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Sexual Self-Schema, Perceptions of Breast Talk, and Physical Self-Concept in Breast Cancer Survivor

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ABSTRACT

The quality life of breast cancer survivors has been the psychology's focus of attention. However, studies discussing their sexuality highlighted from the social psychology perspective are still not very much, especially in Indonesia. This study aimed to predict sexual self-schema of breast cancer survivors based on their perceptions of the breast talk and physical self-concept. This study used a predictive-correlational design and employed psychological scales measuring instruments, multiple linear regression data analysis technique as well as purposive sampling method. This study was conducted on 130 women breast cancer survivors (M_{age} = 39.45 years old; SD_{age} = 3.542 years; all been married) in Special Capital Region of Jakarta - the capital city of Indonesia, and its surrounding areas (Bogor, Tangerang, and Bekasi). The study results showed that the perception of functional breast talk and physical self-concept are able to predict sexual self-schema in positive directions. Other perceptions of breast talk (medicalized, gendered, and sexualized breast talk) are not able to predict it. This study has important implications in order to improve the life quality of the survivors, namely by managing fair discourses about breast in the public and keeping the proper physical self-concept since the early stage of life.

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1. INTRODUCTION

Although there is no cancer registration in Indonesia at the national level, it is known that according to the recent data from 12 cancer registration centers in Indonesia in 1994, breast cancer is the second most common cancer after cervical cancer [1]. Gautama [2] of Dharmais Cancer Hospital even stated that breast cancer is the number one cause of death of women in Indonesia. Psychology has been, still is, and will always give pivotal contributions to the prevention, treatment, and control of cancer [3]. "Quality of life" is one of the important psychological keywords in the applied research of health psychology, including towards breast cancer survivor. By identifying problems that constrain the quality of life, as well as the predictors of that problem, cancer survivors would be helped to live her life fully and optimally. Quality of life is [4] (p. 1):

> "*individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns. It is a broad ranging concept affected in a complex way by the person's physical health psychological state, level of independence social relationships, personal beliefs and their relationship to salient features of their environment."*

Concerning to the quality of life, Ratna stated that the cancer situation may disturb emotional relation between couples through the decision of no longer having sexual intercourse, with the assumption that sexual activity can lead to fatigue and make the cancer more severe [5]. Silence and absence relating to sexual life in this context are situations regarded by many people as "reasonable", although we also recognize that these things have an impact on the quality of life. The decrease in sexual life quality can indeed be an objective physical effect of therapy and medications (e.g. because of their impact on the hormonal system), but also can be the result of *social decisions* taken by the couple on the basis of *perceptions* (for example, the perceived sexual attraction, and perceived sexual capacity). Meanwhile, in fact, pleasure and sexual satisfaction and orgasm as well are not impossible things to happen when cancer survivors experience changes in their sexuality [6].

Sexuality remains as an important dimension of the quality of life after a woman has been diagnosed with breast cancer [7]. The possibilities of sexual life in breast cancer survivors become critical to investigate because, according to Ratna, sexual needs that are not well managed by cancer survivors and their partners will lead to potential sexual dysfunction not only in cancer patients but also on their partners, as well as the potential of infidelity [5]. This is the main urgency of the need for this study.

In their review of numbers empirical research findings pertaining to the sexual psychology of breast cancer survivors, Emilee, Ussher, and Perz found that their sexuality can be summarized as a result of the dynamic interaction between the material aspect (the possibility of sexual dysfunction), intrapsychic aspects (emotional and body image changes due to physical changes), and socio-cultural aspects (sexual renegotiation with partners, and discursive construction of breasts) [8].

This present study focused on the social psychological aspects of the sexual life of women breast cancer survivors. Wilmoth found through his qualitative empirical research that altered sexual-self is an integral aspect of the change in the identity of a breast cancer survivor [7]. Unlike the experience of peri-menopause, this alteration is comprehended more influential by the women because it starts earlier, runs faster and is life-threatening as well. Giving meaning to the new sexual identity obtained after undergoing diagnosis and therapy is part of the self-growth of the survivors. Still in relation to the self dimensions, Markopoulos et al. found that the types of surgery (breast-conserving *vs.* mastectomy with delayed breast reconstruction *vs.* modified radical mastectomy) are variables that moderate the psychological impact of breast cancer diagnosis on self-esteem [9]. Based on these two studies [8],[9], the author argued that self dimensions are the most fundamental entity and that most widely affected by a cancer diagnosis because the self is "the subject of experience" [10] (p . 24). However, different from the existing previous studies, this study specifically paid attention to sexual self-schema of the survivors. Self-schema is a mental structure that people use to organize knowledge about themselves [11]. Sexual self-schema is "cognitive generalizations about the sexual aspects of oneself ... and they guide sexual behavior" [12] (p. 1079). It is important to know the sexual self-schema because this scheme is a central element of sexual life that can predict sexual satisfaction or also sexual problems/difficulties, and further it has a relational impact on sexual partner [13]. To the same stressor attacking a person's sexuality such as breast cancer, one can perform a variety of sexual responses (active *vs*. passive) depends on her sexual self-schema (positive *vs*. negative).

As mentioned by Emilee et al., the social aspect plays a role in the sexuality of breast cancer patients [8]. One of the social aspects raised in this research is the discourse about woman's breast, which is about issues discussed by the public about the breast, or "breast talk". These things are the social constructions that indicate the creation of meaning by the public, which accommodate the socio-historical-cultural context [14]. The narration in the social-community level greatly affects the individual's life; it is no exception for the cancer survivor. Giddens [15] suggested that an understanding of the agentic dimension of a person should be integrated with the consideration of her social action. Humans indeed have a reflexive action that affects the community, but she is also the reproduction of her social life [15]. In relation to breast cancer, Langellier and Sullivan defined breast talk as one's "references to breasts and the specificity of the breast as the site of their cancer, including physical manifestations ...., as well as statements about femininity, body image, and sexuality .... [consisting of] breast as medicalized body parts; breasts as functional to breastfeeding and the body's motility; breasts as gendered to signal women's femininity and body image; and breasts as sexualized" [16] (p. 78, 79). Thus, the society in the context of Langellier and Sullivan's research is the breast cancer survivor communities. Thomas-MacLean revealed the significance of knowledge about the phenomenological dimension of the structure and content of illness stories of breast cancer survivors that were investigated in a study [17]. This kind of investigation may facilitate cancer survivors to understand themselves and their diseases, and it can ease the communication and relationships with healthcare practitioners.

Based on the above description, this study hypothesized (H1, H2, H3, H4) that the perceptions of medicalized breast talk, functional breast talk, gendered breast talk, and sexualized breast talk consecutively are able to predict sexual self-schema from the breast cancer survivor.

In addition to breast talk, another variable that is supposed to predict sexual self-schema is physical self-concept. Breast cancer survivors who undergo treatment for their cancer can experience *persistent effects*, that is the effects of treatment (radiation and/or hormone therapies and/or chemotherapy and/or targeted therapies and/or surgery) in the chronical patient's body, either which has been experienced since the implementation of the treatment or has been just experienced in several months or years after the treatment had been completed [18],[19]. Persistent effects can affect the person's self-concept, especially physical self-concept. Park, Zlateva, and Bank [20] stated that cancer can change self-concept. Self-concept has a hierarchical structure that represents the combinative effects of one's perceptions of her ability, strength, and appearance [21]. The study of Bragado et al. found that in children, chemotherapy worsens their physical self-concept [22]. Esnaola, Infante, and Zuleika found that physical self-concept is made up of components of ability (e.g., "I can run and exercise for a long time without getting tired"), strength (e.g., "I am strong"), attractiveness (e.g., "I feel secure about my physical appearance"), and condition (e.g., "In general, I feel physically well"). It is estimated that the persistent effect causes a decrease in these components [23]. This decrease can make sexual self-schema of the breast cancer survivor becomes more negative. Based on the descriptions, this study hypothesized (H5) that physical self-concept is able to predict sexual self-schema of the breast cancer survivor.

By integrating all of the previous hypotheses, from the first (H1) to the fifth (H5), then the author hypothesized, "There is a theoretical model that can be used to explain a variety of a breast cancer's sexual self-schema." (H6).

2. RESEARCH METHOD

2.1. Participants and Design

Participants of this study were 130 female breast cancer survivors (mean of age = 39.45 years of old; standard deviation of age = 3.542 years) recruited with purposive sampling technique. Participants of the measurement instrument trial were 70 survivors outside of the field research participants.

This research design is quantitative, predictive-correlational design, with data analysis techniques involving a multiple linear regression analysis. The predictor variables of this research are the perceptions toward breast talk (medicalized breast talk, functional breast talk, gendered breast talk, and sexualized breast talk) and physical self-concept. The criterion variable is sexual self-schema of the breast cancer survivor.

2.2. Instruments and Procedure

Participants were given a questionnaire consisting of a number of the scales measuring predictor and criterion variables in Indonesian. Criteria of scale reliability and item validities of the measuring instrument are an internal consistency index (Cronbach's Alpha) that is greater than or equal to 0.6, and the corrected item-total correlations that are greater than or equal to 0.25.

Measurement instrument of sexual self-schema was adapted from Sexual Self-schema Scale [12]. The title of the scale is "*Describe Yourself*". The instruction in this scale is as follows [12] (p. 1100):

> "*Below is a listing of adjectives. For each word, consider whether or not the term describes you. Each adjective is to be rated on a scale ranging from 0 = not at all descriptive of me to 6 = very much descriptive of me. Choose a number of each adjective to indicate how accurately the adjective describes you. There are no right or wrong answers. Please be thoughtful and honest. Question: to what extent does the term _____ describe me?*"

This scale consists of three factors, which originally consisted of 26 items. The first factor is Passionate-romantic. The second factor is Open. The third factor is Embarrassed-conservative. Sexual self-schema is calculated by performing the calculation as follows: *Factor 1 + Factor 2 - Factor 3*. Sample items of Factor 1 are (1) loving, (2) stimulating, (3) arousable, (4) romantic, (5) passionate, (6) warm, (7) revealing. Sample items of Factor 2 are (1) uninhibited, (2) open-minded, (3) frank, (4) experienced, (5) broad-minded, (6) straightforward, and (7) outspoken. Sample items of Factor 3 are (1) cautious, (2) timid, (3) prudent, (4) conservative, and (5) inexperienced.

Validity and reliability test of the instrument gave the following results: On Factor 1, Cronbach's Alpha = 0.751, corrected item-total correlations ranged from 0.320 to 0.709, with 4 items aborted. On Factor 2, Cronbach's Alpha = 0.795, corrected item-total correlations 0.283 up to 0.657, without any items that need to be aborted. On Factor 3, Cronbach's Alpha = 0.608, corrected item-total correlations ranged from 0.280 to 0.492, with 3 items aborted. Thus, the numbers of valid items are 19 items.

Measurement instrument of perceptions of breast talk was adapted from the results of Langellier and Sullivan's qualitative research [16]. The themes of breast talk generated from a depth narration were derived into statement items, with the response scale from *Strongly Disagree* (score of 1) to *Strongly Agree* (score of 6). Examples of Medicalized Breast Talk perception items are "Women's breasts are specific body organs in which the existence can be modified by operation, etc.", "The cultural meaning of the breast is less important than the meaning of the health." Sample items of Gendered Breast Talk perception are "The image of a woman depends on her breasts", "Without breast, there is no intimacy and love in a woman", "The breast visual appearance can not be replaced by other things such as a prosthesis (an artificial breast)", "The breast makes a woman feels to be wanted." Sample items of Sexualized Breast Talk perception are "The breast shows a woman's sexual desire", "I can reach orgasm only through the sensation in my breasts", "The breast dimension is not only physical, but also aesthetic, mental, and emotional." Examples of Functional Breast Talk perception items are "Breast accommodates power to support daily activities", "Breast makes women be active and increase their freedom of movement", and "Breast has the function and meaning that makes women proud."

Validity and reliability test of the instrument gave the following results: On Medicalized Breast Talk perception, Cronbach's Alpha = 0.647, corrected item-total correlations ranged from 0.297 to 0.523. The number of the valid items is 4 of the 10 items proposed. On Gendered Breast Talk perception, Cronbach's Alpha = 0.779, corrected item-total correlations ranged from 0.290 to 0.624. The number of the valid items is 7 of 9 items proposed. On Sexualized Breast Talk perception, Cronbach's Alpha = 0.692, corrected item-total correlations ranged from 0.472 to 0.617. The number of the valid items is 3 of 7 items proposed. On Functional Breast Talk perception, Cronbach's Alpha = 0.6, corrected item-total correlations ranged from 0.277 to 0.459. The number of valid items is 19 items. The number is a valid point 4 of 8 items proposed. Thus, the numbers of valid items of Perceptions of Breast Talk are 18 items.

Measurement instrument of physical self-concept was adapted from the Physical Self-attribute Questionnaire [24]. The author used the first part of the questionnaire. Instructions for this tool are as follows [24] (p. 641):

> *"This questionnaire has to do with your attitudes about some of your activities and abilities. For the first nine items below, you should rate yourself relative to other people your age and gender by using the following scale: Bottom 5%* (score of 1─author's note: the scoring system was not mentioned to participants in this instruction)*, Lower 10%* (score of 2)*, Lower 20%* (score of 3)*, Lower 30%* (score of 4)*, Lower 50%* (score of 5)*, Upper 50%* (score of 6)*, Upper 30%* (score of 7)*, Upper 20%* (score of 8)*, Upper 10%* (score of 9)*, Top 5%* (score of 10)*. An example of the way the scale works is as follows: if one of the traits that follows was 'height', a woman who is just below average in height would choose 'lower 50%' whereas a woman who is taller than 80% (but not taller than 90%) of her female counterparts would choose 'upper 20%'.*"

Sample items are (1) Relative to others your age and gender, rate your physical strength, with those in the "top 5%" being the strongest; (2) Relative to others your age and gender, rate your physical endurance, with those in the "top 5%" being those with the most endurance; (3) Relative to others your age and gender, rate your physical attractiveness, with those in the "top 5%" being the most attractive; (4) Relative to others your age and gender, rate your sport competence, with those in the "top 5%" being the most competent in sports; and (5) Relative to others your age and gender, rate your physical flexibility, with those in the "top 5%" being the most flexible.

Validity and reliability test of the instrument gave the following results: Cronbach's Alpha = 0.852, corrected item-total correlations 0.601 up to 0.718. The numbers of valid items are 5 items.

This study was carried out by the author's initiative and on the agreement of the Psychology Department Head, Faculty of Humanities, Bina Nusantara University, in the form of a letter of assignment to do research, as well as the knowledge of the Research Coordinator of the Department. When filling in the questionnaire, the participants were provided with informed consent, and they were informed of the consequences (such as fatigue) at the time of filling, and that they are entitled to resign at any time throughout the phases of the study.

3. RESULTS AND ANALYSIS

Description of the participants were as follows: In terms of the profession, 48 housewives, 35 entrepreneurs, 34 private sector employees, and 13 civil servants. The participant's domiciles were Jakarta (111), Tangerang (14), Bogor (4), and Bekasi (1). The ethnic composition of the participants were Java (79), Chinese (33), Sundanese (13), Padang (3), Batak (1), and Betawi (1). The composition of the educational

level of participants were Bachelor Stratum 1 (102), and Senior High School (28). The entire participants were married. The participant composition of breast cancer stages were Stage 2 (86), Stage 3 (37), Stage 1 (5), and Stage 4 (2). A total of 72 participants had undergone surgery, and 58 participants had not/did not experience surgery. A total of 89 participants had undergone radiation therapy, 40 participants had undergone mastectomy, and 1 participant experienced hormone therapy.

Multiple linear regression analysis showed the results of F (5, 129) = 5.469, p = 0.000, *R-square* = 0.181. This indicated that the five predictors proposed in the research hypotheses were able simultaneously to predict sexual self-schema with a contribution of 18.1%; H6 is supported by empirical data.

In a more detailed, physical self-concept (*Beta* = 0.268, $p < 0.01$) and perception of functional breast talk (*Beta* = 0.269, $p < 0.05$) are able to predict sexual self-schema in positive ways (see Table 1); H5 and H2 are supported by empirical data. This means that the more a woman has positive physical self-concept, the more positive her sexual self-schema. The more she has a positive perception of functional breast talk, the more positive her sexual self-schema. However, perceptions of medicalized breast talk (*Beta* = 0.010, $p > 0.05$), gendered breast talk (*Beta* = -0.034, $p > 0.05$) and sexualized breast talk (*Beta* = 0.020, $p > 0.05$) are not able to predict sexual self-schema; H1, H3, and H4 are not supported by empirical data.

Table 1. Multiple linear regression predicting sexual self-schema in breast cancer survivor (n = 130)

Variable	*B*	*SE B*	*Beta*	*t*	*p*
Physical self-concept	0.317	0.114	0.268	2.773	0.006
Medicalized breast talk	0.032	0.300	0.010	0.107	0.915
Gendered breast talk	-0.061	0.214	-0.034	-0.286	0.775
Sexualized breast talk	0.076	0.382	0.020	0.199	0.842
Functional breast talk	0.811	0.333	0.269	2.436	0.016

This study found that **physical self-concept is able to predict sexual self-schema of breast cancer survivors in the positive way**. The existence of predictive correlation can be understood first of all because sex itself covers almost all the physical dimensions of romantic relationships [24]. The measuring instrument of physical self-concept used in this present study is thick with elements of knowledge and efficacy of physical competence [25], which is indeed necessary for doing a successful and meaningful sexual activity. In addition, women who perceive themselves physically attractive are also more comfortable with sexual matters [26].

Donaghue found a positive correlation between body satisfaction and sexual self-schema (especially the *passionate/romantic* factor, i.e. the inclination to positive emotions in intimate relationships, and the *open* factor, i.e. the tendency of a person to have an open mind and experience), and explained that sexual self-confidence (i.e. confidence to pursue a quality intimate relationship) connects with the two variables [27]. Sexual activity in this present study is a dyadic activity, in which all women survivors are married and have definitive partners. Alipoor et al. found that the more positive physical self-concept of a woman, the lower her body dissatisfaction [28]. Summarize the entire findings, it can be concluded that the mechanism of predictive correlation between physical self-concept and sexual self-schema is bridged by the degree of confidence and satisfaction of a breast cancer survivor woman with her body.

This study found that **functional breast talk is capable to predict sexual self-schema of a female breast cancer survivor, in the positive way, while other breast talks, namely medicalized, sexualized, and gendered breast talk are unable to predict it**. Perceptions about breast talk are different from physical self-concept for physical self-concept is about their body in a whole or globally, while the discussion on the breast talk specifies in one part of the physical self, i.e. breast.

In order to discuss this issue, first of all, it is necessary to expose in advance the breast functions in the society cognition. The cognition of society is critical to know because the cancer experience and, in particular, how a survivor creates the meaning of the experience, besides based on her personal comprehension, is also a result of dialogues or dialectics between her and the social context [29]. Langellier and Sullivan (1998) proposed two breast functions of thematic analysis of the cancer patient's expression, as follows:

> "*first, how as glandular organ it enables breast-feeding and nurturance, and, second, how as a part supporting the whole body's movement, it enables particular physical activities to be performed on a daily basis .... breast involves meanings of pride, self-reliance, and accomplishment in the body's motility, its spontaneous powers to do particular activities*" [16] (p. 82).

In other words, the maternal function (and not the sexual or visual aspect) of the breast is emphasized in the functional breast talk. It is interesting that for Indonesian women who become participants in this study, the "de-sexualized breast" emphasizing its functions contributes to her sexual self-schema.

The finding is not in line with the Sevelius' findings which stated that "sexualized images of female breasts ... have a negative impact on some women's willingness to breastfeed" [30] (p. ii). According Sevelius, *sexualisation of breasts* has changed women viewpoint from the breast that is breastfeeding as the reasonable practice of "cultural" following the mother's pregnancy and the birth of a child into the breast as sexual objects. As a consequence, in breastfeeding activity, breast shape change (becoming "less/not beautiful") is given a more value, and it made the women worried. Thus, Sevelius' findings implied a negative correlation between sexual self-schema and functional breast, whereas this present study found a positive correlation in the study's participants who were Indonesian people. How to explain this positive correlation?

Sevelius explained his study's result by using *Westernization* concept. According to him, the concept makes breast as the object and gives the feeling of a strong sexual nuance and privacy to the breast. This explanation can only be countered by the discourse being circulated in the community. These recent years, a campaign to activate mothers to breastfeed even to encourage exclusive breastfeeding by mothers become increasingly popular, and it is also supported by the Government and non-governmental organizations in Indonesia [31]-[33]. Global movement through social media aimed at providing wider psychosocial public spaces for breastfeeding mothers is also increasing in the frequency and intensity by the uploading of the nursing mother pictures in the public places to the websites or social media [34]. In addition, expression and imagery that "*Breastfeeding mother is sexy*" has entered Indonesia (e.g. [35], [36]). Wright made this expression well elaborated through his article, "*Breastfeeding is the New Sexy!*", as follows:

> "*When you look at this picture and the others of mothers breastfeeding (nude or not), I want you to see confident, sexy women who bared it all for breastfeeding; who feel sexy at this very stage of life and motherhood. Proud women, who accept where they are now and maintain confidence in the growth process to come. Courageous women in their feat to bring awareness and attention to educate and inspire others to breastfeed!*" [37]

In other words, there is a shift or amelioration toward the meaning of "sexy" and "breastfeeding". It is also cannot be denied that breastfeeding activity has a sexual dimension for some people, as told by a BabyCenter member [38]. She said that her husband was annoyed when she was breastfeeding her son because her husband regarded breastfeeding activity "as something sexual" [38]. Various discourses circulating us indicate that the functional breast is not really "desexualized". In other words, there are sexual layers that covered the functional breast. However, the question is: "Would the contestation between the sexual overtones of the breast (that have a negative connotation, because it is seen as making the women be an "object") and the function of the breast (that have a positive connotation advocating the interests of breastfed children as future generations) be productive discourses for the advancement of our understanding of women's lives in general as well as for improving the women quality of life?". The following issue stated by Theuring might be an important advice that the functional/maternal breast talk does not need to negate or deny the sexuality of the female breast:

> "*I want to feel confident and proud when I breastfeed my child. It's very empowering! And feeling sexually attractive is also just as empowering …. I do not condone the over-sexualizing of women or sex as a way to control women, but I do not feel that we need to desexualize ourselves in order to gain value for mothering in mainstream society. I don't think we need to assume that sexuality is a dirty thing. Sex is not dirty or shameful.*" [39]

Theuring's statement [39] above would clarify why the participants of this study have the perception that functional breast talk is positively correlated with sexual self-schema. It is very likely that the breast cancer survivors who became participants of this study had received a new image of the sexual nuance of breastfeeding.

Functional breast talks still exist in the breast cancer survivor as a memory. This is consistent with the statement of Connerton [40] (p. 80), "The body is the main 'container' of habitual memory … because the past is passed on to us in practices of the body or in the ways of doing and being". A woman's experience in nurturing and caring the others with her breast in the past has given sense of worth to her so that it can provide sexual motivation now and in the future.

Why medicalized breast talk has no effect on sexual self-schema? Breast cancer survivors have a dilemma when encountering medical-clinical-health interventions toward their breasts. Thomas-MacLean

through their qualitative study had succeeded in showing (and socializing as well) that phenomenologically, medical therapy experience bringing transformative experience in addition to the psychological suffering experience as believed by the general public [41]. In addition, women are in the tension between the tendency of approaching and away from the breast treatment. In other words, the medicalization experience is a positive and negative experience as well. For example, participating in the medicalization causes pain and loss of autonomy, risk, and uncertainty, but leaving or disconnecting with medicalization has also been realized to be eliminating the chance of (1) understanding the disease, (2) building the framework of meaning of the illness, and (3) having an existential self-understanding [41]. The entire experiences require certain struggle involving dynamic-contradictory memories, and, therefore, have varying effects on sexual self-schema of the survivors, so there appears no correlation between medicalized breast talk and sexual self-schema.

Why perceptions toward sexualized and gendered breast talk are not able to predict sexual self-schema? Langellier and Sullivan put forward that in gendered breast talk, the breast is "a sign of femininity, beauty, and sexual desirability" [16] (p. 84) and in sexualized breast talk, then breast "incorporated both the look and the feel of the breasted experience ... involved both sexual desirability to others and feeling sexual desire oneself" [16] (p. 87, 88). Empirical data of this study indicated that the gendered and sexualized breast is no longer important, or do not contribute to sexual self-schema. This might be caused by the concrete situation experienced by breast cancer survivors, or even the new identity they successfully achieved. Recent breast conditions may indeed provide a feeling of imperfection or incompletion as a woman [8]. However, rather than focusing on it, the participants in this study appears to be more focused on the consideration of the emotional abilities of the breast that is contained or covered in the the historical memory of its function, as mentioned above. Things which can be managed by the survivors among others are (1) the emotional aspects of the breast, and (2) the physical aspects of the parts of self that are corporally still healthy. Interventions such as "education and lifestyle changes to sexual counseling, pelvic floor therapies, sexual aids, medications, and dietary supplements" [41] (p. S20) first of all are not for the shake of "public interest", like to look feminine or increase sexual attractiveness in the eyes of the public, but to cope with, or minimize the sexual dysfunction potential. Therefore, they have to rely on other modalities, namely "psychological-emotional modalities" (which is encompassed in the functional breast talk), as the primary constituent of their sexual self-schema.

The findings of this present study is in line with the Elliott statement [42] which emphasized that motherhood (as stressed in the functional breast talk), and not merely genital function (which is affected by breast medication), is one of the aspects that can affect the sense of sexual self.

4. CONCLUSION

This study concluded that the perception of functional breast talk and physical self-concept play roles in predicting sexual self-schema in breast cancer survivors.

As the implication, endeavors to build women's physical self-worth internally since early stage of life became urgent. It is evident that a dimension of the breast which is assumed as "asexual", i.e. its nurturance function, indeed contributes to the sexual function and schema later in life, including in times while bearing pain such as cancer. This is the contribution of this study's findings.

In breast cancer survivor, perceptions regarding the historicity of female breast strength in supporting life turned out to be giving sexual meaning that goes beyond the effort to meet the need─which is becoming very difficult─for "being desired erotically-sexually by the public", although it is hard to deny that the sexual layers might also exist in the functional breast. Redefinition of female sexuality that is not only focused on appearances and physical parameters has become a classical debate and rediscovered its context in this research.

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