psychosocial satisfaction while simultaneously experiencing poorer physical well-being, showing that satisfaction and distress may coexist within the same survivorship experience (Mansour et al., 2023).

Body image is one of the most central psychological domains affected by mastectomy. It refers not only to satisfaction with physical appearance but also to how women perceive, evaluate, emotionally respond to, and inhabit their bodies. After mastectomy, body image distress may appear as discomfort looking in the mirror, avoidance of the surgical site, anxiety about clothing, fear of being noticed in public, reduced sexual confidence, and a sense of alienation from the body. A scoping review on body image and quality of life among women who underwent breast cancer surgery emphasized the close relationship between body image disturbance and reduced quality of life, suggesting that bodily self-perception is a crucial survivorship outcome rather than a secondary cosmetic concern (Battistello et al., 2024). A systematic review on mastectomy, body image, and sexuality similarly demonstrated that mastectomy can affect women's sexual identity, intimate relationships, and perception of femininity, highlighting the need to examine the body as a lived and relational phenomenon (Faria et al., 2021). Research comparing rural and urban breast cancer survivors has also shown that body image is associated with quality of life, indicating that women's bodily experiences are shaped not only by surgery but also by social environment, resources, and cultural expectations (An et al., 2022). In this regard, body image distress after mastectomy should be understood as both an individual psychological experience and a socially mediated process.

The psychological impact of breast cancer diagnosis, treatment, and remission extends across the continuum of illness. Diagnosis may produce fear, uncertainty, mortality awareness, and emotional shock; treatment may produce physical exhaustion, loss of control, and identity disruption; and remission may bring relief alongside fear of recurrence, bodily vigilance, and difficulty reintegrating into ordinary life (Graham, 2024). Post-mastectomy women may therefore live in a state of psychological ambiguity: they may be grateful for survival while grieving bodily loss, medically stable while emotionally vulnerable, and socially perceived as recovered while internally struggling with adaptation. Studies focusing on psychophysiological well-being have shown that quality of life among post-mastectomy patients is related to both physical and psychological functioning, reinforcing the need to examine the interaction between bodily and emotional domains (Sajid et al., 2022). In addition, research on vulnerability factors during follow-up has indicated that quality of life can change over time and may be influenced by personal and clinical factors, suggesting that adaptation is not a fixed outcome but a process that continues across survivorship (Lantheaume et al., 2021).

Physical consequences after mastectomy can further complicate psychological adaptation and quality of life. Pain, lymphedema, reduced shoulder mobility, fatigue, scar tightness, and treatment-related functional limitations may serve as constant reminders of illness and surgery. Postmastectomy pain syndrome has been identified as a significant problem that can affect physical function, emotional health, and daily life, making pain an important component of survivorship experience (Salati et al., 2023). Lymphedema after total mastectomy has also been associated with changes in sexual function and quality of life, showing that physical complications can influence intimate, emotional, and social domains (Mülkoğlu et al., 2022). Similarly, research on breast cancer-related lymphedema has emphasized the importance of collaboration between physical medicine, rehabilitation, and surgical care for improving women's quality of life (Turgay et al., 2021). Physiotherapeutic care after mastectomy has been discussed as a key component of recovery because rehabilitation may support mobility, reduce disability, and improve physical functioning after breast cancer surgery (Carvalho & Salerno, 2021). These findings indicate that psychological adaptation cannot be separated from the body's ongoing physical condition, because pain, functional limitation, and altered movement may continuously influence self-perception and quality of life.

The role of social support is also central in post-mastectomy adjustment. Women do not experience bodily change in isolation; they interpret their altered bodies through interactions with partners, family members, peers, healthcare professionals, and broader social expectations about femininity and health. Social support may reduce shame, isolation, and emotional distress, whereas insensitive comments, silence, avoidance, or lack of understanding may intensify body image concerns and psychological vulnerability. Research examining quality of life in relation to social support and body image after mastectomy has shown that social support and body image are important factors in women's quality of life, suggesting that adjustment is shaped by both interpersonal resources and self-perception (Vuletić, 2022). Patient satisfaction studies after mastectomy have also indicated that quality of life is linked to healthcare experiences, expectations, and perceived support, highlighting the importance of patient-centered communication and responsive care (Barkar et al., 2023). Social and educational interventions may further support adaptation. Mobile-based health education and social media-based instructional guidelines have been reported to improve quality of life and emotional status among post-mastectomy women, suggesting that accessible psychoeducational support can help women manage treatment-related challenges, emotional distress, and survivorship needs (Ahmed et al., 2021; Ahmed et al., 2023).

The literature also demonstrates increasing attention to measurement and intervention in post-mastectomy quality of life. Standardized tools have been widely used to assess quality of life among women after mastectomy, especially in quantitative and scoping review research; however, the use of structured measures may not fully capture the lived meanings of bodily loss, self-recognition, sexuality, relational vulnerability, and identity reconstruction (Harerimana & McHunu, 2025). Longitudinal and comparative studies have provided valuable evidence regarding dynamic changes in quality of life, psychological status, and body image according to surgery type and time after treatment, yet such studies often emphasize measurable change rather than the interpretative meanings women attach to those changes (Mudiyanselage et al., 2022). Research assessing quality of life in patients undergoing mastectomy with chemotherapy has similarly contributed important evidence about treatment burden, but the subjective process through which women integrate treatment-related bodily and psychological consequences into their life narratives remains less visible in quantitative designs (Deshpande et al., 2022). Exercise rehabilitation studies have shown that structured nurse-led programs can improve quality of life among women receiving post-mastectomy reconstruction, demonstrating the value of targeted supportive care while also raising questions about how women themselves understand recovery, control, and restored functioning (Kang et al., 2022).

Despite the growing body of evidence on post-mastectomy quality of life, several important gaps remain. Much of the existing literature has examined quality of life through cross-sectional comparisons, standardized questionnaires, clinical variables, or intervention outcomes. These approaches are valuable for identifying patterns, associations, and measurable domains of distress, but they may insufficiently explain how women make sense of mastectomy as a lived disruption of the embodied self. The experience of mastectomy involves more than the presence or absence of symptoms; it includes the meaning of scars, the emotional difficulty of looking at the body, the tension between survival and loss, the negotiation of sexuality and femininity, the decision to conceal or disclose, and the gradual reconstruction of everyday identity. Studies from diverse settings, including Morocco, Ghana, Iraq, Egypt, Bahrain, Sudan, Sri Lanka, the United Arab Emirates, Bulgaria, Poland, Brazil, China, Greece, and Indonesia, show that quality of life after breast cancer surgery is a global concern, yet subjective experiences are inevitably shaped by personal biography, social relationships, cultural norms, healthcare access, and survivorship context (Aldaak et al., 2022; An et al., 2022; Faria et al., 2021; Gică et al., 2024; Hassan et al., 2024; Lemmih et al., 2025; Limantara & Djatmiko, 2021; Narayanan et al., 2023; Nsaful et al., 2024b; Seneviratne et al., 2022; Smail et al., 2022; Socha & Sobiech, 2021; Yaneva et al., 2021; Yfantis et al., 2020). Therefore, an interpretative phenomenological approach is particularly appropriate for exploring how women understand and negotiate the meaning of psychological adaptation, body image distress, and quality of life after mastectomy.

Interpretative Phenomenological Analysis offers a useful framework for this topic because it focuses on how individuals make sense of major life experiences, especially experiences involving identity, embodiment, vulnerability, and change. In the context of mastectomy, IPA allows researchers to move beyond general descriptions of distress and examine the personal meanings women give to bodily alteration, survival, femininity, intimacy, social visibility, and recovery. This approach is especially relevant because women may express contradictory or layered experiences: they may feel strong and fragile, grateful and grieving, socially supported and misunderstood, physically healed and emotionally unsettled. By attending closely to participants' narratives, IPA can illuminate the psychological and existential dimensions of adaptation that may remain hidden in standardized assessments. Such insight can contribute to more person-centered survivorship care by helping healthcare professionals understand not only which domains of quality of life are affected, but how women experience, interpret, and respond to these changes in daily life.

The aim of this study was to explore the lived experiences of psychological adaptation, body image distress, and quality of life among women after mastectomy using an Interpretative Phenomenological Analysis approach.

2. Methods and Materials

2.1. Study Design and Participants

This study employed a qualitative research design using Interpretative Phenomenological Analysis to explore the lived experiences of psychological adaptation, body image distress, and quality of life among women who had undergone mastectomy. Interpretative Phenomenological Analysis was selected because the purpose of the study was not to measure the frequency of experiences, but to understand how women made sense of bodily change, emotional adjustment, femininity, identity, social relationships, and everyday life after mastectomy. The study was conducted in Canada, and participants were recruited from oncology survivorship networks, breast cancer support organizations, and community-based patient advocacy groups. A purposive sampling strategy was used to identify women who had direct experience of mastectomy and were able to provide rich, reflective accounts of their post-surgical adjustment. The final sample consisted of 14 women who had undergone unilateral or bilateral mastectomy due to breast cancer. Participants were Canadian residents, aged 32 to 68 years, and had undergone mastectomy between 6 months and 5 years before participation in the study. Inclusion criteria were being 18 years of age or older, having a history of mastectomy for breast cancer, being able to communicate in English, and being willing to discuss personal experiences related to psychological adaptation, body image, and quality of life after surgery. Women were excluded if they were receiving end-of-life care, had severe cognitive impairment that prevented participation in an in-depth interview, or reported a current acute psychiatric crisis that could make participation emotionally unsafe. Before data collection, all participants received written information about the purpose of the study, voluntary participation, confidentiality, and their right to withdraw at any stage without consequence. Written informed consent was obtained from all participants. To protect confidentiality, all names and identifying details were replaced with pseudonyms, and interview transcripts were stored securely.

2.2. *Measures*

Data were collected using a demographic and clinical information form and a semi-structured interview guide. The demographic and clinical information form was designed by the research team to collect background information relevant to the interpretation of participants' experiences. This form included age, marital status, educational level, employment status, province of residence, type of mastectomy, time since surgery, history of breast reconstruction, adjuvant treatments such as chemotherapy or radiotherapy, and participation in psychological or peer-support services. These data were not used for statistical comparison, but they helped contextualize each participant's narrative and supported the idiographic interpretation of individual experiences.

The primary data collection tool was a semi-structured interview guide developed specifically for this study in accordance with the principles of Interpretative Phenomenological Analysis. The interview guide included open-ended questions designed to elicit detailed personal narratives about life after mastectomy. The questions focused on women's emotional responses to mastectomy, changes in self-perception, experiences of body image distress, perceived femininity and sexuality, coping strategies, relationships with partners and family members, social interactions, quality of daily life, and meanings attributed to survival, loss, and recovery. Example interview prompts included questions about how participants experienced their bodies after surgery, how mastectomy affected their sense of identity, what forms of psychological adjustment were most difficult, how their relationships changed, and what helped them regain a sense of control, confidence, or continuity in life. The interview guide was reviewed by two experts in health psychology and oncology nursing to ensure that the questions were clinically relevant, sensitive, and appropriate for women with a history of breast cancer surgery. Minor revisions were made to improve clarity, reduce emotional burden, and allow participants greater freedom to describe their experiences in their own words.

All interviews were conducted individually in a private setting, either through secure online video conferencing or by telephone, according to the preference of the participant. Interviews lasted approximately 45 to 75 minutes. With participants' permission, all interviews were audio-recorded and later transcribed verbatim. During and immediately after each interview, the researcher also recorded field notes regarding emotional tone, pauses, non-verbal expressions where visible, and contextual observations that could assist interpretation. A reflexive journal was maintained throughout the study to document the researcher's assumptions, emotional responses, methodological decisions, and interpretative reflections. This reflexive process was used to enhance transparency and reduce the risk of imposing pre-existing assumptions on participants' accounts.

2.3. *Data Analysis*

Data were analyzed using the systematic procedures of Interpretative Phenomenological Analysis. Analysis began with repeated reading of each transcript to achieve close familiarity with the participant's account and to preserve the idiographic focus of the study. During the first stage, the researcher made exploratory notes on descriptive content, emotional expressions, linguistic patterns, metaphors, contradictions, and significant statements related to psychological adaptation, body image distress, and quality of life. Attention was given not only to what participants said, but also to how they constructed meaning around bodily loss, altered appearance, vulnerability, resilience, relationships, and everyday functioning after mastectomy.

In the next stage, exploratory notes were transformed into experiential statements that captured the psychological meaning of key passages. These statements were then examined within each individual case to identify patterns, connections, and tensions across the participant's narrative. Personal experiential themes were developed for each participant before moving to the next transcript, in order to preserve the distinctiveness of each woman's lived experience. After all interviews had been analyzed individually, patterns across cases were examined to identify group experiential themes that reflected both convergence and divergence among participants. Themes were refined through continuous movement between individual transcripts, analytic notes, and the developing thematic structure. This iterative process allowed the analysis to remain grounded in participants' own words while also developing a deeper interpretative account of how women understood and negotiated life after mastectomy.

To enhance the credibility and rigor of the analysis, several strategies were used. Transcripts were checked against audio recordings for accuracy, and selected sections of the coding and theme development process were reviewed by a second qualitative researcher. Differences in interpretation were discussed until a coherent and defensible thematic structure was achieved. Reflexive journaling was used throughout the analytic process to identify the researcher's assumptions and monitor how these assumptions might influence interpretation. An audit trail was maintained, including interview guides, field notes, reflexive memos, initial codes, theme development records, and revisions to the final thematic framework. The final themes were selected based on their relevance to the research aim, their recurrence across participants, and their capacity to illuminate the psychological and existential meanings of adaptation, body image distress, and quality of life among women after mastectomy.

3. Findings and Results

The study included 14 women who had undergone mastectomy for breast cancer in Canada. Participants ranged in age from 32 to 68 years, with a mean age of 51.6 years. Nine participants had undergone unilateral mastectomy and five had undergone bilateral mastectomy. The time elapsed since surgery ranged from 7 months to 5 years, allowing the study to capture both relatively recent and longer-term experiences of adjustment. Six participants had undergone breast reconstruction, while eight had not received reconstruction at the time of interview. Ten participants had received chemotherapy, nine had received radiotherapy, and eight were receiving or had received endocrine therapy. Nine participants were married or living with a partner, three were single, and two were divorced or separated. Seven participants were employed either full-time or part-time, four were not working at the time of interview, and three were retired. Participants were recruited from several Canadian provinces and represented different social, relational, and treatment contexts. Although the study did not aim to compare participants statistically, these demographic and clinical differences provided important contextual variation for understanding how women experienced psychological adaptation, body image distress, and quality of life after mastectomy.

Table 1

Group Experiential Themes and Subthemes Identified Through Interpretative Phenomenological Analysis

Group experiential theme	Subthemes	Participants contributing to theme	Interpretative meaning
Disruption of the embodied self	Feeling unfamiliar in one's own body; loss of bodily continuity; altered femininity; difficulty looking at the surgical site	14	Mastectomy was experienced not only as removal of breast tissue but as a disruption in the women's relationship with their body, identity, and sense of womanhood.
Body image distress and social visibility	Mirror avoidance; anxiety about clothing; fear of being noticed; discomfort in social or public spaces; ambivalence toward reconstruction or prosthesis	13	Body image distress emerged as a relational and social experience, shaped by how participants imagined others might see, judge, or interpret their altered body.
Psychological adaptation and meaning reconstruction	Grief and mourning; acceptance of survival; redefining normality; regaining control; integrating illness into self-narrative	14	Adaptation was not a linear recovery process but an ongoing interpretative effort through which participants tried to reconcile bodily loss with survival, continuity, and future life.

Changes in intimacy and relational identity	Fear of rejection; altered sexual confidence; dependence on partner sensitivity; selective disclosure; family support and emotional safety	11	Relationships could either intensify distress or support adaptation, depending on whether participants felt emotionally accepted, physically respected, and socially understood.
Quality of life reorganization	Fatigue and functional limits; medical vigilance; changes in work and daily routines; renewed priorities; appreciation of life	12	Quality of life was reconstructed around both losses and gains, including physical limitations, emotional vulnerability, greater attention to health, and a changed sense of what mattered.

Table 1 presents the main group experiential themes that emerged from the interpretative phenomenological analysis. The findings show that women's post-mastectomy experiences were organized around five interconnected dimensions rather than isolated psychological reactions. The first and most pervasive theme was disruption of the embodied self, which appeared in all interviews and reflected the profound way in which mastectomy altered participants' sense of bodily familiarity, femininity, and self-continuity. Body image distress was closely related to this disruption but had a more explicitly social and visible dimension, as many participants described fear of being seen, evaluated, or treated differently. Psychological adaptation also appeared across all interviews, but participants did not describe it as simple acceptance or emotional recovery. Instead, adaptation involved repeated attempts to reinterpret the meaning of the changed body, the illness experience, survival, vulnerability, and future identity. Relational experiences were especially important because partners, family members, friends, and healthcare providers influenced whether participants felt supported or exposed. Finally, quality of life was described as a reorganized condition rather than a full return to life before cancer. Participants spoke of fatigue, medical uncertainty, changed routines, and reduced spontaneity, but they also described renewed priorities, greater appreciation of life, and a stronger awareness of personal resilience.

Table 2

Psychological Adaptation After Mastectomy

Subtheme	Analytic description	Exemplar participant statement	Interpretative interpretation
Emotional shock and loss of continuity	Participants described the early period after surgery as emotionally disorienting, with a sense that their previous body and life had been interrupted.	"I knew the surgery was necessary, but when I woke up, it felt like a part of my old self had disappeared overnight."	The surgical body became a marker of rupture between life before cancer and life after mastectomy.
Mourning the breast while valuing survival	Women often held two emotional positions at the same time: grief for bodily loss and gratitude for being alive.	"People kept saying, 'At least you survived,' and I was grateful, but I was also grieving something real."	Adaptation required participants to legitimize grief without feeling that grief contradicted gratitude.
Relearning the body	Participants gradually developed new routines of touching, dressing, washing, and caring for the altered body.	"At first I could not touch the scar. Later, washing that area became part of learning that this was still my body."	Physical familiarity became an important pathway through which psychological acceptance developed.
Reconstructing identity	Several women described a gradual movement from feeling defined by cancer toward incorporating the experience into a broader identity.	"For a while I was just a cancer patient. Now I feel like I am a woman who went through cancer, but I am not only that."	Adaptation involved narrative reorganization, in which mastectomy became part of the self but not the whole self.
Regaining control	Participants used practical and symbolic strategies to restore control, such as choosing clothing, deciding whether to disclose, exercising, or participating in support groups.	"Choosing what I wear and who I tell gave me back some control when everything else felt decided by doctors."	Control was reconstructed through small decisions that restored agency in everyday life.
Future-oriented resilience	Some participants described a renewed commitment to life, relationships, and personal priorities after the initial period of distress.	"I do not think I am the same person, but I am stronger in a way I did not expect."	Resilience emerged not as the absence of distress but as the capacity to live meaningfully with bodily and emotional change.

Table 2 illustrates the internal process of psychological adaptation after mastectomy. Participants did not describe adjustment as an immediate or stable state; rather, it was experienced as a gradual and uneven process involving shock, grief, bodily relearning, identity reconstruction, and renewed agency. A central finding was that women often felt pressured by others to focus only on survival, while their own experience included mourning, anger, fear, and sadness. This created an emotional tension between gratitude and loss. The participants' accounts showed that adaptation became possible when they allowed both experiences to coexist: being thankful to be alive while also recognizing that mastectomy had changed their body, confidence, relationships, and sense of self. Relearning the body was particularly important. Many women initially avoided touching or looking at the surgical area, but over time, routine activities such as bathing, dressing, and scar care became part of reclaiming the body as their own. Psychological adaptation was therefore closely connected to embodied experience. It was not only cognitive acceptance, but also a physical and emotional process of becoming familiar with a changed body. Participants who described stronger adaptation often emphasized personal agency, including deciding how to dress, whether to use a prosthesis, when to talk about cancer, and how to define themselves beyond the illness experience.

Table 3

Body Image Distress and the Altered Female Body

Subtheme	Analytic description	Exemplar participant statement	Interpretative interpretation
Mirror avoidance	Many participants avoided mirrors, especially in the early months after surgery, because the reflection intensified awareness of loss.	"The mirror was the hardest part. I knew what had happened, but seeing it made it real every time."	The mirror functioned as a confronting space where medical survival became visible as bodily absence.
Distress about asymmetry and appearance	Participants with unilateral mastectomy frequently described discomfort with asymmetry, while bilateral mastectomy participants described feeling physically flattened or unfamiliar.	"It was not only that one breast was gone; it was that my whole shape looked different to me."	Body image distress was linked to altered body proportion, silhouette, and recognition of the self.
Clothing as concealment and control	Clothing choices became emotionally significant, as participants used clothes to conceal changes and manage public visibility.	"I started choosing clothes based on what would hide me, not what I liked."	Clothing became both a protective strategy and a reminder of bodily insecurity.
Femininity and sexuality	Participants described changes in feeling feminine, attractive, or sexually confident, particularly in intimate relationships.	"I still felt like a woman, but I did not always feel desirable. Those are not the same thing."	Mastectomy challenged culturally and personally held associations between breasts, femininity, sexuality, and desirability.
Fear of being noticed	Several participants worried that others could detect their mastectomy, prosthesis, or asymmetry in public spaces.	"I knew people probably were not looking, but I felt like everyone could tell."	Distress was shaped by imagined visibility as much as by actual social reaction.
Ambivalence about reconstruction and prosthesis	Reconstruction or prosthesis helped some women feel more balanced, but others experienced these options as artificial, uncomfortable, or emotionally complicated.	"The reconstruction helped in clothes, but it did not make me feel like nothing had happened."	Restoring external appearance did not always resolve the deeper psychological meaning of bodily change.

Table 3 shows that body image distress after mastectomy was multidimensional and extended beyond dissatisfaction with physical appearance. Participants described the altered body as something that had to be seen, hidden, touched, explained, protected, and interpreted. Mirror avoidance was one of the strongest expressions of distress, particularly among women who had undergone surgery more recently. For these participants, the mirror did not simply reflect appearance; it confirmed the reality of cancer, surgery, and bodily loss. Clothing also carried strong emotional meaning. Several women described abandoning clothing they previously enjoyed and choosing garments based on concealment, symmetry, and perceived safety. This shift reduced spontaneity and self-expression in daily life. The relationship between mastectomy, femininity, and sexuality was complex. Some participants rejected the idea that breasts alone defined womanhood, yet still acknowledged that mastectomy affected their sense of attractiveness, sexual ease, and bodily confidence. These accounts suggest that body image distress was not only personal but also culturally mediated, because women interpreted their bodies through social expectations about femininity, wholeness, and desirability. The findings also indicate that reconstruction and prosthesis were not simple solutions. Although they helped some participants feel more comfortable in clothing or public settings, they did not fully erase the emotional meaning of mastectomy or the awareness that the body had been permanently changed.

Table 4

Quality of Life After Mastectomy

Subtheme	Analytic description	Exemplar participant statement	Interpretative interpretation
Physical limitations and fatigue	Participants described fatigue, reduced strength, pain, tightness, or limited arm movement as factors affecting daily life.	"Even when treatment ended, my body did not feel finished with cancer."	Quality of life was affected by the continuing physical presence of illness and treatment after surgery.
Medical vigilance and fear of recurrence	Several women remained highly alert to bodily sensations, follow-up appointments, and signs of possible recurrence.	"Every new pain makes me wonder if it is back."	Survivorship was experienced as a state of uncertainty rather than complete closure.
Work and role disruption	Some participants reported changes in employment, family responsibilities, and confidence in fulfilling previous roles.	"I went back to work, but I was not the same person walking into that office."	Quality of life involved renegotiating social and occupational identity after cancer.
Emotional fluctuation	Participants described periods of strength alongside sudden sadness, anxiety, irritability, or vulnerability.	"I can be fine for weeks, and then something small brings everything back."	Emotional recovery was nonlinear and remained sensitive to reminders of illness and bodily change.
Relationship-based support	Supportive partners, family members, friends, and peer groups helped participants feel less isolated and more understood.	"Talking to women who had been through it made me feel normal for the first time."	Social support improved quality of life by validating experiences that participants felt others could not fully understand.
Renewed priorities and appreciation of life	Many participants described a changed value system, with increased focus on relationships, health, self-care, and meaningful activities.	"I do not waste energy the same way now. I know what matters to me."	Quality of life was reconstructed through a changed sense of meaning, priority, and personal value.

Figure 1

Interpretative Model of Psychological Adaptation, Body Image Distress, and Quality of Life Among Women After Mastectomy

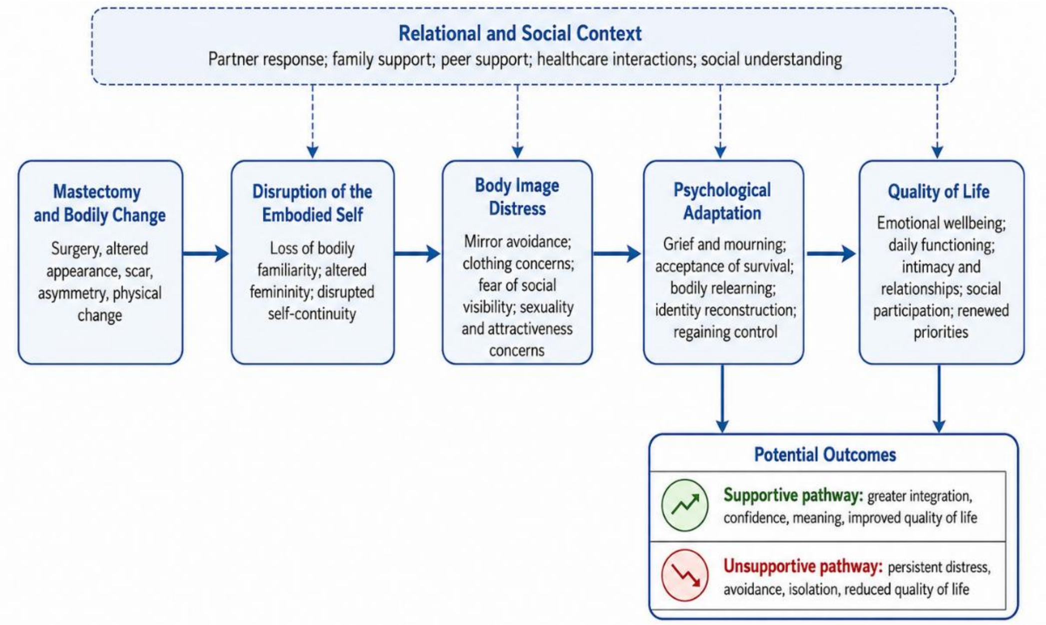

Table 4 presents the ways in which participants experienced quality of life after mastectomy. Quality of life was not described merely as physical health or absence of disease, but as a broad reorganization of bodily functioning, emotional stability, social roles, relationships, and personal meaning. Physical limitations remained important even after active treatment had ended. Participants described fatigue, pain, limited movement, tightness, and reduced stamina as reminders that the body had not simply returned to normal. Fear of recurrence also affected quality of life, as many participants remained alert to bodily sensations and medical follow-up. This vigilance created a sense of living between recovery and uncertainty. Work and family roles were also affected, not only because of physical limitations but because participants felt psychologically changed. Some women returned to previous roles while feeling internally different, less confident, or more aware of their vulnerability. However, the findings also showed that quality of life could improve through relational support, peer connection, self-care, and renewed priorities. Participants often described meaningful changes in how they valued time, relationships, health, and emotional authenticity.

Therefore, quality of life after mastectomy appeared as a dynamic balance between continuing losses and emerging forms of meaning.

Figure 1 summarizes the interpretative relationship among the main findings of the study. The model indicates that mastectomy first disrupts the embodied self by altering participants' physical appearance, bodily familiarity, and sense of continuity. This disruption contributes to body image distress, particularly through mirror avoidance, clothing concerns, fear of social visibility, and changes in femininity and sexuality. Psychological adaptation develops as women attempt to make sense of this disruption through grief, acceptance, bodily relearning, identity reconstruction, and the recovery of agency. Relational experiences influence this process at each stage, because supportive partners, family members, peers, and healthcare professionals can reduce isolation and validate the woman's changed self-experience, while insensitive responses can intensify distress. Quality of life emerges from the interaction between these processes. When body image distress remains unacknowledged and relational support is limited, women may experience greater emotional vulnerability, avoidance, and reduced participation in social or intimate life. When psychological adaptation is supported, women may develop a more integrated sense of self, improved confidence, and renewed life priorities. The model therefore suggests that quality of life after mastectomy is shaped not only by physical recovery, but also by how women interpret bodily change, negotiate social visibility, and reconstruct meaning after cancer.

4. Discussion

The present study explored psychological adaptation, body image distress, and quality of life among women after mastectomy using an Interpretative Phenomenological Analysis approach. The findings showed that mastectomy was not experienced merely as a surgical event or a medical endpoint, but as a profound disruption of the embodied self. Participants described the post-mastectomy body as unfamiliar, emotionally difficult to confront, and symbolically connected to loss, survival, femininity, sexuality, and identity. Across interviews, women reported a complex process of adaptation in which gratitude for survival coexisted with grief for bodily loss. This dual emotional position is important because it challenges the common assumption that successful cancer treatment automatically produces psychological recovery. Rather, the findings suggest that women after mastectomy may continue to experience vulnerability, bodily alienation, fear of recurrence, relational uncertainty, and altered quality of life even after the completion of active treatment. This interpretation is consistent with previous evidence indicating that breast cancer diagnosis, treatment, and remission can have enduring psychological consequences and that survivorship often involves anxiety, identity disruption, and emotional reorganization (Graham, 2024; Lantheaume et al., 2021; Yfantis et al., 2020).

One of the central findings of this study was the theme of disruption of the embodied self. Participants repeatedly described feeling unfamiliar in their own bodies, avoiding the surgical site, struggling with bodily asymmetry, and experiencing a discontinuity between their pre-mastectomy and post-mastectomy selves. This finding supports previous studies showing that quality of life after mastectomy is strongly influenced by body-related concerns and by the extent to which women can integrate bodily changes into their self-concept (Battistello et al., 2024; Vuletić, 2022). The present study extends these findings by showing that this disruption was not limited to dissatisfaction with appearance; it involved a deeper disturbance in bodily recognition. For many participants, the altered body became a visible reminder of cancer, medical intervention, vulnerability, and mortality. This explains why some women reported difficulty looking in the mirror or touching the scar, even when they cognitively accepted that the surgery had been necessary. Such experiences are aligned with research emphasizing that breast cancer surgery can affect body image, sexuality, and the meaning of womanhood in ways that exceed cosmetic concerns (An et al., 2022; Faria et al., 2021).

The second major finding concerned body image distress and social visibility. Participants described mirror avoidance, clothing-related anxiety, concern about asymmetry, fear of being noticed in public, and discomfort in intimate contexts. These results are consistent with studies showing that body image is closely associated with quality of life among breast cancer survivors and that women's perceptions of their changed body can affect emotional well-being, sexuality, confidence, and social participation (An et al., 2022; Battistello et al., 2024). In the present study, body image distress appeared to be both private and social. Privately, women struggled with the visual and tactile reality of their altered body. Socially, they worried about how others might perceive them, whether their mastectomy or prosthesis was visible, and whether they would still be viewed as feminine or desirable. This finding corresponds with previous literature showing that post-mastectomy quality of life is shaped not only by clinical recovery, but also by women's ability to maintain social confidence, sexual identity, and relational security (Faria et al., 2021; Mülkoğlu et al., 2022; Narayanan et al., 2023).

Another important finding was that psychological adaptation was nonlinear and interpretative rather than immediate or purely cognitive. Participants did not describe adaptation as simply "accepting" the surgery; instead, they moved through repeated cycles of grief, bodily relearning, identity reconstruction, and renewed agency. Many women described a tension between mourning the loss of the breast and feeling grateful to be alive. This tension reflects the emotional complexity of survivorship and is consistent with previous research showing that women's quality of life after breast cancer treatment includes both distress and resilience (Jayasinghe et al., 2020; Sajid et al., 2022; Seneviratne et al., 2022). The present study adds nuance by showing that adaptation may depend on whether women are allowed to acknowledge grief without feeling that they are being ungrateful for survival. When participants felt that others minimized their bodily loss by emphasizing survival alone, they often experienced isolation or emotional invalidation. In contrast, when their grief and survival were both recognized as legitimate, they were better able to integrate the mastectomy experience into a broader life narrative.

The findings also demonstrated that breast reconstruction or prosthesis did not automatically eliminate body image distress or restore quality of life. Some participants reported that reconstruction or external prosthesis helped them feel more comfortable in clothing and public spaces, but others described ambivalence, discomfort, or a sense that external symmetry did not fully address the emotional meaning of bodily loss. This finding is consistent with research comparing quality of life after mastectomy with and without reconstruction, which suggests that reconstruction may improve some dimensions of satisfaction and psychosocial well-being but does not necessarily remove physical, emotional, or identity-related difficulties (Hassan et al., 2024; Limantara & Djatmiko, 2021; Nsaful et al., 2024a, 2024b). Studies on conservative breast surgery with reconstruction have similarly shown beneficial effects on quality of life and emotional well-being, yet these outcomes should not be interpreted as evidence that aesthetic restoration alone resolves post-surgical distress (Abuelnour et al., 2024; Zaher et al., 2024). The current findings suggest that clinical conversations about reconstruction should include psychological meanings, expectations, bodily sensation, intimacy, and identity, rather than focusing only on appearance.

Quality of life emerged in this study as a reorganized condition rather than a return to the pre-cancer state. Participants described persistent fatigue, pain, fear of recurrence, limitations in daily functioning, changes in work roles, emotional fluctuations, and altered priorities. These findings align with previous studies showing that breast cancer treatment can continue to influence physical, emotional, and social functioning after surgery (Aldaak et al., 2022; Deshpande et al., 2022; Gică et al., 2024; Lemmih et al., 2025). Physical symptoms were particularly important because they functioned as ongoing reminders of illness. Pain, tightness, reduced movement, lymphedema, and treatment-related fatigue affected not only bodily comfort but also emotional security and confidence in daily life. This is supported by literature on postmastectomy pain syndrome and lymphedema, which indicates that physical complications after mastectomy can impair quality of life, sexual functioning, and psychosocial well-being (Mülkoğlu et al., 2022; Salati et al., 2023; Turgay et al., 2021). Therefore, the present findings reinforce the need to conceptualize quality of life after mastectomy as an interaction between physical recovery, emotional adaptation, body image, and social functioning.

The relational and social context was another major element in participants' accounts. Supportive partners, family members, peers, and healthcare professionals helped women feel understood, accepted, and less alone. Conversely, silence, avoidance, insensitive comments, or pressure to appear "strong" sometimes intensified emotional distress. This finding supports previous research showing that social support is associated with quality of life and body image among women after mastectomy (Vuletić, 2022). It also aligns with evidence that patient satisfaction and quality of life after mastectomy are influenced by healthcare experiences, communication, and perceived support (Barkar et al., 2023). In the present study, peer support was especially meaningful because participants felt that other women with similar experiences could understand the bodily and emotional complexities of mastectomy in ways that others could not. This finding is compatible with studies showing that educational and digital interventions can improve quality of life and emotional status among women undergoing or recovering from mastectomy (Ahmed et al., 2021; Ahmed et al., 2023). However, the current findings suggest that such interventions should include not only informational content, but also emotional validation and opportunities for shared meaning-making.

The findings also have implications for survivorship care and assessment. Previous reviews have emphasized the importance of standardized tools for measuring post-mastectomy quality of life, and quantitative instruments remain valuable for screening distress, comparing outcomes, and evaluating interventions (Harerimana & McHunu, 2025). However, the present IPA findings show that standardized assessment may not fully capture the layered meanings of bodily change, femininity, sexuality, grief, social visibility, and identity reconstruction. Longitudinal studies have demonstrated that quality of life, psychological status, and body image may change over time after different types of breast cancer surgery, but the subjective meaning of these changes requires qualitative attention (Mudiyanselage et al., 2022). Likewise, rehabilitation and exercise programs have shown promise in improving quality of life after mastectomy or reconstruction, yet women's experiences of regaining control, confidence, and bodily trust may be as important as measurable functional gains (Carvalho & Salerno, 2021; Kang et al., 2022). Thus, the present findings support an integrated survivorship model in which physical rehabilitation, psychological support, body image care, sexual counseling, and relational support are treated as interconnected components of recovery.

5. Conclusion

Overall, this study contributes to the literature by providing an idiographic and interpretative account of how women make sense of life after mastectomy. While previous studies have documented the impact of mastectomy, reconstruction, anticancer therapy, and demographic or clinical factors on quality of life across different cultural contexts (Álvarez-Pardo et al., 2022; Mansour et al., 2023; Socha & Sobiech, 2021; Yaneva et al., 2021), the present study emphasizes the lived meanings through which women experience these outcomes. The findings suggest that psychological adaptation after mastectomy involves the gradual integration of bodily loss into a revised self-narrative. Body image distress can act as a barrier to this integration when women feel alienated from their body or exposed to social judgment. Relational support can facilitate adaptation by validating women's experiences and reducing isolation. Quality of life, therefore, is not simply an outcome after treatment but a continuing process shaped by bodily change, emotional interpretation, social recognition, and renewed meaning.

6. Limitations & Suggestions

This study had several limitations that should be considered when interpreting the findings. First, the sample size was small, as is appropriate for Interpretative Phenomenological Analysis, but the findings cannot be generalized statistically to all women after mastectomy. Second, participants were recruited from support networks and community-based groups, which may mean that women who were more willing to reflect on and discuss their experiences were more likely to participate. Third, the study included women with different times since surgery, treatment histories, and reconstruction statuses, which enriched the data but also introduced variability in the stage of adaptation. Fourth, the interviews relied on retrospective self-report, and participants' accounts may have been shaped by memory, emotional state, and current life circumstances. Finally, although reflexive strategies were used, qualitative interpretation is inevitably influenced by the researcher's perspective, and other researchers may have emphasized different meanings within the same narratives.

Future research should examine post-mastectomy adaptation using longitudinal qualitative designs that follow women from the pre-surgical period through treatment, early recovery, and long-term survivorship. Such studies could clarify how body image distress, psychological adaptation, relational support, and quality of life change over time. Future studies should also compare the lived experiences of women with unilateral mastectomy, bilateral mastectomy, reconstruction, delayed reconstruction, and no reconstruction in order to better understand how different surgical pathways shape identity and quality of life. More attention should be given to culturally diverse populations, younger women, older women, single women, women in rural areas, and women from minority communities, because social expectations about femininity, sexuality, illness, and support may differ across groups. Mixed-methods research could also be valuable by combining standardized quality-of-life measures with in-depth interviews to integrate measurable outcomes with lived meanings.

Healthcare professionals should recognize that recovery after mastectomy involves more than wound healing, treatment completion, or survival. Women need opportunities to discuss body image distress, grief, sexuality, fear of recurrence, relational concerns, and changes in identity without feeling that these concerns are secondary or inappropriate. Psychological screening and referral pathways should be integrated into breast cancer survivorship care, and body image support should be offered as a routine component of post-mastectomy follow-up. Clinicians should provide clear and realistic information about reconstruction, prosthesis use, rehabilitation, scar care, physical limitations, and emotional adjustment, while avoiding the assumption that any single option will resolve distress for all women. Peer support groups, partner-inclusive counseling, sexual health consultation, and rehabilitation services can help women rebuild confidence, regain agency, and develop a more integrated relationship with their changed body.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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Authors' Contributions

All authors equally contributed to this article.

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