ISSN: **3107-6513**

The Fractured Self of Filipino Educators with Life-Altering Health Conditions

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Abstract—

This qualitative phenomenological study explored the lived experiences of Filipino educators navigating life-altering health conditions such as cancer, chronic kidney disease, and cardiovascular disease, while maintaining professional roles within a selected school division in Negros Occidental, Philippines, during School Year 2025–2026. The study aimed to inform administrative policies, enhance teacher well-being, and guide workplace accommodations. Semi-structured, expert-reviewed interviews were conducted and analyzed using Moustakas's modified seven-step Van Kaam method to transcribe, code, and synthesize the narrative data into core thematic structures. The findings revealed "The Fractured Self" as the overarching theme, capturing an ontological crisis wherein educators experienced a dismantling of professional competence and personal vitality. This identity disruption encompassed four interconnected sub-themes: (1) Burden of Physical Debility and Sensory Distress, reflecting biological somatic betrayal; (2) Psychological Fragility and the Shadow of Uncertain Mortality, marked by emotional vulnerability and awareness of finitude; (3) The Veiled Self, involving social masking and seclusion to prevent professional alienation; and (4) The Dignity of Normalcy, characterized by resisting pity and negotiating professional image against patient reality. Ultimately, navigating a life-altering illness disrupted educators' physical capacity, emotional well-being, and professional identity, forcing a continuous inner negotiation between personal debility and professional dignity. To support affected faculty, educational leaders and managers must move beyond standard leave models by implementing flexible workload accommodations, establishing confidential and non-punitive disclosure channels, and offering structured, phased re-integration frameworks that honor teacher autonomy, preserve well-being, and mitigate professional alienation.

Keywords—*Fractured Self, Filipino Educators, Life-Altering Health Conditions*

I. INTRODUCTION

Educators shape the next generations to become productive members of society. They are instrumental in equipping learners with pivotal life skills, such as communication, logical reasoning, and reflective judgment. However, teaching transcends the simple scope of sharing knowledge. It has transformed into one of the most exhausting and demanding professions in the world.

Teaching has been commonly observed across the globe to cause higher rates of stress, burnout, depression, and anxiety than the general population (Cavallari et al., 2024). In the United States, the educators' anxiety disorder rate is higher than that of other professions, including the hospital and office workers (Kush et al., 2022). The National Education Association survey revealed that 67% of 3,621 educators found burnout a serious issue because of student absences and increasing workload (Peck, 2025). The effect of heavy workloads, high emotional labor, and administrative tasks is reported to deteriorate the health of educators (Lu et al., 2025; Pakdee et al., 2025; Carroll et al., 2022; Kariou et al., 2021; Harding et al., 2019).

In the Philippines, educational reforms have also been observed contributory to increased teachers' health risks. Excessive workloads, inadequate salary, managing oversized classes and student behaviors, and lack of administrative support were found to be major sources of stress (Maguate & Guarin, 2024; Asuncion & Santos, 2023). Research confirms that stress causes concentration and sleep disruptions, which elevate the risk of illness (Gonzales, 2024), and can eventually trigger worst-case scenarios such as depression and anxiety (Sarabia & Collantes, 2020).

Beyond common fatigue and physical ailments, stress directly triggers a higher incidence of cardiovascular diseases, anxiety, and depression (Yap et al., 2025; Chu et al., 2024; Satyjeet et al., 2020). In turn, stress and depression exacerbate the risk of developing chronic kidney disease while worsening the quality of life for affected individuals (Francis et al., 2024; Roy et al., 2024; Xu et al., 2024). Furthermore, educators may face an elevated risk of cancer, as chronic stress impairs immune responses, promotes tumor growth, and impacts multiple body systems (Shchaslyvyi et al., 2024; Lempesis et al., 2023; Liu et al., 2023).

Cancer, cardiovascular disease (CVD), and chronic kidney disease (CKD) are chronic conditions resulting from combined genetic, physiological, environmental, and behavioral factors, presenting unpredictable situations that significantly alter daily life (World Health Organization, 2024; Benkel et al., 2019). Indeed, cancer and cardiovascular diseases account for nearly half of all mortalities among adult Filipinos and Malaysians (Khetan et al., 2024), while CKD further contributes to an elevated CVD risk among adult cancer patients (Liu, 2023). In

ISSN: 3107-6513

an educational context, managing these severe conditions raises critical concerns regarding teacher absenteeism, disrupted curriculum delivery, and classroom discontinuity (Jones-Carmack, 2024). Consequently, these disruptions can diminish student engagement, impacting both academic performance and long-term career development (Guo et al., 2025; Li & Xue, 2023; Saucier et al., 2022; Zhang et al., 2024).

Initiatives that prioritize educators' health are therefore essential to sustain professional longevity, as teacher well-being directly influences overall job performance (Perez & Madrigal, 2021; Taylor et al., 2024; Teacher Development Trust, 2025). Furthermore, established frameworks emphasize the government's duty to ensure that health and well-being policies are accessible, well-funded, and effectively implemented World Health Organization, 2022). In the Philippines, several statutory directives address these needs such as Article IV of Republic Act No. 4670 (the Magna Carta for Public School Teachers), which outlines key health measures; Civil Service Commission Memorandum Circular No. 41 (s. 1998) that details sick leave provisions; and Executive Order No. 64 (s. 2024) that increases the annual medical allowance for DepEd personnel to ₱7,000 (DepEd Calabarzon, 2025). While such measures ease financial burdens, comprehensive reforms are still required to strengthen work ability, support workplace reintegration, and establish targeted return-to-work programs across the education sector (Afia et al., 2023; DOLE Labor Advisory No. 20, Series of 2023).

Impelled by these circumstances, this phenomenological research aimed to explore the lived experiences of educators with life-altering health conditions in a selected school division in Negros Occidental. This study aimed to increase awareness among educational leaders and managers to make informed decisions to initiate programs that foster well-being and emotional support; develop a supportive school environment, augment performance and retention, amend practices and policies on leave, and devise modified work schedules or assistive aides for educators who remain serving despite their conditions.

II. METHODOLOGY

This study utilized a qualitative phenomenological approach to explore the lived experiences of practicing educators with life-altering health conditions as they navigate their professional duties. Phenomenological inquiry aims to describe and grasp the universal essence of a phenomenon (Creswell, 2024), while preventing predetermined biases from influencing understanding. By examining human lived experiences to gain a profound understanding of how individuals make sense of them (Bekele & Ago, 2022), this design was ideal for obtaining insights into participants' resilience across biological, psychological, social, and spiritual dimensions while maintaining active teaching careers. The study was conducted within a selected school division in Negros Occidental, Philippines. The social, geographical, and administrative context of this locale provided a focused and accessible population appropriate for the study's phenomenological nature.

A. Selection Criteria and Participants

Participants were classroom teachers facing life-altering health conditions such as cancer, chronic kidney disease (CKD), and cardiovascular disease (CVD). Purposive sampling and strict inclusion criteria yielded 14 qualified participants, achieving data saturation while aligning with phenomenological sample recommendations of 5 to 25 participants (Bekele & Ago, 2022). Inclusion required current employment in the division, medical verification of cancer, CKD, or CVD, active treatment or post-treatment duty, and willingness to share rich insights. Participants confirmed physician notification via signed consent and notarized sworn statements. Recruitment involved word-of-mouth, school administrators, support groups, the division health unit, and teacher associations, screened via an eligibility questionnaire. Participants signed informed consent forms outlining study objectives, privacy, and withdrawal rights, and engaged in 30- to 60-minute semi-structured interviews.

TABLE I. SUMMARY OF PARTICIPANT DEMOGRAPHIC AND PROFESSIONAL PROFILES

Participant ID	Age	Sex	Number of Years Teaching	Health Condition Category *(Cancer, CVD, or CKD)*
P1	52	F	12	Cancer
P2	29	F	8	CVD
P3	55	M	29	CVD
P4	55	F	13	CVD
P5	43	M	14	CKD
P6	50	F	27	Cancer
P7	58	F	34	Cancer
P8	44	F	10	CKD
P9	51	M	28	CVD
P10	27	F	3	CVD
P11	57	F	33	CVD
P12	56	F	33	Cancer
P13	30	F	8	CVD
P14	49	F	9	Cancer

B. Data Collection

Data were gathered through in-depth semi-structured interviews approved and validated by four qualitative research experts. The protocol was reviewed by a practicing psychologist and Registered Guidance Counselor to ensure participant safety, featured open-ended questions covering physical, emotional, social, professional, and spiritual dimensions, along with support systems. Audio-recorded in private settings with a counselor present or on standby, sessions used pseudonyms to protect participant identity.

C. Data Analysis

Verbatim interview transcripts were analyzed using thematic analysis to extract the eidos, or essence, of the phenomenon (Farrell, 2020; Philosophy Institute, 2023). Following the modified seven-step Van Kaam method (Moustakas, 1994; Galinha-de-Sá & Velez, 2022; Roman-Sanchez, 2022), data analysis involved horizontalization by treating all expressions equally and removing repetitive statements (Moustakas, 1994; Owusu, 2022). Horizons were reduced into core themes, clustered, and validated against original transcripts. Textural descriptions captured what was experienced, structural descriptions utilized imaginative variation to detail how it occurred, and intuitive integration synthesized these into a unified statement of essence.

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D. Methods of Validation

Trustworthiness was established using Guba's criteria (Kakar et al., 2023). Credibility was ensured via researcher self-awareness (Ahmed, 2024) and member checking with signed participant verifications (Slettebø, 2020; Stahl & King, 2020; Delve & Limpaecher, 2023). Transferability was maintained through thick contextual descriptions (Haq et al., 2023; Riazi et al., 2023). Dependability was secured via process documentation, audit trails (Amin et al., 2023; Eryılmaz, 2022), and external audits of coding ledgers and thematic maps. Confirmability was achieved through reflexive journaling, peer debriefing, inter-rater checks, and a subjectivity statement (Haq et al., 2023; Rose & Johnson, 2020).

E. Ethical Considerations

The study strictly observed beneficence, non-maleficence, and respect for persons (Akaranga & Makau, 2016). Voluntary written consent and sworn statements confirming medical clearance were secured prior to data collection. Continuous debriefing protocols were integrated after interviews and during member checking under RGC supervision to safeguard psychological well-being. Participation remained strictly voluntary without institutional risks. Confidentiality was preserved by assigning pseudonyms and masking institutional identifiers. Finally, ethical review and approval were secured from the Research Ethics Committee of Philippine Normal University before data collection, and ethical standards of authorship and data ownership were maintained.

III. RESULTS AND DISCUSSION

The Fractured Self

A life-altering diagnosis triggers an ontological crisis that dismantles the integration of an educator's personal vitality and professional competence (Spencer & Almack, 2022). In education, instruction relies on the physical body as the primary pedagogical tool and conduit of relational energy (Lopes, 2012; Yoo, 2017). When chronic illness strikes, this instrument fails, precipitating an existential, psychological, and physical breakdown (Morris, 2020). Grounded in the Biopsychosocial-Spiritual Model (Engel, 1977; Tumulak et al., 2024). The Fractured Self illustrates how physiological disease initiates a feedback loop of psychological fragility and biographical disruption (Bury, 1982; Galbadage, 2020), forcing educators into an ongoing struggle to reconcile a vulnerable health status with a functional identity (Locock et al., 2026; Spence et al., 2023) 68]. This daily lifeworld of biological suspense was articulated by the participants, who described navigating routine activities with the constant, unsettling awareness of being "like a walking time bomb." Clinically, this chronic fear manifests in heightened comorbid anxiety, depression, and marked declines in health-related quality of life (Bakhsh & Mahallawi, 2025; Hwang & Oh, 2024), as highlighted by Participant 1's recall of trembling uncontrollably upon diagnosis under the immediate threat of impending mortality (I was shaking and the first thing that entered my mind was that I was going to die). Although Philippine policy shifts such as DepEd Order No. 002, s. 2026 (Wellness Leave) and DO No. 5, s. 2024 (Workload Rationalization) aim to prioritize teacher welfare (Lajara & Acielo, 2026), a structural paradox persists: formal institutional provisions directly clash with pervasive school cultures of teacher martyrdom, forcing ill educators into exhausting emotional labor to project competence while their bodies collapse (Agbayani-Pineda, 2025; Köskün, 2025). Serving as the overarching theme for these findings, The Fractured Self manifests across four interlinked sub-themes: *(1) Burden of Physical Debility and Sensory Distress, (2) Psychological Fragility and the Shadow of Uncertain Mortality, (3) The Veiled Self,* and *(4) The Dignity of Normalcy.* This phenomenon encapsulates the continuous, self-evaluative negotiation between the former and present self in adapting to chronic illness (Manea et al., 2023).

Burden of Physical Debility and Sensory Distress

For the ill educator, chronic illness triggers a distressing ontological shift. The classroom, which once served as a space of vibrant relational energy, pedagogical flow, and unchallenged authority, is abruptly transformed into a landscape of constant physical peril and sensory vulnerability. Grounded in the biological dimension of the BPSS framework, physical ailments are fundamental disruptions that thoroughly dismantle an individual's lived reality and loss of agency (Tumulak et al., 2024; Carel, 2021). Teaching is a fundamentally embodied act wherein educators rely on the body as their primary pedagogical instrument; thus, chronic illness triggers a painful alienation from both flesh and vocational space (Lopes et al., 2012; Yoo, 2017). The body, formerly an invisible, reliable instrument of professional service, rebels to become an unpredictable source of acute distress and deep alienation, precipitating a permanent "bodily doubt" that forces a reflective epoché regarding a teacher's past and future self (Galbadage et al., 2020). For teachers, this severe debility becomes an enveloping context where structural precariousness and imminent pathology redefine their daily ongoingness and survival. This is not a fatigue that can be slept away; it is experienced as a total, inescapable collapse of the life-force itself. Participant 1, Participant 6, and Participant 12 describe a lifeworld where energy has completely bottomed out, leaving them anchored to a state of permanent, heavy weakness ("My body collapsed, it changed... my energy level dropped"—P12). This sense of profound depletion is vividly captured by Participant 2, who notes: "I experienced frequent fatigue and occasional chest pain... I often feel drained and exhausted even after a full night's rest." This phenomenon is empirically validated as a hallmark of life-altering health conditions, as educators facing oncological crises encounter an immense toll on their physical baseline that directly diminishes their capacity to project a professional presence (Homkes, 2023). This ontological transition is driven by an unrelenting depletion of somatic capital manifesting as an overwhelming exhaustion that completely defies the restorative promise of rest (Homkes, 2023).

Perhaps most harrowing are the somatic descriptions of chest pain, which strip away the professional exterior to reveal raw, unadulterated physical agony. While Participant 2 notes frequent, lingering discomfort, Participant 14 likens the sensation to the violent impact of being "punched." This somatic trauma is echoed by Participant 4, whose description reveals how physical suffering intertwines with existential panic: *"Then my chest started to hurt as if it were splitting apart... but in my mind, I was thinking I might be having another stroke."* Here, the flesh becomes a site of terror, where a localized physical sensation immediately triggers the psychological trauma of anticipating a fatal medical event.

Beyond the immediacy of felt pain lies the constant, quiet anxiety of the invisible, the phenomenological burden of living as a fundamentally compromised being in a contaminated

world. Participant 1 and Participant 7 articulate the high-stakes vulnerability of navigating public school spaces with a severely damaged immune system: "That period was extremely challenging and risky due to the threat of the virus, especially with my weakened immune system." (P7). This alienation from the former, healthy self culminates in a deep biographical fracture. Participant 11, lying awake through nights defined by high fevers and deep muscle aches, undergoes a profound shift in self-awareness: "At night, I got a fever, all my body muscles are aching. That's the time I told myself that I'll always remember that I am already a different person." This realization marks the definitive end of the internalized habit of limitless self-sacrifice, as the structural transformation of the biological body permanently alters a teacher's appearance, stamina, and voice, creating a painful, alienating disconnection from their established professional identity.

Experienced as a total collapse of life force, this severe fatigue reduces daily life to an hour-by-hour struggle to maintain basic consciousness, forcing ill teachers to rely on artificial stimulants or push through until total internal breakdown (Brown & Leigh, 2020). Under this weight, movement becomes a calculated risk; simple motor acts, standing, or traversing the classroom invoke severe spatial anxiety, pre-syncope, and fear of falling (Galbadage et al., 2020). Sudden, violent sensory intrusions such as acute heart palpitations, dizziness, and excruciating chest pain shatter professional composure, reflecting documented occupational cardiovascular risks (Orlova et al., 2024). Furthermore, immunocompromised states from treatments like chemotherapy expose teachers to extreme infection risks (Abdollahimohammad et al., 2019; Clegg et al., 2013), while metabolic imbalances and fluid retention induce paralyzing physical cramps (Orlova et al., 2024). This somatic betrayal eventually breaches cognitive faculties through Cancer-Related Cognitive Impairment or "chemo-brain," severing thoughts from speech and severely impairing executive function and instructional delivery (Boykoff et al., 2009). Ultimately, this state of profound physical frailty runs into direct conflict with traditional, ableist institutional expectations that romanticize performing through pain (Brown & Leigh, 2020). In the Philippine public school context, heavy non-teaching administrative burdens force ill teachers to divert critical recovery energy toward bureaucratic compliance (EDCOM 2, 2025; Medez, 2024). To counter this biological depletion, school heads must operationalize a whole-person approach grounded in humanized, transformational leadership, providing concrete accommodations, administrative relief, flexible scheduling, and compassionate re-integration to preserve experienced staff and safeguard their healing process (Bam & Lulema, 2025; Costa, 2025).

Psychological Fragility and the Shadow of Uncertain Mortality

Beyond physical debility lies an intense mental battle where somatic distress turns into existential panic and a cognitive preoccupation with mortality (Noe-Steinmüller et al., 2024; Weimer & Vaughan-Marra, 2022). Unreliable bodily feedback drives interoceptive hypervigilance, transforming classrooms into spaces of psychological suspense (Nebel et al., 2025; Robinson et al., 2024). Their narratives reflected a mental landscape where, as Participant 1 articulates, "The real battle happens in the mind…" This internal struggle is defined by persistent "bouts of depression and anxiety" (P1, P5) and a heavy, lingering sense of "self-pity" (P1). This psychological fragility describes an ontological crisis where the professional environment, once an unchallenged arena of control, pedagogical flow, and authority, is transformed into a theater of unrelenting biological and psychological suspense.

A formal diagnosis or a sudden, catastrophic health crisis, such as a stroke, serves as a violent, unmasked reminder of life's fragility. Participant 4 recounted how anxiety and stress spiked following an acute stroke, driven entirely by a singular, intrusive, and terrifying thought: "I thought I was going to die." This sentiment was echoed by Participant 13, who noted that while the medical diagnosis itself was not a complete shock, "it drove home for me that I could die." From the very beginning of her oncology treatments, Participant 14 lived with the agonizing uncertainty of "whether I would survive or not", a persistent fear that Participant 7 described as the deep dread of "prolonged suffering" and the constant, haunting possibility that she could be "lost entirely." This shadow of uncertainty and the acute fear of sudden death are conceptualized in recent literature as death anxiety (Bharti & Bharti, 2024).

Moreover, this existential panic rapidly extends outward into the familial sphere, as teachers like Participant 6 grapple with intrusive, distressing questions that bridge their professional identity with their domestic responsibilities: *"Gosh, will I die from this illness? Oh no, what will happen to my family?"* The psychological weight of a chronic, debilitating illness can become entirely unbearable, leading to a state of total existential despair. This is poignantly and tragically illustrated by Participant 5, who reached a severe psychological breaking point where the combined, unyielding pressure of clinical depression and anxiety led to an explicit desire to "end my life just to have an instant escape from everything." This dark depth of despair is fueled by a total lack of bodily control and a loss of personal independence, alongside an intrusive, recurring fear described by Participant 1 that *"anytime something worst could happen like I might suddenly die."* This is mirrored in the experience of Participant 2, who lived with the constant, threatening "warning of having a heart failure" looming over his daily instructional life.

This profound erosion of the self is further complicated by the loss of an autonomous life, intense vocational loneliness, and severe emotional imbalance. The participants' experiences confirm that being forced into a state of physical dependency, coupled with the resulting deprivation of everyday operational spontaneity, creates a paralyzing sense of uncertainty that drastically shrinks temporal horizons (Bharti & Bharti, 2024). Teachers also dread public loss of control or physical embarrassment, such as fainting during instruction or having a wig dislodged in front of students and peers. Neoliberal performativity cultures exacerbate this strain by punishing human frailty (Perryman, 2024). To mitigate this vulnerability, school heads must counter systemic pressures through compassionate leadership (Brierton, 2024) and psychological safety (I & Kamalanabhan, 2025), operationalizing DepEd Order No. 14, s. 2020 and DepEd Memorandum 072, s. 2021 to replace rigid compliance with institutional care (Tual & Omandam, 2023).

The Veiled Self

Another unique struggle that emerged from the participants' narratives pertained to the teacher's public image and the sudden, devastating deterioration of their aesthetic identity. The expectation that teachers must remain unbroken pillars of strength compels ill personnel to adopt defensive seclusion to protect their dignity and remaining energy (Iovino et al., 2023). This highlights the profound phenomenological struggle of ill educators to safeguard their vulnerability amidst distressing bodily changes by deliberately retreating into protective seclusion. Rather than exposing their altered physical states to public scrutiny, they consciously erect rigid boundaries to preserve their emotional stamina and defend their inner lives from the intrusive gaze of the school community. For these participants, the fractured self is not merely an internal, invisible psychological state; it manifests outwardly as a deliberate, calculated withdrawal from the social and professional circles they once anchored—a defensive move toward seclusion driven by a profound sense of physical insecurity and a critical need for emotional and biological protection.

The physical toll of invasive medical treatments often leaves visible, dramatic markers that shatter an educator's professional image. Participant 1 shares the intense internal conflict of self-acceptance versus social shame, noting: *"I have accepted my condition, but I am ashamed of being bald."* This sudden loss of hair is experienced as a devastating blow to their core identity, with Participant 1 admitting, *"Seriously, my level of confidence was greatly affected."* This sentiment is echoed with raw, unmasked vulnerability by Participant 14, who recalls the early days of her diagnosis: *"I was embarrassed to go out when my hair first started falling out... I felt so ugly. No eyebrows, no hair. I looked really terrible."* These distressing accounts find deep resonance in recent research on appearance-altering conditions, where a systematic meta-synthesis by Hurrell et al. (2026) outlines how hair loss profoundly damages everyday social interactions. Dramatic aesthetic alterations, including alopecia, surgical scars, and extreme weight changes, induce deep shame and disrupt professional self-concept as individuals continuously struggle to manage the sharp discrepancy between their internal identity and their outward, altered appearance (Hurrell et al., 2026; Hurrell, 2026).

Beyond aesthetics and appearance, protective seclusion becomes a strict matter of biological and psychological survival. Participant 1 describes a heartbreaking but necessary shift in her pedagogical style and spatial presence: *"I intentionally keep distance from my students since I was immunocompromised... just to protect myself."* Here, the foundational teacher-student bond is physically severed by the absolute necessity of a biological buffer to prevent opportunistic infections. This defensive distancing is not limited to students; Participant 6 describes a similar, protective wall built directly within the faculty room: *"I created a gap with my co-teachers. I don't join their conversations."* For Participant 6, this disengagement serves as a safeguard to manage unpredictable mood fluctuations, fearing they might inadvertently say something hurtful because, as they state, *"I can't predict my own mood."* A third participant established emotional boundaries to protect against cardiovascular stress, while post-stroke cognitive decline further generated social hesitation, as described by a participant who admitted to hesitating during interactions due to fear of verbal disorientation. This retreat frequently manifests as an intentional detachment from the everyday trivialities and dramas of school life. Participant 13 describes adopting a detached *"'I don't care' or 'I don't mind'"* attitude, no longer concerning himself with *"unnecessary trivial matters"* in order to shield his heart from emotional stress. However, this protective detachment is often tinged with intense performance anxiety. Participant 4 shares the deep hesitation that accompanies cognitive and physical decline following his stroke: *"Sometimes I feel embarrassed because I feel something changing for the worse inside me. I hesitate to interact sometimes because I'm afraid I might say something strange or off."* The statements from Participant 4 and his peers highlight how acute physical insecurity and cognitive fluctuations lead to a protective seclusion where the educator voluntarily withdraws to avoid the perceived shame of their condition. This withdrawal not only disrupts classroom procedures, instructional continuity, and curriculum delivery but it turns the professional environment into a cold space of isolation rather than one of collaboration.

Furthermore, for those navigating chronic kidney disease like Participant 5 and Participant 8, the grueling hassle of dialysis procedures demands massive logistical adjustments that alter regular social intercourse and drastically increase their reliance on others, which can severely strain familial and collegial relationships alike. For teachers like Participant 14 and Participant 2, who feel "*embarrassed to go out*" or find it *"challenging to maintain close relationships,"* these unpredictable flare-ups and invisible symptoms frequently cement a state of silence and isolation that requires deliberate professional modifications and structured communication frameworks. Together, these shards of experience depict educators who are hiding in plain sight, physically present in their classrooms but emotionally, socially, and relationally secluded to protect the fragile remains of their health, dignity, and socioeconomic stability. This protective withdrawal, however, does not occur in a vacuum; it is heavily exacerbated by the inherently demanding, high-scrutiny nature of the teaching profession itself, where rapid technological shifts, intense administrative overloads, and constant societal monitoring make it increasingly challenging for educators to maintain baseline well-being.

These deliberate wall-building and distancing behaviors are recognized in modern organizational psychology as specific forms of stigma management. Stigmatized or chronically ill individuals frequently employ explicit "boundary management" and "information management" to construct a temporary safe haven away from the constant threat of professional judgment or pity. However, while concealing symptoms is used to maintain a facade of a competent professional image, it is intensely cognitively exhausting and leads directly to compounding social isolation, vocational loneliness, and severe strains on long-term professional relationships. Grounded in Goffman's Theory of Stigma, this intentional retreat acts as a strategic barrier against public scrutiny and professional burnout (Chaudoir et al., 2013; Puhakka, 2021). To support these "veiled" educators, local leaders must foster inclusive environments that normalize health disclosures without fear of judgment, utilizing policy

ISSN: **3107-6513**

flexibilities such as DepEd Memorandum No. 024, s. 2026 (Blended Learning during severe hazards) and DepEd Order No. 002, s. 2026 (Wellness Leave) to safeguard teacher well-being (Merto & Mañacap, 2025; Olapane, 2026).

The Dignity of Normalcy

The final sub-theme, The Dignity of Normalcy, highlights the profound phenomenological struggle of ill educators to preserve their professional identity against the encroaching, marginalizing label of the vulnerable patient. It captures the participants' deeply human desire to be seen for their professional capabilities and enduring identity as educators, rather than being defined by their medical conditions. Consequently, this reflects their active struggle to resist unsolicited pity, maintain control over how they are perceived within the school community, and preserve a sense of ordinary, respectful professional life amidst the disruptions of chronic illness. For these teachers, the social holding of their experience is best achieved through the absolute absence of overt sympathy. For Participant 1, the desire for a completely normal work environment operates as a psychological defense mechanism against the reality of a life-threatening illness: *"I want them to act normally as if nothing happens… I don't want to feel like I'm really sick... as long as they don't overdo it to the point where I seem so pitiful."* This sentiment is shared by Participant 14, who expresses a raw, visceral distaste for the pitiful label: *"I hate hearing people treat me like that... it feels awful to be the object of pity."* This fierce resistance to sympathy often stems from the intense social stigma and institutional alienation associated with chronic conditions.

Maintaining a completely normal atmosphere serves as an essential psychological anchor amidst the ongoing disruptions of chronic illness. Participant 3 finds internal peace in the absolute absence of special treatment, stating: *"It feels just normal, and that's what I want—for everything to just remain normal."* Similarly, Participant 6 completely rejects the visible, anxious concern of onlookers: *"I don't want them looking so concerned or acting like they pity me."* By insisting that peers and students act normally, these educators attempt to prevent their medical condition from becoming the defining, central feature of their professional relationships. For many educators, looking fine is a highly deliberate tactic. Teachers with chronic conditions manage their ever-present and often invisible symptoms through meticulous silence to consciously avoid the devastating stigma of being perceived as less competent, physically fragile, or pitiful.

Even when caught in this structural vice, participants like Participant 14 remain completely resolute: *"I want things to be normal, as if nothing happened. I don't want to be constantly reminded that I am sick."* The internal desire to protect loved ones and colleagues from the crushing emotional and logistical weight of their illness often leads to a self-imposed, protective isolation. Participant 4 frames this performance of normalcy as an altruistic act for his family's future: *"I want us to continue acting normally despite what happened to me... I don't want to be a hindrance to their dreams."* For Participant 10, the terrifying fear of being an encumbrance is so profound that it directly dictates her social habits and isolation: *"Lately I've chosen to spend more time alone because I don't want to feel like a burden to anyone."* When the physical body can no longer meet the performance-first, highly optimized demands of the modern workplace, individuals frequently experience a painful forced recalibration of their roles (Nebel et al., 2025). This recalibration often results in severe social withdrawal as a desperate way to protect both their own professional dignity and the emotional well-being of their families, caregivers, or colleagues (Nebel et al., 2025).

This desperate attempt to manage outward perception often leads to a painful, alienating disconnect with the outside world. Participant 10 shares the heavy emotional toll of being structurally misunderstood: "*Some people who don't know about my diagnosis think I'm overreacting or simply uninterested... This affected me emotionally because I feel misunderstood."* This implies that the acute fear of professional judgment, negative evaluation, or severe job insecurity frequently prevents educators from ever divulging their medical conditions to the wider school community.

In line with the social domain of the BPSS Model, ill educators actively resist the marginalizing label of the vulnerable patient, fighting to protect an ordinary professional standing (Tumulak et al., 2024). Rather than seeking overt sympathy, participants preferred an unexceptional work environment as a vital psychological anchor and defense against bodily doubt (Nebel et al., 2025). Preserving routine provides continuity, allowing teachers to retain professional agency (Jones, 2020) and protect their families from distress. However, hiding severe symptoms to maintain a facade of peak performance forces teachers into high rates of presenteeism while critically ill, which consumes vital physiological energy needed for biological recovery (Biron et al., 2022; Sharma, 2025). Theoretically aligned with Goffman's Impression Management (Nickerson, 2026), this drive to project unbroken competence turns daily teaching into exhausting emotional labor (Mellors & Gaspar, 2025). School administrators must adopt compassionate management that respects The Dignity of Normalcy (Harris & Jones, 2023), delivering discreet, confidential accommodations that treat health adjustments as standard professional modifications rather than acts of pity (Bonneveux et al., 2025).

CONCLUSION

The findings of this inquiry demonstrated that navigating a life-altering health condition as an educator precipitated a profound ontological crisis conceptualized as The Fractured Self that disrupted the fundamental synthesis of professional identity, physical capacity, and psychological well-being. The study revealed that chronic illness was experienced not merely as an isolated clinical impairment, but as an existential breakdown of the body as a pedagogical tool. Educators continuously negotiated a delicate boundary between personal debility and professional dignity across four interlinked dimensions: the physical burden of somatic betrayal and cognitive fatigue, the psychological suspense of mortality anxiety, the strategic social seclusion of The Veiled Self, and the active preservation of professional agency through The Dignity of Normalcy. These empirical insights carried significant theoretical and practical implications for institutional governance within educational systems. First, educational policy had to dismantle pervasive cultural paradigms that romanticized physical sacrifice and presenteeism, recognizing embodied vulnerability as a

universal human condition to support faculty without imposing social stigma or forcing defensive professional masking. Second, to bridge the persistent policy-practice gap, school systems needed to operationalize compassionate management by embedding structural flexibilities into daily operations, including non-punitive workload downscaling, administrative relief, remote or blended instructional modalities during health crises, and specialized wellness leave provisions. Finally, institutional support had to respect educators' autonomy and desire for professional normalcy by delivering confidential, humanized accommodations that transformed health modifications into standardized professional adjustments rather than discretionary acts of pity. Ultimately, preserving the sustainability of the teaching force required shifting from an administrative culture centered purely on bureaucratic output to one grounded in humanized, transformational leadership, establishing confidential disclosure channels, psychological safety nets, and phased re-integration frameworks that safeguarded the well-being of chronically ill educators while honoring their enduring vocational wisdom, biological survival, and human dignity.

RECOMMENDATIONS

Based on the findings of this study, the following recommendations are structured for educational policy, leadership, and practice.

1. Policy frameworks must explicitly decouple professional commitment from physical self-sacrifice. Revise faculty evaluation metrics to assess pedagogical impact and output rather than physical presence or excessive overtime.
2. Conduct institutional awareness initiatives that normalize human vulnerability and chronic illness, shifting organizational culture away from expectations of ideal, stoic bodies toward inclusive workplace norms.
3. Establish formalized, standard mechanisms for temporary or permanent workload downscaling, administrative duty waivers, and flexible instructional modalities (e.g., hybrid teaching, asynchronous course design, co-teaching models) during active health flare-ups.
4. Develop flexible, banked, or intermittent medical leave policies tailored specifically to chronic illness, allowing faculty to manage non-linear health conditions without exhausting standard sick leave or facing career penalties.
5. Transition wellness accommodations from discretionary acts of mercy or principal-dependent favors into standardized rights and entitlements.
6. Create safe, centralized disclosure channels that protect educator privacy, preventing the need for defensive professional masking or forced public self-disclosure.
7. Establish structured, gradual re-entry programs for educators returning from medical leave to prevent immediate physical burnout and cognitive fatigue.
8. Preserve the professional dignity and identity of chronically ill educators by pairing them with specialized advisory, mentoring, or curriculum-design roles when full-time classroom instruction becomes physically unfeasible.

ACKNOWLEDGMENTS

The completion of this study stands as a milestone in my growth within educational leadership, a journey made possible through the Almighty God, whose sustaining grace provided the strength to run this race for His greater glory. I extend my profound gratitude to my adviser, Dr. Noel S. Marañon, for his expert mentorship in bridging human narrative with structural leadership demands. I am deeply indebted also to the fourteen educator-participants whose radical honesty and endurance anchored this study.

ETHICAL APPROVAL

The study proposal was submitted to the Philippine Normal University Research Ethics Board for ethical review and obtained the Clearance to Proceed with Reference Number: PNU-MN-2025-OVR-FM-008 dated December 9, 2025. Upon completion of the study, a second round of ethical review was conducted, and the Certificate of Compliance with Reference Number: PNU-MN-2025-OVR-FM-018 was finally granted on July 29, 2026.

DECLARATION OF AI USE

This manuscript was prepared through the intellectual contributions of the author(s) to the study design, data analysis, interpretation of results, and scholarly content. Google Gemini was used solely to assist with reference formatting. The authors accept full responsibility for the accuracy, integrity, and final content of the manuscript.

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