

Article

Body Image, Sexuality and Coping in Women Surviving Breast Cancer: A Phenomenological Qualitative Study

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Abstract

Breast cancer entails profound physical, emotional, and relational changes that persist beyond biomedical treatment and may substantially affect women's body image, sexuality, and engagement in daily occupations. This descriptive phenomenological qualitative study examined the lived experiences of eight Spanish breast cancer survivors through in-depth semi-structured interviews conducted after completion of oncological treatment. Transcripts were analyzed using discourse analysis with iterative interpretation. Three interrelated findings were identified: (1) bodily changes linked to mastectomy and adjuvant therapies disrupted continuity with the previously known body, eliciting estrangement, vulnerability, and grief for the former bodily self; (2) sexuality emerged as a particularly vulnerable domain, shaped by diminished desire, vaginal dryness and pain, shame, altered self-perception, and the need to renegotiate intimacy within the couple; and (3) coping and meaning-making were strengthened by psychological support, efforts to emotionally protect family members, and, notably, peer support and helping other women as key sources of resilience. These findings highlight the need for integrated, culturally sensitive, person-centered survivorship care that explicitly addresses sexuality, body image, and emotional well-being. Occupational therapy may contribute by supporting embodied identity reconstruction, participation in meaningful occupations, and the reconfiguration of intimacy after breast cancer.

Keywords: breast cancer; body image; sexuality; phenomenology; coping; occupational therapy; intimacy; women's health; lived experience; qualitative research

1. Introduction

Breast cancer is the most common malignant tumor among women in Spain and remains a major public health problem, not only because of its increasing incidence, but also due to the profound and lasting consequences it has on women's physical, emotional, and social well-being [1]. According to the most recent data from the Spanish Network of Cancer Registries (REDECAN), approximately 36,395 new cases of breast cancer were diagnosed in women in 2024, continuing the gradual upward trend observed in the last decade [1]. Internationally, breast cancer accounted for more than 2.3 million new cases in 2022, making it the most frequently diagnosed cancer in women worldwide [2]. Beyond acute treatment, the transition from hospital-based oncology care to home-based survivorship represents a critical period in which women must reorganize daily routines, self-care practices, and family roles while managing persistent treatment-related effects.



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This transition can intensify uncertainty and expose gaps in continuity of support, particularly for embodied concerns such as fatigue, body image, and sexuality, which are often under-addressed in routine follow-up. Although survival rates have improved significantly due to early detection and advances in treatment, many women face persistent challenges that extend well beyond completion of therapy [3].

Breast cancer treatments such as mastectomy, lymph node dissection, chemotherapy, radiotherapy, endocrine therapy, and reconstructive surgery often produce profound bodily changes. These changes affect not only physical functioning but also women's sense of identity, continuity, and relationship with their bodies. Phenomenological and qualitative research has shown that breast cancer disrupts the lived body, creating a sense of unfamiliarity, fragmentation, and biographical rupture that challenges women's previous self-concept [4,5]. Surgical removal of the breast and postoperative asymmetry have been described as deeply symbolic events that alter the meaning of femininity and the sense of being "at home" in one's body [6,7]. Hair loss is identified as one of the most emotionally devastating experiences, because it publicly reveals the illness and exposes women to social interpretations of vulnerability, fragility, and illness identity [8].

The effects of treatment are not limited to visible changes. Many women experience long-term functional limitations, fatigue, neuropathy, sensory alterations, and chronic pain, all of which influence daily occupations and overall quality of life [9,10]. Recent studies highlight that these embodied disruptions can persist for years after treatment, affecting mobility, self-care, and the ability to engage in meaningful activities [11]. These physical and sensory transformations contribute to a process of grieving the former body and learning to adapt to a new embodied reality.

Sexuality is another dimension profoundly affected by breast cancer. International evidence shows that up to 70 percent of breast cancer survivors report sexual difficulties, including decreased desire, vaginal dryness, dyspareunia, loss of pleasure, and difficulties reaching orgasm [12,13]. These changes are strongly associated with endocrine therapies and the abrupt hormonal alterations that accompany treatment [14]. Body image disturbances have been identified as a central factor influencing erotic self-perception, perceived attractiveness, and willingness to engage in intimacy [15]. Qualitative research also shows that women frequently struggle with shame, fear of rejection, discomfort during sexual activity, and concerns about their partners' reactions to their bodies [16,17].

The couple relationship plays a critical role in the reconfiguration of sexuality. Studies emphasize that emotional communication, partner support, and dyadic coping are key predictors of successful adaptation in the sexual domain after breast cancer [18]. Conversely, lack of communication or emotional distancing can exacerbate sexual difficulties and deepen feelings of isolation [19]. For many women, sexuality becomes intertwined with issues of identity, vulnerability, and relational intimacy, rather than merely a matter of physical functioning.

Most qualitative accounts of embodied and sexual changes after breast cancer have been produced in high-income settings. However, qualitative evidence from lower- and middle-income contexts is growing and suggests that gaps in supportive care, sociocultural norms, and access to follow-up services may shape body image and intimacy concerns in distinct ways [20–22]. In addition, although breast cancer predominantly affects women, qualitative syntheses on men with breast cancer highlight experiences of stigma, masculinity-related marginalisation, and intimacy challenges, underscoring that identity disruption is not exclusively a female experience [23,24]. These broader perspectives help situate the present study while maintaining its focus on Spanish women survivors.

The Spanish sociocultural context introduces additional layers of complexity to these experiences. Research in Southern European countries shows that cultural norms surround-

ing femininity, motherhood, partnership roles, and body aesthetics influence how women interpret breast cancer and how they negotiate their identity after treatment [25]. In Spain, where the female body holds strong social symbolism related to care, relational roles, and appearance, changes in body image and sexuality have particularly significant emotional and relational consequences.

Despite the relevance of these issues, there is still limited qualitative research exploring the lived experiences of Spanish women with regard to body image, sexuality, and emotional adaptation after breast cancer. Most studies continue to focus on measuring symptoms or evaluating psychological distress, while the subjective, embodied, and relational dimensions of survivorship remain underexplored. There is a clear need for research that captures the complexity of women's narratives and the meanings they assign to their bodies and intimate lives after cancer.

Occupational therapy has the potential to play a valuable role in this area, since the discipline emphasizes the connection between the body, identity, and meaningful daily occupations. Occupational therapists can support women in adapting to bodily changes, restoring participation in everyday activities, and addressing the emotional and relational aspects of survivorship, including sexuality and intimacy [26,27]. However, the explicit integration of sexuality, body image, and emotional well-being into occupational therapy practice for breast cancer survivors remains underdeveloped, particularly within the Spanish context.

For these reasons, the aim of this study is to explore, through a phenomenological qualitative approach, how Spanish women who have survived breast cancer experience bodily transformations, how they understand and navigate changes in their sexuality, and which coping strategies they develop to reconstruct their identity, their sense of embodiment, and their well-being in daily life.

2. Materials and Methods

2.1. Study Design

A qualitative study with a descriptive phenomenological approach was conducted. This design was selected because it allows for an in-depth exploration of the lived experiences and meanings that women assign to the bodily, emotional, and sexual transformations associated with breast cancer. Phenomenology seeks to understand the essence of experience from the participants' perspective, while discourse analysis provides a framework for examining how these experiences are articulated, organized, and interpreted through language [10–13]. Together, these approaches enabled a rich and contextualized understanding of how body image, sexuality, and coping processes are constructed after breast cancer.

2.2. Participants

Eight Spanish women who had survived breast cancer participated in this study. A theoretical purposive sampling strategy was used to recruit women who could provide meaningful information about the phenomenon under study. Eligibility criteria aimed to recruit women aged 40–65 years to focus on midlife survivorship and to reduce heterogeneity related to age-associated factors that may influence sexuality and daily functioning. However, consistent with purposive sampling in qualitative research, we allowed limited flexibility around this range when participants' experiences remained highly relevant to the phenomenon under study. Two women slightly older than 65 were therefore included because they met all other criteria and contributed substantively to the thematic development. This deviation was documented a priori as an allowable exception within the sampling strategy rather than a post hoc decision based solely on perceived 'richness'. Being married

or in a committed intimate relationship was not a prerequisite for inclusion; sexuality and intimacy were explored irrespective of relationship status.

Recruitment was facilitated through the Spanish Association Against Cancer (AECC) and health professionals working in oncology and occupational therapy settings.

The sociodemographic characteristics of the participants are presented in Table 1.

Table 1. Sociodemographic characteristics of the participants.

Participant	Age	Marital Status	Children	Year of Diagnosis
P1	48	Married	Yes	2020
P2	63	Married	Yes	2007
P3	49	Married	Yes	2013
P4	72	Married	Yes	2009
P5	69	Married	Yes	2003
P6	54	Married	Yes	2013
P7	66	Married	Yes	2010
P8	57	Married	Yes	2020

This degree of homogeneity, particularly regarding marital status and motherhood, allowed for deeper comparisons across participants' experiences and facilitated the identification of shared patterns in body image, sexuality, and emotional adjustment.

2.3. Data Collection

Data were collected between February and March 2023 through in-depth semi-structured interviews and a field diary. The interview guide was grounded in descriptive phenomenology (lived body/embodiment), the concept of biographical disruption, and relational and coping frameworks (dyadic coping, resilience, and meaning-making), with a particular emphasis on an occupational perspective to explore the impact on everyday occupations and participation (Table S1). Interviews were conducted in private spaces within the Spanish Association Against Cancer (AECC), although some were held via video-conference to accommodate participants' preferences. All interviews were conducted by a trained member of the research team. Interviews were audio-recorded with participants' permission and transcribed verbatim. Written informed consent was obtained prior to participation, including consent for audio-recording and the use of anonymized quotations. A field diary was kept to document contextual details, emotional cues, and reflexive notes, thereby supporting and enriching the interpretive process.

Interviews were conducted until saturation was achieved, that is, when additional interviews no longer yielded substantively new information relevant to the study aims.

2.4. Data Analysis

A discourse analysis approach was applied, following a systematic coding process, and was used to support a descriptive phenomenological aim focused on the lived meanings expressed in participants' accounts. Prior to and throughout analysis, reflexive bracketing was encouraged through analytic memos and team discussion to minimize the influence of preconceptions.

First, an open coding phase was conducted to identify units of meaning that emerged directly from the participants' narratives. These codes were then compared constantly to refine categories and detect conceptual patterns, ensuring that coding remained grounded in the participants' lived descriptions. In the axial coding phase, 833 initial codes were grouped into 38 subcategories based on semantic relationships. Finally, these subcategories were integrated into three overarching thematic dimensions, leading to an interpretative synthesis that articulated the essential features of the participants' experiences.

The analysis was iterative and interpretative. Transcripts were read multiple times, and analytical memos were written to support reflexivity and deepen the interpretation of meanings. Field diary notes were incorporated to contextualize emotional nuance and capture nonverbal elements relevant to the analysis.

2.5. Trustworthiness

To ensure methodological rigor, several strategies were employed. Credibility was enhanced through triangulation between interviews and field notes, prolonged engagement with the data, and iterative analysis. Transferability was supported by providing detailed descriptions of the participants and study context. Dependability was achieved through transparent documentation of the analytic process. Confirmability was supported by reflexive practices throughout all phases of the study, following established criteria for trustworthiness in qualitative research [17]. In line with the phenomenological approach, the research team engaged in reflexive practices to identify and minimize potential influences arising from researchers' assumptions and analytical decisions throughout the study [28]. There was no prior relationship between the researchers and the organizations involved in recruitment, nor with the women participants, thereby reducing the risk of coercion or bias associated with dual roles [29]. Reflexive notes and team discussions were used to enhance transparency and interpretive rigor.

2.6. Ethical Considerations

The study adhered to the principles of the Declaration of Helsinki and complied with Spanish data protection regulations (Organic Law 3/2018). The study was approved by the Bioethics Committee of the University of Extremadura (Approval Code: 48_2022). All participants provided informed consent after being informed about the purpose of the study, the voluntary nature of participation, and their right to withdraw at any time. Audio recordings were deleted after transcription to ensure confidentiality and anonymity.

3. Results

The analysis made it possible to reconstruct a complex and multidimensional lived experience in which bodily transformations, sexuality, and coping processes appear as deeply interconnected elements. Women did not describe these domains as separate compartments, but as parts of the same life trajectory shaped by diagnosis, treatment, and the need to adapt to a changing body and a continuously renegotiated identity. Accordingly, the results are presented through three main themes that reflect recurrent patterns of meaning expressed across participants' narratives regarding bodily change, sexuality, and coping during survivorship, and aim to convey the narrative, emotional, and reflective richness of the shared experiences.

3.1. Bodily Transformations and Feelings of Estrangement: The Rupture with the Known Body

The participants described the bodily transformations resulting from breast cancer as abrupt, invasive, and profoundly disturbing. For all of them, the body became the space where the illness left its most visible imprint and, at the same time, where the sense of vulnerability became most tangible. Mastectomy was experienced not only as a surgical procedure but also as an intervention that symbolically fractured the continuity of their bodily identity.

The women spoke of the impact of "discovering themselves" after surgery, confronted with a body that no longer corresponded to their memory or previous self-perception. The sense of loss extended beyond the breast tissue itself, touching a part of them that had carried deep emotional, sexual, cultural, and social significance throughout their lives.

“Then they removed it completely, and when I was just operated, because of the pressure I felt here, I felt like running away. . . I wanted to be as I was before.” (P2)

This desire to “be as before” reflects the longing to restore a previous body, one that is no longer accessible and that forces women to begin a process of bodily mourning. They must confront not only the physical absence of the breast but also the emotional tension of accepting a body that feels altered, incomplete, or strange.

In addition to surgery, functional limitations directly affected their independence. Everyday activities such as walking, lifting the arm, cooking, or performing household tasks became difficult, generating feelings of frustration, dependence, and emotional exhaustion.

“I couldn’t go from my room to the kitchen. . . I couldn’t, I just couldn’t walk.” (P2)

Chemotherapy further intensified this sense of vulnerability. The participants described this treatment as one of the most difficult moments in the entire process, not only because of the physical symptoms (nausea, fatigue, general discomfort) but also because of the sensation that their vital energy was draining and that their bodies had become difficult territories to sustain day after day.

“With the chemotherapy. . . every time they gave it to me, it was suffering.” (P7)

Other sensory changes profoundly altered their relationship with their own bodies. For some, their body odor became unbearable; for others, the metallic taste and hypersensitivity transformed the experience of eating or interacting with others. These seemingly secondary changes contributed to feelings of disconnection and rejection toward a body that “no longer responded” as before.

“I couldn’t stand my own smell. . . opening the living room door was unbearable for me.” (P2)

Hair loss, mentioned by all participants, represented a particularly painful emotional threshold. It was not only a visible sign to others but also a direct blow to identity and femininity internalized over the years. Hair was interpreted as one of the most difficult symbolic losses, perhaps because it marks the illness so visibly and confronts women with external perceptions of fragility.

“My husband cried so much while cutting my hair. . . I told him: shave it before everything falls out.” (P2)

This moment was described with great emotional intensity, showing that alopecia is not merely an aesthetic change but an intimate and relational experience that impacts self-perception and social interaction.

Finally, many participants expressed the feeling of not recognizing themselves in the mirror, a daily act that became a confrontation with their new bodily reality. The reflected image no longer matched their internal sense of self, generating feelings of strangeness and disorientation.

“Seeing myself in the mirror was very strange. . . I didn’t see myself as me.” (P8)

Taken together, this dimension shows that the body after breast cancer becomes a changing territory, filled with meanings and emotions, where women must learn to reconstruct their bodily identity from a place of profound vulnerability.

3.2. Sexuality and Intimate Relationships: Between Silence, Vulnerability and the Search for a New Intimacy

Sexuality was one of the areas in which the women expressed greater difficulties, not only because of the physical changes associated with the illness and treatments but also due to the emotional and symbolic burden that accompanied the process. Sexual desire

decreased drastically during and after treatment, and many women described long periods in which sexuality receded into the background or disappeared entirely.

The loss of libido was linked to fatigue, bodily discomfort, hormonal changes, and the emotional distress associated with the entire process. For some, thinking about sexuality did not make sense at a time when the priority was physical and emotional survival.

“Sexuality... during treatment, I don’t know if it was between zero and nothing.” (P3)

The experience of sexual relations was marked by physical pain, particularly associated with vaginal dryness, discomfort, and fear of “not responding” as before. The women expressed frustration when facing a body that did not seem to accompany their intention to resume intimacy.

“When it comes to sexual relations, I’ve been left with horrible vaginal dryness.” (P8)

The emotional dimension became a key component. Bodily shame, fear of being seen naked, the sense of having “lost attractiveness,” and uncertainty regarding the partner’s reaction all contributed to silence, avoidance, and the feeling that sexuality needed to be rethought from a completely new place.

The role of the partner was decisive in understanding how these difficulties emerged or intensified. Many women reported that their partners adopted a protective role during treatment, transforming the relationship into one of care that, although supportive, altered the traditional intimate dynamic.

“My husband devoted himself completely to me... he took care of me so much.” (P2)

Not all participants lived this accompaniment in the same way. Some experienced a lack of emotional communication, which made them feel alone in a process that required sensitivity and listening. The inability of the partner to show affection or speak openly about the illness deepened the distress of those who needed a more explicit emotional presence.

“I didn’t find that support... he doesn’t show his emotions.” (P4)

Others expressed feelings of guilt or of being a burden to their partner, particularly when the relationship became structured around physical care. This shift in roles generated tensions that directly impacted sexual life.

“I felt like I was giving him so much work... I had to ask him for everything.” (P8)

These experiences show that sexuality after breast cancer does not disappear but must be renegotiated from a new understanding of the body, desire, and intimacy. The process requires time, communication, and the slow rebuilding of trust shaken by the bodily transformations.

3.3. Coping Strategies and the Reconstruction of Meaning: Resilience, Mutual Support, and New Identities

The diagnosis and treatment of breast cancer introduced a profound life crisis that required the activation of multiple coping strategies. Motherhood emerged as a powerful emotional driver. The women expressed that their first concern upon receiving the diagnosis was their children, who became emotional anchors and sources of motivation throughout the process.

“The first thing I thought was: my God, my children.” (P4)

The way they communicated the illness to others was shaped by the desire to protect their families and avoid causing additional suffering. Some women adopted a “containing” role, displaying strength even when feeling vulnerable internally.

“I’m the boat... and if I don’t sink, I don’t want to see anyone upset here.” (P5)

Psychological support was another crucial element. Several participants explained that mental health professionals helped them rebuild self-esteem, process complex emotions, and develop a more compassionate relationship with their bodies.

"The psychologist taught me to love myself... to love myself with a scar." (P3)

However, the most powerful coping strategy was engaging in support networks and helping other women who were going through the same process. Volunteering and peer support became practices that not only benefited others but also generated a strong sense of purpose, belonging, and personal empowerment for the participants.

"Helping people is very comforting." (P6)

This mutual support enabled women to transform personal suffering into a meaningful resource for others, creating a therapeutic and reciprocal experience.

"I call them, I encourage them... and that has helped me too." (P7)

Finally, the participants agreed that breast cancer produced a deep emotional and existential reconfiguration. Many described gaining a new way of valuing daily life, recognizing their true sources of support, and redefining their priorities.

"It has been a bitter and sweet experience... I have learned to see people for who they are." (P5)

This meaning-making process reveals that the experience of breast cancer is not only associated with loss but also with the possibility of generating new identities, connections, and ways of being in the world.

4. Discussion

The findings of this study offer a comprehensive and culturally grounded understanding of how Spanish women who have survived breast cancer experience a complex process of bodily, emotional, and relational transformation. The narratives reveal that breast cancer is not solely a biomedical event but a profound biographical disruption, one that challenges deeply rooted meanings associated with femininity, sexuality, and embodied identity. This aligns with phenomenological perspectives that emphasize the centrality of the lived body in constructing the self, as discussed by Giorgi [4] and Sanguino [5], and with broader feminist frameworks highlighting how the body is socially, culturally, and symbolically produced [7]. Within this framework, the participants' accounts reflect an intricate reconstruction of identity that requires negotiating physical changes, emotional wounds, relational shifts, and the need to find new meanings in everyday life.

From a broader perspective, the bodily disruption described by participants aligns with qualitative evidence from other gender-specific cancers, particularly prostate cancer, where treatment-related changes (sexual dysfunction, incontinence, altered bodily control) have been shown to challenge identity, masculinity, and continuity of self, often framed as forms of biographical disruption and "new normalcy" [30–32]. Likewise, although breast cancer predominantly affects women, research on breast cancer in men highlights experiences of stigma, bodily estrangement, and identity renegotiation in a condition culturally coded as female, reinforcing that cancer-related embodiment changes can destabilize gendered identities across sociocultural contexts [23,24,33]. Situating our findings within this wider evidence base strengthens the interpretation of breast cancer as a biographical rupture while preserving the gender- and context-specific meanings attached to the breast, femininity, and sexual identity.

A central contribution of this study lies in its illumination of how mastectomy and oncological treatments disrupt women's bodily continuity. Aguayo Zurita [7] highlights the symbolic relevance of the breast in the construction of femininity and emotional identity, and the present findings reinforce this view by showing that the removal of the breast is

experienced as a rupture not only of anatomy but also of selfhood. Participants described the shock of confronting a body that no longer corresponded to their memory, echoing the “estrangement” or “othering” of the body described in Reinado et al. [6]. This sense of unfamiliarity aligns with Bai et al. [34], who found that body image concerns may persist for decades after surgery, and with Wu et al. [11], who observed dynamic fluctuations in body image and quality of life throughout treatment trajectories.

Hair loss was especially significant. Vieira Archangelo et al. [8] describe alopecia as one of the most visible and symbolically potent sequelae of breast cancer treatment, as it externalizes the illness and simultaneously challenges cultural constructs of femininity. This matches the emotional intensity expressed by participants, who associated hair loss with vulnerability and with the collapse of their previous sense of self. Chemotherapy-related fatigue, sensory alterations, and general physical weakness also contributed to a destabilized bodily experience, consistent with Carralero et al. [9], who emphasize how these symptoms constrain everyday occupations and reduce physical autonomy.

Additionally, the functional and emotional consequences of lymphedema and upper-limb impairments, although not universal among participants, resonate with the work of McLaughlin et al. [35], who document the profound effect of these sequelae on daily functioning, self-esteem, and identity. Evidence-based interventions from Occupational Therapy, such as TAPA ([36,37]), demonstrate the potential of activity-oriented and proprioceptive approaches to mitigate these embodied disruptions and restore functional participation. Stehle et al. [38] further reinforce the importance of such interventions, especially in supporting return-to-work and role performance in survivorship.

Collectively, these findings underline that the body after breast cancer becomes a vulnerable and continuously negotiated territory, where women oscillate between rejection, adaptation, and slow processes of reconciliation. This underscores the need for therapeutic approaches that prioritize embodied meaning-making and identity reconstruction.

Sexuality emerged as one of the most significantly affected dimensions, shaped by an intricate blend of physical, emotional, relational, and sociocultural factors. Castillo et al. [12] document high prevalence of sexual dysfunction among breast cancer survivors, including decreased libido, vaginal dryness, and pain during intercourse. The participants’ accounts strongly align with these findings, while adding depth by illustrating the cumulative effects of emotional insecurity, shame, and fear of being perceived as unattractive. Franco et al. [15] emphasize the importance of body image as a central mediator of sexual well-being, and this study corroborates that a disrupted relationship with the body becomes a barrier to sexual desire and intimacy.

Sexuality is also shaped by broader cultural norms. As noted by Figueroa Varela [16], sexuality cannot be understood without considering relational expectations, sociocultural mandates, and identity scripts. This resonates with Sánchez-Sánchez [25], who reports that Spanish femininity is often tied to aesthetic, maternal, and relational ideals. Within such a context, the physical changes caused by breast cancer intensify emotional vulnerability and uncertainty regarding partners’ perceptions.

Partner relationships played a decisive role. Badr and Taylor [18] discuss how dyadic coping facilitates emotional resilience and intimacy during illness, while Lambert [19] demonstrates that emotional communication from partners strongly predicts psychological adjustment. In this study, women who experienced sensitive emotional support from partners described more adaptive sexual readjustments, whereas those facing emotional distance or avoidance reported heightened isolation. These relational patterns are consistent with Salakari et al. [13], who found that sexual satisfaction among survivors is profoundly linked to relational dynamics and perceived emotional safety.

Participants also highlighted the emergence of a caregiver–care recipient dynamic that complicated sexual expression. Taze and Kanan [17] describe how asymmetrical caregiving roles can disrupt intimacy, diminish spontaneity, and evoke guilt, all of which were reflected in our participants' narratives. Velásquez Silva [14] further argues that the absence of structured sexual counseling during cancer treatment contributes to confusion, silence, and deterioration of erotic identity, reinforcing the importance of integrating sexuality into clinical care.

Coping processes reported by participants align with previous evidence emphasizing the role of emotional regulation, family involvement, and psychological support in survivorship. Ramos Bernal [39] describes how coping in breast cancer often involves meaning-making processes and the reinterpretation of suffering, both of which were central in this study. The role of children as a primary source of motivation has also been documented by Sáenz-de-Villaverde López [40], who highlights the strong emotional and symbolic weight of motherhood in Spanish families and its influence on women's adjustment.

Psychological support was essential for helping women rebuild self-esteem, process trauma, and navigate body image disruption. Franco et al. [15] reinforce the value of interventions aimed at self-esteem and body acceptance, which are key in integrating the post-cancer body into identity. The participants' accounts reflect these therapeutic benefits clearly.

However, the strongest source of resilience was peer support. Taze and Kanan [17] and Vieira Archangelo [8] document the profound therapeutic effects of solidarity among women undergoing similar experiences. This study confirms that mutual support fosters emotional recovery, strengthens identity, and facilitates meaning-making by transforming personal suffering into shared empowerment. As several women reported, helping others created a sense of purpose that eased their own healing process.

Occupational Therapy (OT) is uniquely positioned to address the multidimensional challenges identified in this study. Merino Suárez [26] highlights the fundamental role of OT in supporting women's adjustment to bodily changes, restoring routines, and facilitating participation in meaningful occupations. Lozano et al. [27] argue for integrating emotional, somatic, and occupational perspectives to comprehensively address disruptions caused by breast cancer. Petruskeviciene et al. [41] further demonstrate that community-based OT programs improve quality of life, engagement, and occupational satisfaction among survivors.

In addition, interventions addressing lymphedema and upper-limb impairments, such as the TAPA protocol developed by Muñoz-Alcaraz [36,37], provide evidence-based frameworks for restoring functional independence and promoting embodied well-being. These approaches complement psychosocial and relational interventions, suggesting that survivorship care must be interdisciplinary and explicitly address body image, sexuality, emotional well-being, and occupational identity.

Overall, this study underscores the need for holistic models that integrate biomedical treatment with embodied, relational, and occupational dimensions of care. Such an approach would honor the complexity of women's experiences and acknowledge their capacity to reconstruct identity, intimacy, and daily life after breast cancer. This study presents several limitations that should be considered when interpreting the findings. First, the sample size was small and consisted of women belonging to a specific geographical and sociocultural context, which may limit the transferability of the results to other groups of women with different backgrounds or experiences. Furthermore, although the phenomenological qualitative approach allows for an in-depth understanding of subjective experience, it relies heavily on participants' narrative ability and on the quality of the relationship established during the interview process. Another limitation is that the interviews were conducted after the completion of treatment, which may introduce recall biases or retro-

spective reinterpretations of the experience. Finally, the fact that some interviews were conducted via videoconference may have influenced emotional expression, although efforts were made to create a trusting and supportive environment across all interview formats.

Future research could expand on these findings by including more diverse samples in terms of age, socioeconomic background, sexual orientation, or body diversity, with the aim of exploring how intersecting factors shape the experience of breast cancer and its impact on sexuality and body image. Longitudinal studies would also be valuable, as they could track the evolution of bodily and sexual experience over time and examine how women adapt throughout different stages of survivorship. Comparative studies across therapeutic modalities (for example, breast-conserving surgery versus mastectomy, or immediate versus delayed reconstruction) could further illuminate differences in embodied and sexual adjustment. Additionally, it would be relevant to explore intervention models led by Occupational Therapy that integrate sexuality, embodied experience, and occupational performance, evaluating their effectiveness in improving emotional well-being and quality of life. Finally, incorporating the perspective of partners would be essential to gain a more comprehensive understanding of how intimacy is renegotiated and how relational dynamics contribute to the recovery process.

5. Conclusions

This study provides an in-depth understanding of how women who have survived breast cancer experience the profound transformations that affect their bodies, sexuality, identity, and everyday lives. The findings reveal that breast cancer is not only a biomedical condition but a multidimensional phenomenon that reshapes women's embodied sense of self and requires continuous renegotiation of intimacy, emotional balance, and personal meaning. Bodily changes, including mastectomy, functional limitations, and treatment-related effects, were experienced as a rupture in bodily continuity, while sexuality emerged as a particularly vulnerable domain influenced by physical symptoms, emotional insecurity, and relational dynamics. Despite these challenges, the women demonstrated significant resilience, drawing on psychological support, family roles, and especially peer networks as sources of empowerment and meaning-making.

Supplementary Materials: The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/sexes7010009/s1>, Table S1. Semi-Structured Interview Guide.

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Data Availability Statement: The data supporting the findings of this study are not publicly available due to privacy and ethical restrictions, as they contain identifiable personal information from participants. Anonymized excerpts are available from the corresponding author upon reasonable request.

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