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# Exploring Women's Support Needs After Breast Reconstruction Surgery

## A Qualitative Study

### KEY WORDS

Breast cancer  
 Breast reconstruction  
 Psychosocial support systems  
 Qualitative research

**Background:** The procedures for breast reconstruction (BR) after mastectomy frequently initiate a difficult recovery period. A better understanding of women's support needs after surgery would improve patient care. **Objective:** The aim of this study was to identify patients' support needs after BR. **Methods:** In a retrospective study design, 21 participants described their support experiences after BR, including their sources of support and the impact of support on their recovery in a semistructured interview. Transcriptions of the interviews were analyzed using thematic analysis. **Results:** Four support needs were identified and were composed of elements of instrumental, emotional, and informational support. These needs were addressed to varying degrees by healthcare providers, family members, and other women who had BR experience. **Conclusion:** Women's experience of BR and their ability to cope are markedly better when their support needs are effectively addressed. Greater attention to their needs for support has the potential to improve patient care. **Implications for Practice:** Nurses play a pivotal role in providing information to women who are recovering from BR. Improved access to communication channels between nurses and patients would likely improve patients' support experiences. In addition, nurses can assess the women's specific support needs and partner with families to help them understand how best to support women during recovery.

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**W**omen facing a diagnosis of breast cancer (BC) have many difficult decisions to make, including whether to undergo breast reconstruction (BR) surgery. Breast reconstruction surgery can be an important process in the physical and psychological recovery from BC.<sup>1,2</sup> Research that explores patients' perspectives is fundamental to the responsive and compassionate delivery of patient-centered care and develops both information and psychosocial support interventions and decision-making tools. By understanding the support needs of patients who have undergone BR procedures, healthcare practitioners can bolster their ability to offer support to those who have this surgery and to extend knowledge of such support to patients who might be considering doing so. In this study, we explored women's support experiences after undergoing BR surgery with the aim to establish their needs for support.

## Value of BR

Numerous studies have revealed various potential benefits of reconstruction.<sup>3-6</sup> For some women, BR has initiated the return of their femininity and facilitated their acceptance of mastectomy.<sup>4,7,8</sup> For those who have delayed BR (DBR), surgery has allowed them to discard their prosthesis and achieve greater physical comfort.<sup>9</sup> For still others, surgery has enabled them to "feel whole."<sup>6,10,11</sup> In multiple studies, women have described this sense of being restored in terms of "normality," "wholeness," improved body image, and self-esteem.<sup>4,5,12-17</sup> Women might also perceive BR as the final stage in their recovery from BC.<sup>2,15</sup>

## Struggle With Recovery

Although many women have been satisfied with reconstruction, others have found the experience very distressing.<sup>1,17</sup> Even for those who have been satisfied with the final outcome, the immediate outcome of surgery has often been upsetting in physical, emotional, and relational terms.<sup>9,12,18-21</sup> Some have found the overall duration and extent of recovery surprising.<sup>6</sup> Surgery had a significant emotional impact, and some women have not felt adequately prepared.<sup>22,23</sup> Breast reconstruction procedures have resulted in feelings of regret or loss, decreases in self-esteem, and increases in anxiety and depression.<sup>19,24,25</sup>

After reconstruction, women often express concerns with their physical appearance. Some have been worried about their breasts being noticeably different, and many have found that a new breast did not match their expectations, especially in terms of scarring.<sup>1,6,18,21,26</sup> Women have been dissatisfied with the discomfort, immobility, and lack of natural feel of the new breast.<sup>6,17,19,21,27</sup> Reconstruction has also required significant adjustment within an intimate relationship. Physical intimacy has been reduced because of body image concerns; women have experienced sexual anxiety and have been concerned about their partner's acceptance of their modified body.<sup>1,15,28,29</sup> Although no definitive consensus exists regarding whether mastectomy with BR is better for a woman's psychological health than mastectomy alone, women continue to choose reconstruction for its perceived benefits.<sup>17</sup> Our goal with this study was to understand the support women need as they undergo BR.

## Value of Support

Some research has explored women's support experiences as they undergo BR.<sup>1,27</sup> Psychological support can be instrumental in achieving a "new normal."<sup>19</sup> Researchers have described women's support needs as multifaceted, comprising spiritual, emotional, physical, and familial elements.<sup>5</sup> Patients undergoing BR have received informational support from healthcare providers (HCPs) in conjunction with emotional support from spouses and family members.<sup>1,9,12</sup> Indeed, research has revealed how influential a role HCPs have on women's expected outcomes of BR.<sup>21,22</sup> Accordingly, having confidence in HCPs during recovery has also been deemed important.<sup>22</sup> Not surprisingly, so has spousal support, with the pivotal role of partners highlighted in women's acceptance of their new body.<sup>26,28</sup> Researchers have suggested that a couple's communication, pain management, and acceptance of a new body image are potential mechanisms underlying partner support.<sup>30-33</sup>

Although the efficacy of support is evident in the illness context of BC, studies that focus on women's experiences of support for BR have been limited.<sup>4,34,35</sup> For example, studies of women's recovery from BR have indicated the need for support—but without examining the nature of such support. In this study, we explored women's experiences of support while they underwent reconstructive surgery. By considering women's experiences of support, we aim to identify their post-operative support needs. Ultimately, achieving a better understanding of women's support needs could inform nursing practice and direct future research.

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## ■ Methods

We used qualitative interviews to explore women's support needs in a retrospective design. We began participant recruitment through the Breast Health Centre (BHC) in Saskatoon, Saskatchewan, with the approval of the University of Saskatchewan Behavioural Ethics Research Board. The Saskatoon BHC provides assessment, diagnosis, and care plans for women who have BC.<sup>36</sup> In Canada, nurse navigators support patients' interactions with the healthcare system. Such support typically includes providing access to therapies and resources, ensuring continuity of care, and guiding patients through changeover points in the care process.<sup>37</sup> As part of the Saskatoon BHC interdisciplinary team, nurse navigators provide education, facilitate support services, and represent a consistent point of care.

Because this was an exploratory study, we had broad inclusion criteria. To be eligible for participation in the study, prospective participants had to have completed BR and had to speak English. Women were excluded if they were currently undergoing treatment of BC. The nurse navigators provided BHC surgeons with a list of eligible patients, after which the surgeons provided prospective participants with a pamphlet informing them about the study. Those potential participants who expressed an interest were contacted by a researcher to schedule an interview. Before the interview, participants signed consent

forms that outlined their rights of confidentiality, anonymity, and voluntary participation.

Data collection took place during spring and summer 2016. The number of participants who ultimately participated in the study was limited by the May to September 2016 time frame and total honoraria available for interviewees. The study featured a semistructured interview guide that had been pretested and refined with the help of 2 women. Use of this interview guide allowed direct comparisons between respondents' answers while simultaneously permitting participants' freedom of response and giving them the ability to speak to personally significant aspects of particular questions.<sup>38</sup> The interview assessed women's support experiences during recovery and included questions such as "Thinking about when you first decided to have breast reconstruction, do you feel like there was support available to you to help cope with this process?" and "Is there additional support you wish was available?" The interviews generally occurred at the BHC or the University of Saskatchewan. After consent was obtained from a participant, the interview commenced, with the participant receiving a \$100 CAD honorarium.

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## ■ Data Analysis

After the interviews had been transcribed verbatim, 1 researcher generated preliminary themes from participants' descriptions of their BR experiences and the meanings they attributed to those experiences. A second researcher confirmed and, when appropriate, refined the initial analysis. Throughout the analysis process, participant confidentiality was ensured through the use of password-protected file systems for electronic data and physically locked cabinets for data hard copies. Furthermore, pseudonyms were applied to each interview transcript before data analysis and were carried through to reporting findings.

The epistemological stance of the research is essentialist/realist; we attempted to report the experiences of the participants directly to address the research question regarding the exploration of support needs for women who have undergone BR.<sup>39</sup> Because the objective of the study was to describe a phenomenon that, to date, had not been articulated elsewhere, thematic analysis, because of its descriptive power, was deemed an appropriate method of data analysis. Thematic analysis is a versatile method, appropriate for many epistemological orientations, which can be applied as a means of achieving the level of thematic depth and breadth required by a researcher.<sup>39</sup>

Because of the exploratory nature of the study, we determined the importance of using a data-driven method to the analysis to best address our research question. Therefore, we used an inductive approach to thematic analysis.<sup>39</sup> Analysis of the data set was guided by the research question. Themes were most frequently identified at a semantic level. In most instances, women provided straightforward descriptions of their experiences. In other instances, such as when a woman reacted emotionally to her support experience, the research team decided to investigate latent elements of the data in an attempt to understand the circumstances responsible for the reaction.

Using Braun and Clarke's<sup>39</sup> 6-phase thematic analysis, both researchers read through the data set and indicated initial patterns related to women's support experiences. Data excerpts related to the research question were then isolated and coded. Coding was data driven, and we subsequently sorted codes into initial themes based on observed patterns. These initial themes were then refined to ensure the distinctness of all themes and to reflect categories of support needs. Support needs were conceptualized as including both instrumental and emotional support and an awareness of the contextual nature of support. A reduction in psychological distress was deemed to be characteristic of a support need being addressed.<sup>40</sup>

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## ■ Results

Ultimately, 21 of 24 women who were approached for this study participated. Two women declined to participate, and 1 woman who began the interview revealed that she was taking cancer treatment, rendering her ineligible to participate. The interviews typically lasted between 45 and 90 minutes. The mean age of participants was 53 years (range, 40-74 years). Two-thirds of the participants were married or had a partner ( $n = 14$ ), and most participants were employed ( $n = 11$ ). The time between each participant's BR and her participation in the interview ranged from 2 months to 8 years. Most participants ( $n = 12$ ) had had unilateral immediate BR, but 1 woman who had immediate BR on 1 breast had DBR on the other, and the remainder of the women had had DBR ( $n = 8$ ). See the Table for a complete list of participant characteristics.

Our analysis revealed that women's support experiences were shaped by interactions with HCPs, family members, friends, and other women who had experienced BR. Subsequently, 4 support needs were identified as having a particular impact on women's recovery process: "access to information," "help with daily tasks," "emotional connection," and "being understood." In addition, we noted that some women's support experiences and their need for support differed markedly from those of other women in the study.

### Access to Information

Having expedient access to information resources about the physical aspects of recovery affected the emotional state of participants. Women reported that the ability to contact HCPs with questions and concerns about their recovery contributed to a feeling of reassurance and "peace of mind." Many participants were pleased by the accessibility of the nurse navigators and valued the ability to have their concerns and uncertainties addressed with relative immediacy. As 1 participant stated, "The nurse navigators really made you feel that you could contact them anytime with any kind of question" (Sonya). Another participant spoke of contacting her HCP when her body was "bruised and swelling and puffy," at which the HCP "reassured me that I was...healing fine." This participant emphasized that "assurance—the peace of mind is kind of everything to a patient"

**Table • Patient Characteristics by Surgery Type**

Pseudonym	Age, y	Type of Surgery	Education	Marital Status	Employment Status
Agnes	45-49	Implant	Postsecondary	SD	Not paid employment
Carmen	50-54	DIEP flap	Postsecondary	SD	Not paid employment
Caroline	40-44	Implant	Postsecondary	Single	Disability
Cecile	45-49	TRAM flap	High school	MC	Full-time
Darlene	50-54	Implant	Some postsecondary	MC	Self-employed
Dianne	55-59	Implant	Postsecondary	MC	Full-time
Florence	70-74	Implant	Postsecondary	Single	Retired
Gale	50-54	Implant	Postsecondary	SD	Full-time
Hilda	40-44	Implant	Some postsecondary	MC	Full-time
Jean	70-74	Implant	Postsecondary	Widowed	Retired
Juanita	70-74	Implant	Postsecondary	MC	Retired
Kathy	60-64	Implant	High school	MC	Part-time
Krista	40-44	Implant	Some postsecondary	MC	Not paid employment
Lauretta	50-54	Implant	Postsecondary	MC	Not paid employment
Natalie	50-54	Implant and latissimus dorsi flap	High school	MC	Part-time
Penelope	60-64	DIEP flap	Postsecondary	SD	Retired
Rosa	40-44	Implant	Postsecondary	MC	Full-time
Sally	60-64	TRAM flap	Postsecondary	MC	Disability
Silvia	45-49	DIEP flap	High school	MC	Full-time
Sonya	40-44	Implant	Postsecondary	MC	Full-time
Trisha	50-54	Implant	Postsecondary	MC	Full-time

Abbreviations: DIEP, deep inferior epigastric perforators; MC, married or Common Law; SD, separated or divorced; TRAM, transverse rectus abdominis myocutaneous.

(Kathy). In as many words, this participant directly acknowledged the value of being able to access her HCP—and that such access reduced her distress.

By contrast, women who felt uninformed by their HCP were distressed by the facts of recovery. Indeed, some participants who were surprised by the physical realities of surgery and recovery struggled to manage their recovery. One participant wished she had been better informed about “how to care for [herself] after the surgery...when...switching from the expanders to the implants” (Hilda). Another participant felt uninformed about the physical aspects of recovery—specifically, how long she would have to wear the abdominal binder. She had “asked [the surgeon] how long [I had] to wear [the abdominal binder] or the brassiere.... I had no idea” (Carmen). The HCP, she acknowledged, might have attempted to provide her with the information, but the lingering effects of the surgical sedative had interfered with her retention: “For all I know, maybe the nurses did tell me that, but I was so out of it from the drugs that I didn’t realize” (Carmen). Her experience illustrates the influence that situational factors have on information retention.

Considering participants’ experience communicating with HCPs as a whole, the ability to promptly have questions related to surgical recovery answered seemed to reduce women’s experience of distress by assuring them that their experience was not unusual and by addressing any current issues. Thus, access to information was an important component of support. Speaking of the supportiveness of the nurse navigators, 1 participant noted: “I never got ‘Why [are] you calling?’... They’re always like ‘Okay, how can we help?’” (Rosa).

## Help With Daily Tasks

A few participants expressed the importance of having others support them by “doing things,” especially during the early stages of recovery, when their mobility was particularly limited. A participant whose children helped her during her initial recovery stated that she “[did not] know what I would’ve done on my own” (Penelope). One participant was grateful to have women from her church and her workplace “check on me and bring things over” (Rosa). Another participant’s husband cared for her by supplementing her physical mobility, especially by assisting her with her medication and with bathing: “You need to have support at home. You need to have someone there for you, day and night” (Darlene). This support need was characterized by women’s distress over their physical helplessness after surgery, which was reduced by the physical actions carried out by those close to the women.

## Emotional Connection

The presence of family members and close friends was crucial to addressing women’s emotional needs after reconstruction. Women felt emotionally vulnerable and expressed a desire for emotional connection with family and close friends. Participants did not expect family members to relate to their struggle; instead, they valued their family members’ willingness to provide emotional support, to listen, and to “just be there.” Indeed, several participants commented that they were upset by family members or friends’ attempts to relate to their experience:

Just talk to them. Just let them know that you're—you're there. Because, and not say "Well, I can relate" or "I know how this is," because if you haven't gone through it, I don't think you can relate. And it becomes quite annoying to—to listen to someone say, "Oh, yeah, I know what you mean." (Gale)

The importance of family members and friends' "being there" was echoed by another participant: "As far as my family and friends were concerned, they were there when I needed them" (Jean).

The forms of support offered arose out of the level of emotional connection between persons. For example, participants praised their partner's ability to understand where they were at and to try to put them at ease. One participant appreciated her husband's tendency to make "silly jokes," emphasizing that he understood her emotional state. Participants, sensitive to their new bodies and concerned about their partner's perception of their new breast, were relieved when their partner was accepting of their new breast: "He's never made me feel like it's, you know, repulsive" (Sonya). When speaking of her reluctance to resume intimacy, 1 participant noted, "He's been incredible, and so, if anything, like, it's been me holding back, not him" (Cecile).

The importance of the familial emotional support was also apparent in instances in which it was lacking. Participants expressed great distress at a lack of support that sometimes manifested in the form of family members or partners' inability or unwillingness to talk; in 1 instance, a participant described her outright abandonment by her partner in reaction to her BR: "As soon as I had my surgery, my mastectomy, it was like he was just very anxious to get out of my life" (Gale). Another participant's daughter was unwilling to discuss what her mother was experiencing: "[She] doesn't want anything to hear about it, even when [I have] tried to talk to her" (Carmen). These accounts may reflect a sense of isolation. Contrasted with the experiences of participants who had received reliable emotional support, these findings demonstrate that effective emotional connection reduced feelings of abandonment and isolation. Another participant was concerned about those close to her attempting to placate her anxiety: "It would be really annoying to have someone talk to you that doesn't know what it's all about and is just kind of, 'Oh, this is all going to be good' and, you know, 'This isn't going to hurt' or 'That's not going to hurt'" (Gale). Acknowledging that diagnosis and surgery affect the woman's family as well as the woman herself, 1 participant intimated that support for her husband would have been helpful: "I don't think they have the support for the men, or the spouse, you know" (Sally).

Considering the different women's experiences as a whole, the presence of family members and close friends helped to address the feelings of emotional vulnerability. The presence of family facilitated emotional connection. With such social support, women did not feel isolated and were better able to cope with recovery.

## Being Understood

As a result of reconstruction, many women felt different and struggled to adapt to their changed bodies. Furthermore, the

bodily changes posed a challenge for women to make sense of their experience and to understand the impact reconstruction would have on their life as a whole. Women's emotional distress over feeling different was ameliorated by the input of women who had experienced BR. Most participants commented on the value of the support provided by such women. One participant stated, "Other women who've gone through breast cancer, I think, are the best supports you can get" (Gale). Contact with women who had recovered from BR provided participants with someone to whom they could relate. The value of group support with such women was eloquently stated by 1 participant:

To be in that group and to be amongst those women made me feel more confident about what I was and to see that all of these women, as different as we all are, were still able to carry on with their life and that there's still life after having breast cancer and that it's a different choice for each person. (Gale)

The value of group support in reducing women's feeling of difference was reiterated by other participants: "You could share with them like you're not the only one" (Agnes). Referring to a cancer support group, 1 participant described how the group helped her "feel...better about [herself] and not so different" (Carmen). Another participant did not use group support but instead found similar validation from a friend who had BR experience: "She shared her story, and I think that was the most helpful, is talking to another woman who has gone through it. Because if you've never gone through it, you have no idea the emotional rollercoaster that you're on" (Darlene). Regardless of whether the support was provided on a group basis or an individual basis, formal and informal support helped to address participants' feelings of difference.

When participants related their experience to other women who had BR, they found more immediate understanding. This contrasted sharply with the difficulty that some participants experienced in trying to communicate with those who had never had reconstruction. One participant described the difficulty of explaining the reconstruction process: "Sometimes it kind of becomes overwhelming to explain to everybody or to anybody on the street you see.... I don't want to go into it" (Agnes). Participants were also exasperated with people's misconceptions of the process: "Don't say things like 'free boob job'; it's not a free boob job. Even if it was, you wouldn't want to get one that way" (Sonya). Ultimately, the support provided by women who had been through the process reduced participants' distress by helping them to make sense of their experience and helped them to continue on with their lives.

## Exceptions to Support Needs

Despite a general consistency among the findings regarding the nature of participants' support needs, 3 participants' experiences opposed the general trend. One participant's husband was so stunned after her diagnosis that he was unable to provide her with support: "He was kind of in shock, and I don't think he really knew how to support me or what he could do, and so he was kind of barely hanging on and coping himself" (Rosa).

Instead, she was able to find support from members of her church, who “would contact [her] and check on [her] and bring things over, which was really nice” (Rosa). A second participant with no close family did not report any distress associated with recovery from BR and did not express a need for emotional support at all: “So I had homecare when I needed them. And honestly I don’t feel as though—I mean, I didn’t go to any of the support groups” (Florence). A third woman was distressed by her lack of support but seemed to accept its unavailability and chose to “just deal with it” (Agnes).

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## ■ Discussion

This study sought to explore the support needs of women who undergo BR. The findings demonstrate that HCPs have the potential to address participants’ information needs, that close friends and family members may ameliorate feelings of isolation, and that women who have experienced BR are able to diminish feelings of “difference.” However, women’s experiences are not identical; a standardized approach to patient care is not sufficient.

Our findings with regard to support provided by HCPs and family members align with results from other studies. In a meta-synthesis, a researcher identified emotional and instrumental support as 2 forms of social support.<sup>40</sup> Instrumental support includes assistance with physical aspects of recovery such as helping with meals and mobility issues. Emotional support was characterized as including behaviors that would reduce anxiety, stress, and hopelessness. The knowledge that there are people who are available was also a feature of emotional support. Simply being present could effectively facilitate support. Typically, nonprofessionals were preferred as providers of support.<sup>40</sup> Other researchers described emotional support as including sharing experiences, which were characterized by attachment and assurance of worth and confidentiality.<sup>41</sup> Finally, emotional and instrumental support were useful coming from any source, whereas informational support was most useful when it originated from the HCP.<sup>42</sup>

Participants in this study placed great value on their ability to contact an HCP easily and thereby meet their information needs. Postsurgery, participants felt physically vulnerable and uncertain of what their personal recovery experience would involve. The information supplied by HCPs helped reduce this uncertainty, ultimately providing participants with “peace of mind.” Other research has shown that women who have access to a breast care nurse have found that obtaining information and reassurance from the nurse improved psychological coping.<sup>23</sup> Although instances of women feeling uninformed about the realities of recovery were rare in the current study, studies have frequently mentioned women’s distress in response to a lack of information.<sup>8,22,23,28,43</sup> Women have been displeased by a lack of information regarding general care, complications, usefulness of massage, clothing options, degree of scarring, and the possibility of cancer recurrence in the postoperative period.<sup>18,22,23</sup>

Challenges when effectively informing patients persist.<sup>6,18,23</sup> Some researchers suggest that information provision should be more patient centered, because patients vary in terms of the

amount of information they can receive at 1 time.<sup>6,18</sup> In addition, the stress associated with the diagnosis of cancer is a barrier to successful HCP-patient communication.<sup>23</sup> Participants from this study appreciated both the services provided by the BHC and the accessibility of the nurse navigators.

The support need “emotional connection” was identified by noting the importance of the supporting role played by family and close friends. As demonstrated by other research into emotional support, being present and available facilitated support.<sup>40</sup> Feelings of isolation were mitigated by close family and friends. It is possible that such support counteracts feelings of emotional vulnerability postsurgery, such as anxiety, depression, and identity threat. Participants emphasized the importance of family members being present and willing to listen instead of trying to placate their anxiety. In instances when women had difficulty communicating with close others about their ordeal, significant distress resulted. Other research has commented that effective emotional support involved family members’ sensitivity to the woman’s emotional state, which ultimately satisfied the need for emotional connection.<sup>41</sup> In addition, an important feature of emotional support involved family members’ willingness to be present and to provide physical contact and closeness.<sup>41</sup>

Our present study’s findings with respect to the value of peer support in addressing women’s need to be understood are echoed by other research. Peer support is helpful for those dealing with illness.<sup>41,44,45</sup> Its effectiveness relies on the peer’s ability to relate to the person and the value of shared experience.<sup>45</sup> Such experience reduced women’s feeling of isolation and helped women to understand what they were going through.<sup>41</sup> The ability to share one’s experience has been shown to reduce rumination and assist in cognitive processing of cancer.<sup>46</sup> Similar features of peer relationships were found in this study. Having contact with women who had experienced BR, whether on an individual basis or in a group setting, was considered important by nearly all participants and formed the basis of the support need “being understood.” Indeed, participants who did not experience such a relationship expressed a desire for one. Other research has shown that BC support groups have been considered valuable by women struggling to cope with the experience.<sup>1,47,48</sup> Support groups provide women with emotional and informational resources that improve their ability to cope. In addition, women are able to discuss their body image concerns with those who have had the same experience.<sup>1</sup>

Participants in our study also described the difficulty of trying to communicate their experience with those who had not experienced reconstruction. They believed that other people did not understand the nature of the procedure and the amount of pain and emotional distress involved in recovery. Participants also commented that support groups helped them to realize that their experience was not uncommon; moreover, information provided by the group aided their own recovery. Other research has documented women’s desire to have contact with women who have had BR.<sup>6,22</sup> In other illness contexts, peer support reduced feelings of isolation and helped women make sense of their experience.<sup>41</sup> Such findings mirror those of this study: group support appeared to be important in helping participants come to terms with their new body and “carry on with life.”

The support need “help with daily tasks” emerged from participants’ descriptions of the invaluable support they received from children, spouses, friends, and members of their community. From 1 husband’s direct role in helping with mobility issues and self-care activities to friends’ provision of meals, participants reported that the recovery process was made possible by such support. Echoing another study, women’s husbands took on the role of “gate keeper,” caring for the wife and communicating with family and friends about her recovery.<sup>28</sup>

Women’s BR experiences were not identical. Not all participants experienced simultaneous support from HCPs, family members, and other women who had experienced BR. As mentioned, 1 participant received support from members of her church group when her husband was too overwhelmed to provide her support himself. This finding suggests that certain emotional support needs can be addressed by nonfamilial persons. Another participant, for whom support was unavailable, simply chose to “deal with it.” A third woman, who did not have any close family members, did not express a need for emotional support. The experience of the latter 2 participants demonstrates that women’s reactions to their changed bodies can differ. Consequently, to achieve more responsive and better patient care, HCPs should accommodate women’s varying needs for support and other resources.

The results of this study should be tempered by consideration of the exploratory nature of the study. The needs identified in this study likely would be present in other populations in differing geographic regions with varying demographic features as suggested by the alignment of this study to other support research. However, it is also likely that other support needs exist, and additional research is needed to identify such needs.

## Further Research

The findings of the study suggest possible avenues for future research. Many participants reported being quite satisfied with the accessibility of the nurse navigators, as well as with how that access provided “peace of mind.” Further investigation of the barriers to information delivery and their effect on women’s feelings of uncertainty is warranted. Although many women were satisfied with their spouse’s level of support, 1 woman in particular relied on extensive instrumental support from her husband. A more precise understanding of how such support impacts women’s emotional and psychological well-being is needed.

Findings regarding women’s emotional support needs are novel, and they reveal a need for further investigation. This study revealed that emotional responsiveness on the part of family members addresses feelings of isolation in women who are recovering from BR. Further research is needed to understand the precise mechanism of this relationship. Two participants had support experiences that differed from those of the other women in the study: one did not express a need for support, and a second participant was distressed by her lack of support but coped with her experience regardless. Such exceptions suggest a need to understand the motives of women’s responses to recovery from BR. Finally, because the participants differed with respect to the type of BR surgical procedure they experienced, research

investigating how women’s support needs differ with procedure types would be valuable.

## Limitations

The findings of this study were limited by certain aspects of the study design. Because this study was exploratory, the consequent use of only a few exclusion criteria resulted in a heterogeneous sample. The participants varied widely in regard to their age, the type of surgical procedures they underwent, and the duration between their surgery and their interview. Such variations might have affected women’s support experiences. With respect to the wide variation in the time between surgery and the interview, past research has reported that women’s perception of reconstruction became more favorable after they had completely recovered.<sup>19</sup> Accordingly, participants who were still struggling with the realities of recovery may have had a more pessimistic perception of their support experience than did those who had already recovered more completely. Finally, the sample of participants was drawn from a limited geographic region and, indeed, from a specific healthcare organization. Because of limitations in terms of both time and travel, we were unable to include more rural participants in the study. The BHC services provide efficient access to information, and it is possible that women without access to such a service would have had a more negative evaluation of the support provided by their HCPs.

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## Conclusion

The findings suggest that, when women’s support needs are effectively addressed, their experience of BR is improved. These 4 needs consist of aspects of emotional, instrumental, and informational support. Informational needs were typically addressed by HCPs. Their guidance allowed women to have peace of mind and to navigate their physical conditions. Emotional support was typically provided by family members and close friends. Emotional connection was facilitated when family members and close friends were present and available. Peer support also facilitated recovery through the unique understanding women who had experienced BR could provide. Ultimately, this study’s findings suggest that, when support needs are effectively addressed, women are better able to put the struggle of BR and BC as a whole behind them.

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## Implications for Nursing Practice

The support needs identified in this study present several opportunities for improvement in nursing care. The first support need emphasized the essential role nurse navigators play in addressing women’s postoperative concerns. Women were able to contact nurse navigators with questions about their postoperative condition and were able to alleviate concerns about infection and identify any complications. Not all jurisdictions have nurse navigators or an equivalent role; however, HCPs’

capacity to improve women's psychological well-being by responding promptly to their questions is a useful observation for all jurisdictions. Ideally, patients would be able to contact a nursing professional with whom they had contact; however, if women had the opportunity to direct their questions to a help line, then they could be responded to by a qualified nursing professional.

The findings also highlight the importance of the support provided by family members and close others. Although nurses cannot provide such support directly, they can inform both the patient and her family members of the value and nature of the support they can provide. Family members could be informed of the importance of their attention and availability and of their role in addressing her interpersonal needs. Families could also be advised regarding their communication with women during recovery. Women may require nondirective support from the most connected family members. The nursing professional could help the patient to assess her own support needs and to consider who in her social environment would be most capable of providing such support. When a woman is not aware of this emotional aspect of recovery, then nurses can facilitate the patient identifying and meeting those support needs.

Women in this study were nearly unanimous in their evaluation of peer support and its positive impact on recovery. Nurses can assist with women's access to such support. In fact, several participants wanted a detailed list of different groups they could contact. The ability to make sense of and assign meaning to women's experience of healing from reconstruction is an often overlooked aspect of their treatment and recovery; however, it is an essential part of their ability to move past BC. Some women commented that they would prefer to have an individual they speak with one-on-one as opposed to a support group. Therefore, access to a continually updated database of support groups and individuals would meet this need. Once the nursing professional addressed the women's own support preference, they could be directed to the most relevant source of peer support.

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