

Exploring Women's Experiences of TRAM Flap Breast Reconstruction After Mastectomy for Breast Cancer

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Purpose/Objectives: To explore and describe women's experiences of transverse rectus abdominus musculocutaneous (TRAM) flap breast reconstruction following mastectomy for breast cancer.

Design: Qualitative, exploratory, and descriptive.

Setting: A private hospital in Perth, Western Australia.

Sample: Purposive sampling. Inclusion criteria were English-speaking women who had undergone TRAM flap breast reconstruction 6–24 months prior to the study. Response rate was 78%. Ten women were recruited, five who had undergone immediate breast reconstruction and five who had undergone delayed breast reconstruction.

Methods: Data were collected through individual semistructured interviews and analyzed with a thematic approach. Saturation was reached after 10 interviews. Coding and categorizing were undertaken with each transcript until the process revealed recurring themes. A focus group interview was conducted with the participants.

Findings: Three major themes emerged from the data: losing a breast matters, adjusting to a changing body image, and redefining normality.

Conclusions: The study highlights the significant impact of breast cancer, mastectomy, and breast reconstruction on the lives of women. All facets of a woman's life may be affected, often resulting in a holistically life-changing experience. Support needs for the women were not fully met. A greater understanding of the holistic experience and expectations of women who choose to have breast reconstruction following mastectomy is required to facilitate improved education and support.

Implications for Nursing: Nurses play an important role, not only in the provision of physical care to women postoperatively, but also for education and psychosocial support. This study gives practicing nurses greater insight into the holistic experience of women undergoing TRAM flap breast reconstruction.

Key Points . . .

- ▶ Women may be underprepared for transverse rectus abdominus musculocutaneous (TRAM) flap breast reconstruction and, subsequently, have unrealistic expectations about the physical, emotional, and social outcomes of breast reconstruction.
- ▶ Women who undergo TRAM flap breast reconstruction need support from healthcare professionals and the community.
- ▶ The process of adjusting to the impact of breast reconstruction can differ between women having immediate or delayed TRAM flap breast reconstruction.
- ▶ Women perceived that society viewed breast reconstruction as “a primarily cosmetic procedure, minor surgery, and not necessary,” leading to feelings of guilt resulting from the women's perceived failure to cope with their breast cancer and breast reconstruction experience.

2000). Despite an increasing trend toward breast reconstruction, the incidence of women opting to undergo such procedures is relatively low. In Australia, approximately 25% of women who undergo mastectomy opt for breast reconstruction (Breast Cancer Network Australia, 2007).

Psychological Impact of Mastectomy

A large body of evidence has been established since the 1980s highlighting the psychological distress associated with a breast cancer diagnosis and treatment (Daniel & Maxwell, 1983; Hartl et al., 2003; Kissane et al., 1998; McCain, 1993; Neill, Armstrong, & Burnett, 1998; Schain, Jacobs, & Wellisch, 1984; Spencer, 1996; Zabora, BrintzenhofeSzoc, Curbow, Hooker, & Piantadosi, 2001). In addition to dealing with a life-threatening illness and the often debilitating treatment, the impact on a woman's body image and sexuality can be profound (Kissane, White, Cooper, & Vitetta, 2004). In many

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Breast cancer is a pertinent health issue for women around the world. In Australia, breast cancer is the most common cancer diagnosed in women (26%) (Australian Bureau of Statistics, 2006). The percentage of cancers that are located in the breast is around 32% in the United States (Centers for Disease Control and Prevention, 2003) and approximately 25% in the United Kingdom (National Statistics Online, 2003). The lifetime risk for Australian women younger than age 85 being diagnosed with breast cancer is one in eight (Australian Institute of Health and Welfare [AIHW] & National Breast Cancer Centre [NBCC], 2006). Despite advances in breast-conserving surgery, mastectomy continues to be one of the main treatments for early-stage breast cancer, with approximately 40% of women diagnosed undergoing mastectomy (AIHW & NBCC). Most are eligible for breast reconstruction.

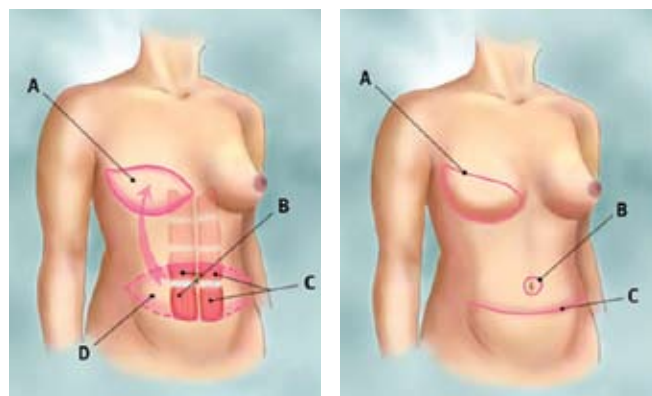
Surgical breast reconstruction is offered to women in an attempt to ameliorate the psychosocial impact of mastectomy (Al-Ghazal, Fallowfield, & Blamey, 2000; Wilkins et al.,

cultures, breasts are linked to aspects of femininity, including motherhood and sexuality (McCain; Sawaya, 1984). Removal of a breast can lead to diminished feelings of femininity, decreased self-esteem, a decrease in sexual interest, and, in some cases, depression (Daniel & Maxwell; Schain et al.; Spencer). Cohen, Kahn, and Steeves (1998) concluded that the breast cancer experience does not simply involve the aspects of body image related to surgical outcome. Through in-depth interviews with 20 women, they reported that experiencing breast cancer results in an array of mental and emotional responses.

Breast Reconstruction

Transverse rectus abdominus musculocutaneous (TRAM) flap breast reconstruction was identified as the most common form of autologous breast reconstruction in a 1999 review (NBCC) and continues to be so today (T. Connell & T. Cooper, personal communication, August 8, 2006). TRAM flap breast reconstruction was developed by Carl Hartrampf and first performed in 1980. The procedure involves the transfer of skin, subcutaneous tissue, fat, and a portion of the rectus abdominus muscle from the abdomen to the site of deficit left by mastectomy (Clayton & Waller, 1996; Moran, Herceg, Kurtelawicz, & Serletti, 2000; Sandau, 2002) (see Figure 1). The TRAM flap may be pedicle or free. In a pedicle flap, the tissue remains attached to its donor site and is tunneled under the skin of the chest wall to the recipient site (Fournier & Schafer, 2001; Sandau). Free flaps are the more commonly practiced method because of their robust blood supply (Elliott, Eskenazi, Beegle, Podres, & Drazan, 1993; NBCC). The tissue is excised and freely lifted to the recipient site. Blood supply is maintained via microvascular anastomosis of the deep inferior epigastric artery and vein to the thoracodorsal or internal mammary artery and vein (Clayton & Waller; Fournier & Schafer; Harden & Girard, 1994; Moran et al; Sandau).

The TRAM flap breast reconstruction may be performed as an immediate or delayed procedure. Immediate breast

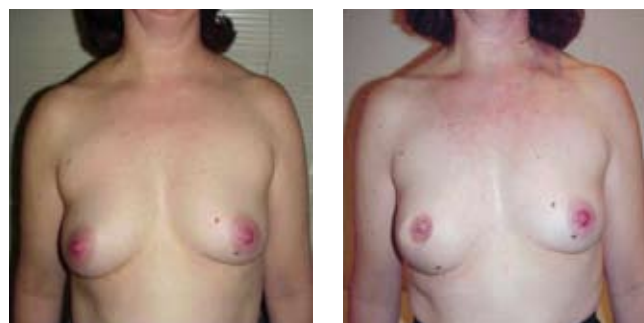


TRAM—transverse rectus abdominus musculocutaneous

Note. In the image on the left, A is the mastectomy site, B is the right transverse abdominus muscle, C is the abdominal muscle, and D is the segment of abdominal tissue (skin and fat) to be transferred along with muscle to create the new breast. In the image on the right, A is the reconstructed breast, B is the repositioned belly button, and C is the abdominal surgery incision.

Figure 1. TRAM Flap Breast Reconstruction Procedure

Note. Images copyright Breastcancer.org. Used with permission.



Before

After

TRAM—transverse rectus abdominus musculocutaneous

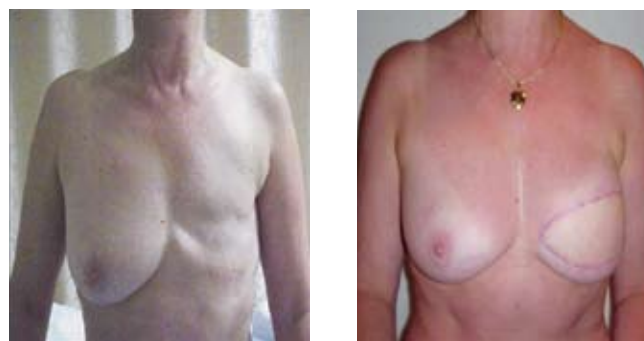
Figure 2. Immediate TRAM Flap Breast Reconstruction

Note. Images courtesy of Tony Connell. Used with permission.

reconstruction is performed during the mastectomy operation (see Figure 2), whereas delayed breast reconstruction takes place at least three months after mastectomy to allow for sufficient healing and recovery of tissue integrity (see Figure 3) (Silverstein et al., 1991).

Psychosocial Impact of Breast Reconstruction

Research has focused on comparing body image and sexuality outcomes of women who undergo breast reconstruction and women who choose to undergo mastectomy alone or some form of breast-conserving surgery (Al-Ghazal et al., 2000; Harcourt et al., 2003; Reaby, Hort, & Vandervord, 1994; Yurek, Farrar, & Anderson, 2000). Little research has focused on the reconstruction experience alone, and no studies have specifically addressed TRAM flap breast reconstruction. The majority of earlier studies used a quantitative approach and revealed contradictory results of the impact of mastectomy or breast reconstruction on self-esteem, body image, and sexuality (Al-Ghazal et al.; Harcourt et al.; Reaby et al.; Yurek et al.). Harcourt and Rumsey (2001) reiterated that point in their review on psychological outcomes of breast reconstruction.



Before

After

TRAM—transverse rectus abdominus musculocutaneous

Figure 3. Delayed TRAM Flap Breast Reconstruction

Note. Images courtesy of Tony Connell. Used with permission.

The review reported a lack of research studies exploring the psychological impact of breast reconstruction.

Nissen, Swenson, and Kind (2002) conducted qualitative focus group interviews with 17 women who had undergone immediate breast reconstruction. The participants said breast reconstruction helped them feel some form of normalcy after their breast cancer surgery. Although the women reported that some aspects of body image improved, other quality-of-life areas did not. A quantitative pilot study examining aspects of body image, coping, depression, and anxiety in women who had undergone breast reconstruction in the prior year found that the group had adjusted well psychologically after breast reconstruction. Anxiety and depression scores were within normal ranges (Anderson & Kaczmarek, 1996). The authors did not specify whether participants underwent immediate or delayed breast reconstruction.

Since the 1980s, the superior psychosocial benefit of either immediate or delayed breast reconstruction has been debated. Some believe that those undergoing delayed breast reconstruction have time to experience the psychological impact of living with mastectomy and, therefore, psychologically recover better after reconstruction (Harcourt & Rumsey, 2001; Schain et al., 1984; Winder & Winder, 1985). Others argue that women having immediate breast reconstruction show superior outcomes because they have not lived with the loss of a breast (Al-Ghazal et al., 2000; Bostwick, 1995; Clayton & Waller, 1996; Neill & Briefs, 1997; Noone, Murphy, Spear, & Little, 1985). A 2004 pilot study challenged that perspective by finding that women having immediate breast reconstruction do experience loss. Breast reconstruction became a part of their loss as opposed to the replacement of a breast (Hill, 2004).

A quantitative study compared the psychological impact that immediate and delayed breast reconstruction had on women. The results showed that women undergoing immediate breast reconstruction exhibited less distress and improved psychosocial well-being (Al-Ghazal et al., 2000). Regardless of the debate regarding superior outcome, whether to reconstruct a breast and when are personal decisions.

The aim of the present study was to explore women's experiences after undergoing TRAM flap breast reconstruction. The choice to focus on TRAM was made because of its increasing popularity as a form of autologous breast reconstruction following mastectomy.

Methods

A qualitative, exploratory, and descriptive research design was chosen for this study because of the complexity and uniqueness of human experiences and the importance of studying such experiences from a holistically subjective perspective. The theoretical perspectives of interpretivism and hermeneutics guided the study. Interpretivism evolved with the purpose of attempting to understand and explain human and social reality. The basic process of interpretivism involved contrasting the interpretive approach of understanding needed in the human and social sciences with the explicative approach of explanation that is found in the natural sciences (Crotty, 1998). Hermeneutics is derived from the Greek word "hermeneuein," meaning to "interpret and understand with the aim of rendering it familiar, present and intelligible" (Palmer, 1969, pp. 12–14). The hermeneutic circle is integral to the process of understanding. This method of interpretation requires relating

whole meanings to parts and back to whole again and being able to move freely between parts and whole (Crotty).

Ethical approval for this project was obtained from the hospital facility and the tertiary institution. The study complied with the National Guidelines for Ethical Practice. No identifying material was used, and data storage complied with standard regulations.

Recruitment

Participants were women who had undergone a TRAM flap breast reconstruction procedure from January 2001–January 2003. Prior approval was sought from the plastic and reconstructive surgeons, who were supportive of this study. Women were invited to participate through letters sent via their surgeons, thus maintaining confidentiality. The letters contained an information sheet outlining the study's intention and process and a cover letter from the surgeon. The cover letter also informed women they were under no obligation to participate and could withdraw their participation at any time without it affecting the care they received from the surgeon or the hospital facility. In total, 83 letters were sent to eligible women and 65 (78%) responded. The number of participants was too large to accommodate because of time and size constraints, so 10 women were selected to represent the population in terms of timing of surgical procedure, geographic dwelling, and adjuvant therapy requirements. Inclusion criteria specified that women had to have undergone surgery 6–24 months prior, speak English, and be older than 18 years of age.

Participants

The sample consisted of five women who had immediate breast reconstruction and five women who had delayed breast reconstruction. Time lapsed since surgery ranged from 10–31 months (\bar{X} = 18.5 months). The mean age of participants was 48.5 years, ranging from 39–59 years. Eight women lived in a metropolitan area, and two lived in rural settings (see Table 1).

Data Collection and Analysis

Data were collected through individual, face-to-face interviews in the participants' homes, lasting one to two hours each. The interviews were semistructured, and women were questioned about their decisions regarding breast reconstruction and feelings, experiences, and the impact of breast cancer, mastectomy, and breast reconstruction on their functioning and lifestyle. A later focus group interview was held with 8 of the 10 participants. The semistructured focus group interview was conducted to confirm relevance of the identified themes to the women's perception of their experience and to encourage individual expression, group interaction, and identification of issues and possible resolutions (Kreuger, 1998). All interviews were audiorecorded and transcribed verbatim.

Thematic analysis of the data was performed. Transcripts were analyzed separately, and common ideas were combined and grouped into discussion topics. Commonalities and differences were identified to develop emerging themes and sub-themes. The process was conducted manually; transcripts were read twice, and data were organized twice and synthesized. The authors achieved immersion through this method. The findings were described to the participants in a focus group format to ensure accurate interpretation and conceptualization

Table 1. Participant Demographics

Characteristic	n
Marital status	
Married	9
Widowed	1
Geographic dwelling	
Metropolitan	8
Rural	2
Reconstruction	
Immediate	5
Delayed	5
TRAM flaps	
Viable	9
Failed	1
Complications	
Minor	2
Major	3
Revision procedures	9
Therapy	
Chemotherapy	5
Radiation	1

N = 10

TRAM—transverse rectus abdominus musculocutaneous

of the data. Additional data gained through discussion within the focus group were incorporated into the existing findings. Data analysis was undertaken by the primary researcher, with coding checks performed by the supervising researcher.

Findings

The experiences described by the women illustrated that breast cancer and breast reconstruction had an immensely profound impact on their lives and their families. The women described simultaneously dealing with the intensity of being diagnosed with a life-threatening illness, the intimacy of losing a breast, and undergoing TRAM flap breast reconstruction. Therefore, the experiences have been reported jointly to describe the experience depicted by the women. Three themes emerged from the data that described the women’s experiences. Within each theme, subthemes also were identified (see Figure 4).

Losing a Breast Matters

The overall experience of a breast amputation was unexpected, immensely personal, and significant. The women were concerned that others did not recognize their feelings and described feeling abnormal because of their altered body image. Increased self-consciousness, a decrease in self-esteem, and deteriorating confidence levels also were reported. Most women described some form of depression, with two experiencing withdrawal from society and one identifying feelings of isolation from the outside world.

Women who underwent delayed breast reconstruction and experienced a period of living with a mastectomy said they were ill prepared for the impact it would have on them. The women believed they could cope without a breast reconstruction, only to be surprised by the emotional impact of mastectomy. One component of this, living with a prosthesis, often became motivation for the women to choose breast

reconstruction. One woman summarized her experience of living with mastectomy: “At the end of the day . . . it probably would have been easier if you lost two.” Although losing a breast mattered to the women more than they anticipated, they wanted to be acknowledged by more than just their breast. The women attempted to deal with the profound impact mastectomy had on their lives without all of the focus being placed on their breasts.

Several women discussed their struggle to gain acceptance of their physical and emotional situation from others. The women perceived that society primarily views breast reconstruction as a cosmetic procedure, thus implying vanity in women opting to reconstruct their breasts. The women justified their decision to undergo breast reconstruction by saying they were still young, indicating a perceived societal standard of worthiness for breast reconstruction according to age.

I felt I was just too young to just have a mastectomy. . . . [I] sort of thought “I’ve got a lot of years ahead of me to look at deformity like that.” . . . I just thought I was too young to do that. . . . If you’re coming to the end of your life, you might not see [breast reconstruction] as crucial.

Okay, the deciding factors were, because I was still young. If I was maybe in my late 60s or 70s, I wouldn’t have worried about it. It wouldn’t have been an issue as much. . . . I’m young and I felt I had a lot of living left to do. And I wanted to live it as normally as possible.

However, the aging concept was challenged in a later group discussion by some of the women: “I’m 60 in a few months’ time and I’d definitely still have it done.”

The women felt pressure to cope because they perceived that society viewed the need to reconstruct a missing breast as a sign of impaired coping and failure. The women described an inability to express their true feelings to others. While struggling to feel normal, the women felt different.

I was okay as long as I appeared dressed and as if nothing had happened to me. . . . So I think I really tried to pretend everything was okay, that I was normal.

That [prosthesis] actually looked fine, that was okay, but I knew it wasn’t okay. It doesn’t matter what anybody else could see, whether they knew me or they didn’t know me or just walking the streets, you would have thought nothing. But I knew it was all wrong, I knew that it was just totally wrong.

Losing a breast matters
Recognizing the impact of loss of a breast
I am more than a breast.
Struggling to gain acceptance
Adjusting to a changing body image
Timing of breast reconstruction
Situational factors influencing the process of adjustment
Finding support throughout the process of adjustment
Surgeons’ acceptance and recognition of the women and their situation
Redefining normality
Concept of self is rediscovered.

Figure 4. Study Themes and Subthemes

I don't usually talk about my breast cancer. A lot of people who know me now would never know that I've had breast cancer, because I just don't tell them.

Adjusting to a Changing Body Image

Adjusting to a changing body image was the main theme experienced by the study participants. Undergoing TRAM flap breast reconstruction is a process of transition and adaptation. Differences in the women's processes of adjustment were noted to be dependent on the timing of the breast reconstruction, whether it was immediate or delayed. Women who had delayed breast reconstruction experienced improvements in body image and self-esteem after breast reconstruction; perhaps they experienced the loss of a breast after living with mastectomy.

It changed my body image absolutely, because as soon as the bandages and stuff came off, I could see that I was in shape. I couldn't wait to rip off the bandages and see exactly. And it was a little big but it didn't matter. The symmetry was now right. You could stand in front of a mirror and you looked like you were supposed to look and automatically you feel a whole lot better. You're just not missing anything, you're all complete again.

Those having immediate breast reconstruction described an initial decline in self-esteem and body image, which subsequently improved over time. For those women, breast reconstruction initially was part of the loss as opposed to the solution.

I wasn't really wrapped. It was a good shape and realistically I knew it was a damn good job, but I wasn't enthusiastic and I didn't hate it. It was just like I could live with it at the time. I think the TRAM flap is, in effect, an effort to resurrect your body image, your self-esteem, and try and keep it at a reasonable level. I think it has to go down.

Individual situations during each woman's breast reconstruction were an influential part of the adjustment process. Medical, familial, and financial issues compounded their struggle throughout the breast reconstruction. Although the women initially stated they were supported during their breast reconstruction, they later admitted that finding support throughout the adjustment process was challenging. Support was sought from partners, family members, and friends. Several women reported changes in relationship dynamics. Women described some as being closer, which was attributed to sharing of experiences and emotional support, whereas others described deterioration and disintegration of some friendships. Women said that some relationships became distanced because people did not understand the cancer experience or were frightened by it.

I had some friends that I'd had for a long time, which I really don't see now. Because when it happened, some people are scared. They don't know what to say and how to react. So these people I don't see anymore. . . . They had come to visit me in the hospital and you could just see their faces, it was like they were saying goodbye. They hear cancer and they think death. I was already sick with fear without people adding to that. . . . A lot of people don't understand it; they don't understand me.

Regarding intimacy with partners, most women stated that their partners were accepting of their new bodies and that sexual intercourse was not affected; however, women still felt self-conscious about exposing their bodies. One woman said,

"I remember not wanting to be seen naked by anybody. . . . I didn't even want my husband to see the scar. I would always wear a big T-shirt to bed, even when making love."

Redefining Normality

Redefining normality was the aim and anticipated outcome of the adjustment process. The women identified the need to redefine normality once they knew the former version was no longer attainable. Redefining normality did not just involve the aspects of body image and self-esteem related to surgery, but also included redefinition of relationships, family dynamics, situation, lifestyle, and self.

You suddenly go from normal, whoever you are, to getting this life-threatening terrible disease . . . and suddenly you feel like it's all gone. Now you've got to start rebuilding yourself, and yet your confidence is absolutely shattered.

[TRAM flap breast reconstruction] totally changed the world I live in. It changes every area of your life in some way.

The concept of self for most women was rediscovered and redefined, requiring acceptance of this redefinition by self and others. Another adjustment was recognizing that the breast reconstruction was not going to be a true replacement of the lost breast. TRAM flap breast reconstruction did achieve some outcomes of normality for women who had immediate and delayed reconstructions. Some women stated they felt and looked normal once again. A woman with delayed TRAM flap breast reconstruction said,

You're not self-conscious at all because you're just you, you are just now fully attached, you're fully normal. . . . I feel, as far as the reconstruction goes, as I sit here now, I just feel like me, whereas without it I could never have said to you I feel like me.

Revision procedures to the TRAM flap breast reconstruction resulted in further improvement to aesthetic outcomes, enabling the resemblance of the reconstructed breast to be closer to normal. Women described a greater appreciation for life after dealing with the breast cancer and breast reconstruction and realized that life is about fulfillment and enjoyment. That realization led to a reprioritization, resulting in less work, more play, and greater emphasis on consideration of self.

Things get put into perspective for you. You actually don't have to sit down and think, "Well, let's try and figure this out." . . . It sits there on a plate and if you don't eat it, so to speak, you've got to be a silly person. I mean, it just lightens up your world and it says, "Wake up. What are you worried about all this nonsense for? Just live."

A few women said that breast reconstruction changed them. Two said they had become better people. Most described themselves as more sympathetic, empathetic, and compassionate, which led to a willingness to help others going through breast cancer and TRAM flap breast reconstruction. The women felt they had something valuable to share that would help others going through a similar experience. They said it made them feel good about themselves and increased feelings of worthiness. Several women described the experience as the best thing that ever happened to them. One summed up her experience by

saying she had gained more than she had lost. Among the sample, a positive experience resulted from something negative.

Discussion

The experiences described by the women in this study highlight the all-encompassing experience of breast cancer and breast reconstruction. Reconstruction became a means to ameliorate the actual or anticipated burden of mastectomy and improve quality of life for the women. Breast reconstruction clearly involves much more than the physical restoration of a breast; it also incorporates vast psychological and emotional issues.

The profound impact of the diagnosis and treatment of breast cancer experienced by the women in this study may be attributed to the connotations of intimacy associated with the breast and its removal. The breast has long been identified as an integral component of a woman's self-concept, encompassing the areas of motherhood, sexuality, and feminine identity (Sawaya, 1984). The women in this study often referred to a lost feeling of wholeness after a breast removal. Related issues of symmetry, form, function, and sexuality were included in the concept of a satisfactory body image for these women. Those issues have been described in previous research (Kissane et al., 2004).

The women from both the immediate and delayed breast reconstruction groups underestimated the effect of losing a breast. The minimized aspects of body image are not contemplated when considering the loss of a breast because a woman's focus is on survival and dealing with the immediate consequences of her diagnosis. The reality becomes apparent only when women are faced with the loss and realize the significant impact on their body image. The meaning of body image for the women in this study was expressed as feeling normal about their bodies.

The women's perception of how society views breast reconstruction influenced how they dealt with their experiences and made many feel that undergoing reconstruction was not essential because it was not life-preserving surgery and was optional. However, the study participants felt that the surgery was necessary and, in many ways, imperative to improving their quality of life. Society encompassed family, friends, and the broader community within which the women live. Societal understanding can be achieved only when women share their experiences, yet many women believe they can not openly express their feelings. Healthcare professionals must raise awareness of breast reconstruction within society to establish its place as a fundamental part of breast cancer treatment.

When exploring women's breast cancer experiences, Cromptvoets (2006) discussed breast cancer as a process influenced by the meanings constructed from social context. The women's experiences with society's perceptions and their own feelings associated with the loss resulted in confusion and difficulty in expressing views and concerns. That experience signifies women's struggle to gain acceptance, not only from others, but also from themselves. The women experienced an external struggle influenced by the values of society and an internal struggle with self. As a result, some felt guilty because they had difficulty dealing with mastectomy and felt a sense of failure in deciding to reconstruct their breast. The women were dealing with discrepancies between how they felt about their bodies and how they believed they should feel, which was a distinct source of anxiety for the women in this study.

Relationships affected by the process of adjustment did not improve or diminish but demonstrated changed dynamics. The most significant impact was evident with partners and friends. Although the women did not report sexual dysfunction and mostly commented that partners were supportive and accepting, the women's feelings about their bodies affected their overall sexual experience and sense of sexuality. Another study highlighted similar experiences. Although some were proud of their post-breast cancer bodies, they still felt the need to "cover up" to feel comfortable and normal with their partners (Cromptvoets, 2006).

The women in the current study said that hearing other cancer stories from friends and family was distressing. Others may tell stories to express understanding of the situation through some connection, but it also may be a subconscious and deliberate act, almost in the form of a blocking strategy, to distance themselves from a situation they do not feel they can handle. The women felt this devalued and depersonalized their experiences. As a result, the women perceived a lack of understanding from family and friends who did not or could not share the experience and emotional distress.

Distinct differences in the staging of the adjustment process were noted between the immediate and delayed breast reconstruction groups. Women undergoing delayed breast reconstruction already experienced the loss of a breast, which ultimately became motivation to undergo breast reconstruction (Harcourt & Rumsey, 2001; Schain et al., 1984; Winder & Winder, 1985). Women having immediate breast reconstruction experience that loss right after breast reconstruction. Although the women may see the form of a breast, it is not the same as the original breast. The immediate breast reconstruction experience, therefore, becomes part of the loss as opposed to the solution. This is not to advocate delayed breast reconstruction but to highlight that women having immediate TRAM flap breast reconstruction do experience loss.

The obvious difference in the adjustment process between the two groups relates to the women's focus on feeling normal. The women undergoing delayed breast reconstruction move along a path of feeling normal (before cancer diagnosis) to abnormal (after mastectomy) and then return to normal (after reconstruction). In contrast, women having immediate breast reconstruction experience a single transition from normal (before cancer diagnosis) to abnormal (after reconstruction), with a gradual improvement toward normal over one to two years postoperatively. The differing experiences revealed that breast reconstruction is not a solution to the impact of mastectomy. Also, the findings of this study contradict the view of several authors who have argued that those who have immediate breast reconstruction do not suffer distress from losing a breast (Al-Ghazal et al., 2000; Anderson & Kaczmarek, 1996; Bostwick, 1995; Clayton & Waller, 1996; Neill & Briefs, 1997).

The women in the study ultimately realized that the breast was never going to be the same and that their lives had undergone more than just a physical change. This was demonstrated when the women redefined normality as the outcome of the adjustment process. The challenge faced by the women in this study was to maintain harmony of the redefined self within the context of life and family. Women reported that their changed perspective on life led to reprioritization and an altered lifestyle that ultimately improved their lives. A changed outlook on life commonly is attributed to a breast cancer diagnosis and having to face mortality (Kissane et al., 2004); however,

many women in this study attributed the improvement to the advantages of breast reconstruction surgery.

The women in this study indicated that the key to the adjustment process was time, regardless of the support networks and coping mechanisms used during the experience. Women need to develop a new definition of normal, and others must recognize and accept the changed person. The women in the study identified the experience of TRAM flap breast reconstruction and the new definition of normal to be positive experiences in their lives. Crompvoets (2006) identified a similar theme from women's breast cancer narratives; they too identified a need to return to normalcy.

The needed areas of support identified by the women in this study were spiritual, emotional, familial, and physical in nature. The same holistic concerns have been identified in previous research (Wyatt & Freidman, 1996). Descriptions of the women's experiences contradicted their statement of adequate support, which may reveal a discrepancy between the type of support offered and needed. This also highlights the isolation women can experience. Crompvoets (2006) also found women's narratives of their breast cancer experiences to be somewhat contradictory at different points in their stories. Hart (1996) postulated that women's environments and support systems can be the most accurate predictors of the ability to cope with, and adjust to, breast cancer.

Limitations

Because of time constraints, a small number of participants were recruited in this qualitative study. Although the study allowed for in-depth exploration of the women's experiences, the results are not generalizable. This study's sample was taken from a private hospital, with no representation of those within the public health sector. Whether that influences the findings is unclear. Although most TRAM flap procedures in Western Australia are undertaken in the private health sector, further research incorporating both sectors is required. Additional research would benefit from a mixed method, prospective study design, with a larger sample size and longer follow-up. This would allow for more complex analysis of the role of staging in the adjustment process in reconstructive breast surgery.

Conclusion

Being diagnosed with breast cancer and undergoing TRAM flap breast reconstruction are significant and life-changing processes with immense psychological, social, emotional, and physical repercussions. The need for support before, during, and after the procedure is paramount because women often underestimate the impact of losing a breast, whether it is immediately reconstructed or at a later time, and must cope with their perceptions of societal views toward their experience. Although the support that women require involves psychological well-being,

a greater focus on the physical, financial, and social realms associated with recovery is needed. Women who undergo TRAM flap breast reconstruction are not receiving enough support.

A lack of support was reported on a personal and social level. Society's views of breast reconstruction and lack of empathy, as perceived by the women, inflict pressure to cope, leading to feelings of guilt and failure, along with suppression of emotions. Therefore, broadened education is needed to increase society's awareness of breast reconstruction benefits and to encourage understanding and support.

The experience of undergoing mastectomy and TRAM flap breast reconstruction is an adjustment process that extends over a period of time. Greater immediate satisfaction was felt among the delayed breast reconstruction participants. However, chronologically, whether dealing with mastectomy and then breast reconstruction or dealing with the sequelae following immediate breast reconstruction, outcomes are similar.

Implications for Nursing Practice

The issues experienced by women who have a mastectomy and breast reconstruction incorporate the physical, psychosocial, emotional, and social realms. Women are underprepared for TRAM flap breast reconstruction procedures and have unrealistic expectations and limited provision of support, thus compounding the psychosocial recovery period. Nurses play an important role, not only in the provision of physical care, but also in meeting psychosocial needs and facilitating the provision of adequate support resources. This study gives practicing nurses greater insight into the holistic needs of women undergoing TRAM flap breast reconstruction, thus further educating nurses on the diversity and importance of their role in these women's lives. Further research in this area is needed so that women undergoing breast reconstruction and the nurses caring for them have greater knowledge of the experience.

Areas that would benefit from further research include

- Evaluation of the difference in outcome between immediate and delayed TRAM flap breast reconstruction
- Exploration and development of models to assess and assist education and support needs of women undergoing TRAM flap breast reconstruction
- Investigation of the impact of the surgery on a woman's family and spouse
- Further comparative studies between the psychological and physical outcomes of the TRAM flap procedure and other forms of breast reconstruction.

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