

Translating Recommendations into Practice: The Role of Informal Social Support Networks in Lifestyle Behavior Change Among Breast Cancer Survivors

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Abstract

Purpose

Cancer survivorship guidelines encourage healthy eating and physical activity to support long-term health and quality of life. Less is known about how survivors translate lifestyle recommendations into practice.

Methods

We conducted semi-structured interviews with 26 Black and Hispanic/Latina breast cancer survivors residing in the Greater New Haven area. English and Spanish interviews were audio recorded, transcribed and translated verbatim, and analyzed using NVivo qualitative analysis software. Using a grounded theory-informed approach, three trained coders developed and applied an iterative codebook, establishing strong interrater reliability ($\kappa > .80$) prior to independent coding. Reporting followed the Consolidated Criteria for Reporting Qualitative Research (COREQ).

Results

Survivors described drawing on multiple informal networks, including family, friends, faith communities, peers, workplaces, and neighbors, to support lifestyle change. Informal support often combined emotional and instrumental elements, such as encouragement, check-ins, shared activities, and practical assistance (e.g., transportation, meals). Support related to physical activity was described more frequently and in greater detail than diet-related support. Survivors valued survivorship clinics and providers as trusted sources of information; however, informal networks were described as particularly important for translating recommendations into daily routines and sustaining changes over time.

Conclusion

Informal social support shaped how survivors initiated and maintained lifestyle changes after breast cancer. Survivorship interventions may be strengthened by approaches that intentionally connect clinical guidance with survivors' existing social networks. Approaches that integrate social support networks early after diagnosis may directly help translate to clinical lifestyle recommendations into daily practice.

Introduction

Breast cancer survivorship in the United States (US) is marked by persistent inequities in structural and contextual barriers that shape survivorship experiences and constrain health-promoting behaviors over time [1]. These inequities are consequential because lifestyle factors (e.g., diet, physical activity, obesity) during survivorship influence cancer-related outcomes, comorbidity risk, and overall well-being [2].

Lifestyle behaviors are a modifiable determinant of survivorship outcomes, with oncology guidelines emphasizing energy balance across the cancer continuum [3, 4] and time immediately following diagnosis as a key window for behavior change [5, 6]. Pre-diagnosis adherence to healthy lifestyle patterns has been linked to reductions in all-cause and cancer-related mortality among women [7]. Among breast cancer survivors, higher post-diagnosis physical activity combined with greater vegetable and fruit intake has been associated with improved survival regardless of obesity status [8], and dietary patterns have been associated with prognosis in subgroups of survivors [9]. Consistent associations between guideline-concordant behaviors and mortality, cardiovascular risk, and metabolic health have also been observed [3, 10, 11].

Beyond mortality, lifestyle behaviors are also linked to psychosocial and quality-of-life outcomes, including improvements in symptom burden, physical function, and overall quality of life among breast cancer survivors [12, 13]. Despite established guidelines, adherence to lifestyle recommendations remains low among cancer survivors, with persistent disparities. Only a small minority of survivors meet multiple guideline domains simultaneously [14, 15]. Adherence is further shaped by variability in survivorship care delivery, logistical and financial barriers, and confusion arising from complex and inconsistent evidence and messaging [10, 16–18]. Our prior work highlights how these contextual and structural factors constrain survivors' capacity to engage in recommended behaviors [17].

Social support has long been recognized as an important determinant of health behaviors [19–22], operating through emotional, informational, and instrumental pathways [23]. Support may be provided through informal networks (e.g., family members, friends, faith communities, peers, workplaces, neighbors) as well as formal networks (e.g., healthcare providers, survivorship clinics, ancillary services, national organizations) [21, 24–26]. However, the specific ways in which these networks influence survivors' ability to initiate and sustain lifestyle behavior change during breast cancer survivorship, particularly among Black and Hispanic/Latina women, remain understudied. Building on this foundation, further work is needed to understand how survivors navigate lifestyle recommendations within their everyday environments and how different sources of support may shape behavior change during survivorship.

To address this gap, we conducted a secondary qualitative analysis of previously conducted semi-structured interviews to answer the following research questions:

1. Which social support networks (informal vs formal) do breast cancer survivors draw upon to support lifestyle behavior change?
2. What forms of social support do informal networks provide to support lifestyle behavior change during survivorship?
3. How do informal social support networks translate lifestyle recommendations into daily health behaviors?

4. How do informal networks influence both the initiation and maintenance of lifestyle behavior change over time?
5. How do breast cancer survivors perceive the complementary roles of informal social support networks and formal support networks in facilitating lifestyle behavior change?

Methods

Study Design and Theoretical Frameworks

This qualitative study used semi-structured interviews to examine how breast cancer survivors describe the role of social support networks in lifestyle behavior change during survivorship. Data were collected as part of a larger qualitative investigation that included survivors and oncology healthcare providers; the present manuscript reports a focused analysis of survivor interviews only, centered on social support processes related to diet and physical activity. The present report adheres to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines. [27]

The study design and analytic approach were informed by the socio-ecological [1] and social support frameworks [20], which conceptualize health behaviors as shaped by interactions among individual, interpersonal, community, and organizational/institutional factors.

Study Setting and Participants

Participants were recruited between March 2019 and March 2020 from the Greater New Haven, Connecticut, area through a National Cancer Institute (NCI)–designated comprehensive cancer center with an established multidisciplinary survivorship clinic.

Survivors were eligible if they were ≥ 18 years old; had a history of breast cancer (any stage); self-identified as Black/African American and/or Hispanic/Latina; did not have a psychiatric illness or cognitive disorder that would preclude participation; and were not enrolled in a lifestyle intervention at the time of recruitment. Consistent with NCI definitions, participants are referred to as “survivors” regardless of time since diagnosis.

Recruitment and Enrollment

A multimodal recruitment strategy was used to identify survivor participants, including electronic health record screening, clinic-based recruitment during oncology visits, provider referrals, flyers, word of mouth, and outreach through community organizations and support groups. Survivors were approached in person or via mailed letters describing the study and invited to contact the research team if interested. Of 41 survivors approached, 26 enrolled. Reasons for declining participation were not collected. Healthcare provider interviews were conducted as part of the parent study but are not included in the present analysis.

Data Collection

Survivor interviews were conducted in English or Spanish based on participant preference and lasted approximately 60–120 minutes. Interviews took place in participants' homes, private research offices, or by telephone, depending on participant preference. Informed consent was obtained immediately preceding the start of the interview, and verbal assent was also obtained.

The interview guide explored experiences with diet and physical activity before and after cancer diagnosis, barriers and facilitators to behavior change, sources of information and support, and interactions with healthcare teams. Although the parent study was not exclusively designed to examine social support, participants were explicitly asked about support from family members, friends, community members, and healthcare providers related to lifestyle behaviors. The general interview guide has been previously published [17].

All interviews were audio-recorded with participant consent, professionally transcribed verbatim, and de-identified. Spanish-language interviews were professionally transcribed and translated into English verbatim by the Mixed Methods Research Lab (MMRL) at the University of Pennsylvania.

Data Analysis

Twenty-six survivor transcripts were uploaded into NVivo for analysis [28]. The research team initially used a grounded theory approach to code and analyze data, using emerging themes from the interview data to guide the development of the codebook [29]. One significant theme that emerged was social support. Following this, an initial deductive framework of this theme was informed by socioecological and social support theory, including emotional, informational, instrumental, and appraisal support across informal and formal networks. Transcripts were then re-reviewed to identify inductive codes capturing lived experiences related to support, sources of support, accountability, and the initiation and maintenance of lifestyle behavior change. These were established in relation to the different forms and sources of support across networks and were then organized back into the previously mentioned deductive codebook.

Three trained coders independently coded an initial subset of eight transcripts to begin an iterative codebook, then organized the iterative themes into a deductive codebook based on the literature review items via consensus. Coders established strong interrater reliability prior to independent coding ($\kappa > .80$). Coding discrepancies were resolved through consensus during regular analytic meetings. Codes were iteratively organized into higher-order themes aligned with the study's research questions. Themes were reviewed across participants to examine convergence and variation in experiences. Because racial/ethnic identity (Black vs. Hispanic/Latina) and time since diagnosis (≤ 5 vs. >5 years) may shape the support survivors received, we also conducted stratified analyses across these two patient-level characteristics. However, experiences did not vary substantially by these two groups; therefore, we only present an analysis for the overall sample.

Research Team and Reflexivity

Interviews were conducted by one team member (MSP) who self-identifies as Hispanic/Latina and is a native Spanish speaker with doctoral-level training in qualitative and mixed-methods research. Data coding and analysis was conducted by a team of three trained coders (DB, LA, SH) with prior experience in qualitative analysis. The research team held regular analytic meetings to reflect on interpretations, resolve discrepancies, and support reflexivity.

Rigor and Trustworthiness

Multiple strategies were used to enhance rigor and trustworthiness and to address credibility, dependability, confirmability, and analytic transparency. Credibility was supported through in-depth interviews, verbatim transcription, and prioritization of participant voice, with representative quotes used to illustrate themes. Dependability was strengthened through team-based coding with established criteria for interrater reliability and consensus resolution. Confirmability was supported through reflexive discussions and maintenance of an audit trail. Analytic saturation was assessed across study sub-questions, with no substantively new themes emerging in later interviews; a comprehensive quote inventory supported analytic transparency [30].

Ethical Considerations

The parent study was conducted in accordance with the Declaration of Helsinki and approved by the Yale Human Investigation Committee (#2000025065). Analyses were approved by the Institutional Review Board at the Perelman School of Medicine at the University of Pennsylvania (#852208). Verbal informed consent was obtained from all participants prior to participation.

Results

Our study sample has been previously described in detail [31]. Among 26 survivors, the majority were 51 years or older (85%, median = 50 years, SD = 10.67 years), had some college education (62%), self-identified as Black (58%) or Latina (38%), were born outside the United States (54%), were not married (65%), were interviewed in English (69%), were diagnosed within the previous 2 years (42%), and had stage I (42%) or stage II (31%) disease.

Initially, we examined social support references by race/ethnicity (Black vs. Hispanic/Latina) and years since diagnosis (≤ 5 years vs. >5 years). While no substantive differences emerged in the *types* or *forms* of social support described across these groups, participants emphasized different *sources* of support. Black survivors more frequently described support from friends and peer survivor networks, whereas Hispanic/Latina survivors more often referenced faith-based networks as sources of emotional and

practical support. Given the overall similarity in support processes, results are presented for the combined sample.

Theme 1: Informal social support networks involved in lifestyle behavior change

Participants described drawing on multiple informal social support networks to support lifestyle behavior change following a breast cancer diagnosis. These networks included family members, friends, faith communities, peer survivor groups, neighbors, workplaces, and non-profit organizations. Support was typically embedded within existing relationships and social roles rather than newly formed networks. Across interviews, family-based support was most frequently described, followed by support from friends and faith communities. A small number of participants described limited access to friendship-based support, often attributed to work schedules and competing temporal demands.

Family members including partners, children, siblings, parents, and extended family, were commonly described as primary sources of support. Friends, including those from faith-based communities, played an important role through shared activities and emotional encouragement. Several participants highlighted faith-based communities as spaces for prayer, connection, and normalization of the cancer experience. Others described support from peer survivor groups, non-profit organizations, neighbors, and workplaces, which provided opportunities for shared experiences, emotional connection, and practical assistance. For example, one participant described receiving material and logistical support from her employer, including flexible scheduling and meal assistance.

“They were amazing, they gave me a whole bunch of gift cards for Uber Eats so I wouldn't have to cook for my kids. I had to leave early for radiation from my job and they told me not to worry about that one hour, that they would still pay me for that one hour even though I left early to do the radiation. So the people that I work for [...] were also a big support to help me get through this all and with my family.” – P22

“In my case, I am a Christian, I go to church and I have many friends, and the church has supported me one hundred percent, they have been praying and I believe in that, I believe in prayer, I believe that God still works miracles... because if it were not for God, I do not know what I would have done, but I thank God because I have seen one hundred percent support from the family, from the church, from my friends.” – P02

“I go to the Christian church. Ladies, there, who talk to me, and advise me, there are many there who have suffered from cancer, who have undergone surgery, who have also had their breasts removed for that reason, or who have had cancer operations in different places. There are several sisters who always hug me and talk to me nicely.” – P15

Theme 2: Forms of social support provided by informal networks

Across interviews, support related to physical activity was described more frequently and in greater detail than support related to dietary change. Diet-related support was discussed by a smaller subset of participants and was often embedded within broader instrumental or emotional support rather than described as ongoing shared behavior. In general, participants described receiving three forms of support including emotional, informational, and instrumental, often concurrently, from their informal social networks, which collectively facilitated lifestyle behavior change.

Emotional support, defined as listening support, comfort, and security [20], was one of the most commonly discussed forms and included frequent check-ins, increased communication, expressions of closeness with family members, shared prayer, and ongoing encouragement and reassurance.

"My pastors, they were there. They comforted and prayed for me. I went through and they all prayed for me. Like I said they all was praying for me and trusting God and believe in God in my healing. And, so they comforted me that way and loving on me, praying for me. Telling me I could make it you know. Letting me know that they're there for me." – P18

"I gained new friendships through chemo. Looked forward to seeing the ladies. You know, we thought we were in this together." – P10

"My family just you know, showered me with love. And they were always around, my aunt would call me every day, my mom's sister, my uncles would call me, they just were being the best. For others, everybody. So my little cousins knitted me a purple scarf because we believe that purple is the color of royalty, and you know since you a queen – here this scarf is for you. So wear this when you go to chemo, and I still have that scarf, and so they were the best, so they made me want to live and not give up." – P09

Informational support, defined as receiving advice and guidance [20] from informal networks sometimes focused on nutrition, exercise, and medication side effects and frequently came from family members or friends with healthcare backgrounds.

"My friends showed me cookbooks, [I] think one was title like, Cancer Book or something, cookbooks where it has better ways to you know, different meals to cook. You know like if your body went through like a traumatic change, like healthy stuff." – P22

"[Friends and family] advised me of the kind of food I can eat, because my sister is a nurse and she told me. Told me to eat proteins, vegetables, walking good for me, fruits, lots of water, they're very supportive." – P24

"And my aunt's a pharmacist and so I really wanted to talk to her about some of the treatments and drugs and everything and she's been really helpful in giving me advice and just being this good sounding board also." – P11

Instrumental or tangible support, defined as receiving concrete assistance [20], included assistance with household chores, meal preparation, transportation to appointments, childcare, and accompanying them to appointments during treatment or recovery.

"They were really good, very supportive, my sister you know, she had gone through it, and my nieces, even my nephews wanted to help [laughs]. Everybody wanted to come and set up camp in my house when I had the surgery." - P08

"When I got sick it was like she kicked back into the old mom. She was like, oh no, can't be sitting here, I can't be depressed now. Can't do it. You know, I had to take care of my baby. And she was with me through every single appointment. She did not miss an appointment. She was right there. And my mom's almost 80, and she was right there for every appointment. She just kicked back in, she was just taking care of her daughter, taking care of her baby." – P03

"[My kids] went to the surgery with me and all. They stuck by me. They went to chemo, radiation. Even though they had their job they would check-up on me. But they stuck beside me. - P12

Theme 3: Mechanisms through which support facilitates behavior change

Informal social support networks facilitated lifestyle behavior change by translating health recommendations into shared, actionable practices. Rather than providing information alone, informal networks supported behavior change through companionship, accountability, and practical assistance that reduced the physical and emotional burden of adopting new behaviors. Support related to physical activity was more frequently described and often involved shared participation, such as walking together, whereas dietary changes were less commonly discussed and were typically supported indirectly through meal preparation or general encouragement. Participants frequently described engaging in healthy behaviors alongside friends or family members, with friends and family members participating directly in activities such as walking or assisting with meals. Through shared routines, encouragement, and instrumental support, informal networks helped make lifestyle changes feel more manageable and shifted behavior change from individual responsibility to a collective process.

"I have a friend who encouraged me to, you know, cut out the sugar and do pressed juice. Just encouraging me to do more vegetables in my diet." – P25

"They made sure that I wasn't – like I'm here alone. I don't have anybody living with me so they call me [in the] morning, they call me [at]night and they'll come. They take me shopping and things like that and made sure I had whatever I need. And made me feel comfortable that they were very concerned. In fact, I have one daughter that follows my chart, she knows all of my doctors." – P05

Theme 4: Sustaining lifestyle changes through ongoing social support

Informal social support networks played a critical role in sustaining lifestyle changes beyond the period of active treatment. Some participants described initiating dietary changes and physical activity shortly after diagnosis, often prompted or supported by family members and friends. Support frequently continued after treatment completion, with ongoing check-ins, shared routines, and informal monitoring

contributing to the maintenance of behavior change over time. Participants emphasized that continued social engagement helped sustain motivation and adherence to lifestyle changes as clinical visits became less frequent.

"And my aunt's a pharmacist and so I really wanted to talk to her about some of the treatments and drugs and everything and she's been really helpful in giving me advice and just being this good sounding board also." - P11

"[In reference to a local support group] We got to know each other and share each other's stories and we got concerned about each other...you hear their testimony you know about it and within yourself you become a little more adjusted because you know that you're not in it by yourself, there's so many other people." - P05

"My two closest friends that I speak to quite often, maybe like on a daily basis, their outlook on it is giving me positive examples." - P19

Theme 5: Complementary roles of informal networks and formal healthcare support

Participants described formal healthcare support like particularly survivorship clinics as trusted sources of education, validation, and resources related to diet, physical activity, and survivorship care. Survivors did not report a lack of information from providers; rather, they emphasized reliance on informal social support networks to translate clinical recommendations into daily practice. While providers were viewed as credible and informative, informal networks were described as essential for implementing and sustaining guidance outside of clinical encounters. Informal social support networks were described as helping survivors act on that information through shared activities, practical assistance, and ongoing encouragement. Friends and family members often participated directly in lifestyle behaviors, such as walking together or assisting with meals and transportation.

"[The survivorship clinic] was just a great support. The education I received there was excellent. It turned out that the social worker I had in the survivorship clinic at that time that I was seeing was a cancer survivor herself and had the very same experience I had with friends. It was good to have things to read and kind of guides to go by, whether it was the physical therapist, jotting down the exercises I could do or a diagram of how to do something that I can do at home to the nutritionist with different charts and things about food." - P02

"My other friend keeps a balanced diet, and she told me 'Look, follow this diet, it's under recommendation' so I'm starting to eat healthy, I recently began eating more legumes, less bread, less pasta, all those things I don't eat much, and drinking green tea, water with lemon, and then doing exercise, keeping that routine." - P17

"Where I live I have many good friends who accompany me [on walks]." - P04

Overall, participants described a complementary relationship between formal and informal sources of support. Formal healthcare support was typically delivered in an individual-focused and time-limited manner during clinical encounters, whereas informal social support was relational, ongoing, and embedded in everyday life. Informal networks played a central role in translating lifestyle recommendations into sustained health behaviors by providing emotional encouragement, instrumental assistance, and shared participation.

Discussion

In this qualitative study, Black and Hispanic/Latina breast survivors described how informal social support networks shaped both the initiation and maintenance of lifestyle behavior change following diagnosis. Survivors consistently noted that while healthcare providers were trusted sources of information, it was often family members, friends, faith communities, and peers who helped them put those recommendations into practice. These findings reinforce prior work that health behaviors during survivorship are shaped by social relationships and everyday contexts, not just individual motivation [24, 25, 32].

Our findings are consistent with quantitative evidence linking social support to health behavior adoption and maintenance. National survivorship guidelines similarly recommend group-based exercise and exercise partners to promote sustained engagement [33, 34]. Cancer survivors who discuss health behaviors with friends and family are nearly three times as likely to follow new physical activity recommendations [35]. Tangible daily support from exercise peers has been associated with approximately 500 additional steps per day and increased light physical activity [36]. Taken together, these studies support what participants described: companionship, accountability, and shared routines make behavior change more feasible over time.

Social support may also influence behavior through psychological pathways. Structural equation modeling among cancer survivors suggests that health behavior self-efficacy partially mediates the relationship between social support and physical activity, with support associated with both higher self-efficacy and lower anxiety [37]. Survivors in our study described similar dynamics. Encouragement and shared participation appeared to build confidence and reduce emotional burden, suggesting that support strengthens both behavioral capacity and psychological readiness.

At the same time, social support is not always beneficial. Prior research shows that support can become constraining when it involves conflicting advice, social obligations, or perceived pressure [26, 38, 39]. Informal networks may also shape suboptimal health behaviors including alcohol use through normative influence [40]. Although participants in this study largely emphasized supportive experiences, future research should examine how these more complicated dynamics affect engagement with lifestyle recommendations.

Differential Roles of Network Types

Participants' narratives highlight that social support is not uniform. Different network members appeared to play different roles. Family members were most frequently described as central to dietary practices, often through cooking, shopping, and shared meals. This aligns with research demonstrating the influence of family environments on food behaviors [24, 41]. Among Latina survivors, greater support from family members and significant others has been associated with greater fruit and vegetable intake and higher odds of meeting dietary guidelines (family: OR = 3.72, 95% CI (1.21–11.39); significant other: OR = 3.32 95% CI (1.08–10.30)) [41]. At the same time, qualitative studies suggest that survivors sometimes make dietary changes that do not align with evidence-based guidelines when informational support is limited or confusing [42], underscoring the need for clear and accessible evidence-based lifestyle guidance.

In contrast, peers and friends were more often linked to physical activity support in our study, particularly through walking partnerships and shared routines earlier in the treatment phase. This mirrors research documenting the importance of peer companionship for physical activity engagement among breast cancer survivors [1, 43, 44].

Faith-based and peer survivor networks also provided emotional validation, particularly during transitions out of active treatment. Survivors appeared to draw from different network members for different needs, with roles shifting over time. This pattern is consistent with socioecological models that emphasize the interaction of multiple social contexts in shaping behavior [1, 10].

Caregiving responsibilities and gendered expectations may further shape how women mobilize support during survivorship [1, 45]. Although not a primary focus of this study, participants' reliance on family support occurred within the context of broader caregiving and work demands. Social support is also often reciprocal, with survivors both receiving and providing support within their networks [10], a dynamic that warrants further exploration.

Equity and Structural Context

An equity-oriented interpretation of these findings suggests that social support operates within broader structural constraints. Black and Hispanic/Latina breast cancer survivors disproportionately experience financial hardship, food insecurity, transportation barriers, and uneven access to supportive services [1, 16, 46]. In this context, informal networks in our study often functioned as practical safety nets, providing material assistance and emotional buffering where formal systems were limited.

However, reliance on informal networks may also reflect gaps in survivorship care delivery [47–49]. When formal systems are fragmented or referral-based models are difficult to navigate, families and communities may absorb additional responsibilities [50]. Programs that assume equal access to time, financial resources, or supportive environments risk reinforcing disparities [10, 51]. Notably, fewer than half of behavioral interventions targeting Black and Hispanic/Latino cancer survivors incorporate both culturally appropriate strategies and behavioral frameworks [46, 52], pointing to an opportunity for culturally grounded, theory-based approaches.

Acculturation, immigration history and legal status, regardless of language proficiency, may influence survivors' access to cancer care and their reliance on informal support structures [1, 53–56]. A large proportion of Black and Hispanic/Latina participants in our study were born outside of the U.S., and for bilingual survivors in our sample, language proficiency or concordance was not identified as a barrier to accessing formal survivorship resources. Rather, cultural norms around family obligations, privacy, and concerns related to immigration or documentation status might influence survivors' willingness to seek formal support or disclose a need to institutions [55–57]. These dynamics may lead survivors to preferentially rely on informal networks perceived as safer [50, 57]. Survivorship programs and interventions specific for culturally and linguistically diverse patients may diminish barriers to care, promote engagement with resources and clinician recommendations [58, 59]. While our bilingual study design allowed participants to describe support in culturally meaningful terms, future research should examine how language, acculturation and immigration-related factors shape support network processes and behavior change.

Implications for Survivorship Care and Intervention Design

Our findings suggest that survivorship interventions may be more effective when they intentionally engage survivors' existing informal networks rather than focusing solely on individual behavior change. Family-centered and peer-supported approaches have shown promise in promoting physical activity and dietary change among cancer survivors [10, 22, 60]. Mobile app-based peer communities that incorporate accountability features have also shown improvements in physical activity and reductions in distress [61, 62], indicating that digital platforms may extend informal support beyond geographic boundaries.

Participants emphasized that information alone was not enough. Encouragement, shared participation, and practical assistance were central to sustaining behavior change. Linking provider guidance to community or peer-based resources may strengthen continuity beyond clinical encounters [5, 10]. Multi-level strategies that combine social network engagement with structural supports such as transportation, food access, or flexibility around caregiving, may be especially important for reducing disparities [10, 51, 52, 63, 64].

Strengths and Limitations

This study has several strengths. It centers the perspectives of Black and Hispanic/Latina breast cancer survivors, groups that continue to experience disproportionate structural barriers including persistent underrepresentation in cancer survivorship research. The bilingual study design allowed participants to describe support processes in linguistically and culturally grounded ways, deepening contextual understanding. The use of team-based qualitative analysis with strong interrater reliability enhances analytic credibility. Importantly, this study moves beyond documenting whether support exists to examining how it operates in daily life, offering insights that are directly relevant to intervention design.

Several limitations should also be noted. The qualitative, cross-sectional design does not capture longitudinal changes in social networks or lifestyle behaviors. Although participants reflected on

different survivorship stages, future longitudinal or mixed-methods research is needed to better understand how support dynamics evolve. The sample was drawn from a single geographic region, which may limit transferability. Data reflect survivors' perceptions rather than objective measures of support or behavior frequency, and variations in time from diagnosis among participants may have contributed to varying levels of selection bias. Finally, network structure, density, and digital forms of support were not systematically assessed. Integrating qualitative methods with social network analysis and examination of mobile app-based social support platforms would provide a more comprehensive picture of support processes during breast cancer survivorship.

Conclusion

Breast cancer survivors in this study described lifestyle behavior change as a relational process embedded in everyday social life. Healthcare providers were valued as trusted sources of guidance, but informal networks were central to carrying recommendations into daily routines and sustaining change over time. Interventions that connect clinical guidance with survivors' existing social relationships—while remaining attentive to structural and cultural contexts—may strengthen the durability and equity of lifestyle support during survivorship.

Declarations

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Declaration of conflicting interest

Oluwadamilola Fayanju reports research support unrelated to this work from Gilead Sciences, Inc., and honoraria for her service on AstraZeneca's Equity in Action Council. Other authors have no relevant financial or non-financial interests to disclose.

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Ethical approval and informed consent statements

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Verbal informed consent was obtained from all individual participants included in the study prior to the start of the interview.

Data availability statement

The data set generated during the current study is not available given the ongoing use of these data for analyses by our team.

Author contributions

Margaret Pichardo contributed to the original study conception and design. Material preparation and data collection were performed by Margaret Pichardo. Data analysis was performed by DB, LA, and SH. The initial draft of the manuscript was written by MSP and DB. All authors commented on previous versions of the manuscript and read and approved the final manuscript. Funding support and resources for data collection were provided by Melinda Irwin and Tara Sanft. Funding support and resources acquisition for this manuscript were provided by Oluwadamilola Fayanju.

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