PREDICTORS OF SEXUAL SATISFACTION AFTER CANCER IN WOMEN

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ABSTRACT

Gynecological cancers are frequently found in women. There are various sexual-related symptoms influencing the fulfillment of sexual needs among women living with cancer. In addition, psychological burden due to cancer may induce negative emotional stimulus potentially decreases sexual satisfaction. This study aimed at analyzing the predictors of sexual satisfaction after cancer in women. This cross-sectional study involved 35 women living with cancer in two congested communities in Surabaya, Indonesia. The sexual satisfaction questionnaire was used to collect the data of sexual satisfaction. Dest alcriptive statistic and regression test were used in data analysis. The majority were short term survivors of breast cancer under chemotherapy. Surprisingly, 100% respondents reported none sexual-related complaint and sex-generated negative emotions could not predict sexual satisfaction significantly (p=0.087). Sexual satisfaction was mostly sufficient (Mean ± SD = 30.34 ± 5.78) with afraid of sexual partner dissatisfaction being the strongest predictor of sexual satisfaction (p=0.000). It was accounted for 50.9% variances of sexual satisfaction in this population (R^2=0.509). Sexual satisfaction is sufficient in women living with cancer who had none sexual-related complaint. It is predicted strongly by afraid feeling of sexual partner dissatisfaction. Sex-generated negative emotions cannot predict it significantly.

***Keywords**: Cancerous Women, Female Cancer, Sexual Life, Sexual Needs, Sexual Satisfaction.*

INTRODUCTION

Cancer is the growth of new cells that form abnormal tissue that extends beyond the limits of normal tissue and is characterized by uncontrolled function (Jong, 2005). Of the many types of cancer, gynecological cancer is the cancer that has the most influence in the process of meeting one's sexual needs. These gynecological cancers include breast cancer, testicular cancer, prostate cancer, cervical cancer, vaginal cancer, vulvar cancer, endometrial cancer, ovarian cancer, and various types of gynecological cancer (Perz, *et al*, 2013; Huether & McCance, 2008; Gutierrez & Peterson, 2007).

Sex is considered by Maslow (1970) as a basic physiological need that generally takes priority over higher levels of need; sexual needs and how to fulfill them are very much influenced by age, socio-cultural background, ethics, values, self-esteem, and level of welfare (in

Potter & Perry, 2012). Chronic disease, in this case cancer, can affect sexual function and response, and may impact quality of life (QOL), not only in the patients themselves but also in their sexual partners or spouses. Sexuality represents a pillar of QOL, although it is often neglected by both healthcare providers and patients when it comes to cancer (Nimbi et al., 2022). In cancer survivorship, sexual health issues for women who have cancer are an important but under-diagnosed and under-treated issues (Krychman & Millheiser, 2013).

Cancer is a leading cause of death worldwide. For gynecological cancer, the incidence rates in the world are as follows: cervical cancer 12% and endometrial cancer more than 51% of all gynecological cancers, ovarian cancer more than 5% of all cancers that cause female death, followed by vulvar cancer and vaginal cancer least often; testicular cancer is close to 1% and prostate cancer is more than 29% of all cancer incidence in men (Huether & McCance, 2008). In Indonesia, breast cancer (16.6%) and cervical cancer (9.2%) were the two top leading cancer cases based on incidence rate in 2020 for both sexes, especially in female, breast cancer incidence was 30,8% of the population (Globocan, 2020). From the data available in the Ministry of Health, Republic of Indonesia, it can be estimated that the incidence of cancer in Indonesia is 0.1% of the population and more than 50% of cancer patients come in an advanced stage (Tejawinata, 2012).

Until now, the etiology of cancer is still being researched, but there are several risk factors described by experts. According to Otto (2005), in general there are seven risk factors for cancer, namely: tobacco consumption (smokers), a high-fat diet (obesity), alcohol consumption (drinkers), heredity or genetic predisposition, socioeconomic factors (middle to lower)., exposure to sunlight (UV rays), and a sexual lifestyle (often changing partners). For gynecological cancer, hormonal factors (exposure to estrogen) and environmental factors (viral infections) play a very important role in morbidity (Huether & McCance, 2008). For cancer death, the use of tobacco, high body mass index (BMI), alcohol consumption, low fruit and vegetable intake, and lack of physical activity play a very important role (WHO, 2022).

In the case of cancer, the suffering experienced by the patients is not only physical suffering, but total suffering which includes various aspects, namely: physical, psychological, social, as well as cultural and spiritual sufferings (Tejawinata, 2012). Related to the increasing psychological burden that must be borne by people with gynecological cancer, their QOL may decrease along with changes in the process of meeting their sexual needs and their partners. This emotional stimulus may decrease their sexual satisfaction affecting QOL.

Sexual satisfaction is a subjective individual evaluation of his/her sexual relationship which includes positive and negative dimensions expressed by an affective response (Lawrance & Byers, 1995; in Rokach & Patel, 2021). Sexual satisfaction is also a desired feeling that one experiences during sexual interaction (Khoei et al., 2015). It varies between different people at different times and in different situations, and is affected by several factors. A person's sexual satisfaction reflects their judgment and analysis of their own sexual behavior (Afzali et al., 2020). Sexual satisfaction has a very important role in creating marital

satisfaction and any defect in sexual satisfaction is significantly associated with risky sexual behaviors, serious mental illness, social crimes and ultimately divorce (Shahhosseini et al., 2014). This study aimed at analyzing the predictors of sexual satisfaction after cancer in women.

LITERATURE REVIEW

Changes in the process of meeting the sexual needs of cancer patients and their partners, and the impact on household harmony after gynecological cancer diagnosis for the patients who have a partner is very interesting to be studied.

A review towards research articles between 1948-2011 showed that there were twelve studies reported decreased sexual satisfaction among gynecological cancer survivors following their diagnosis and treatment (Cull, et al., 1993; Thranov & Klee, 1994; Bukovic, et al., 1996; Kylstra, et al., 1999; Leenhouts, et al., 2002; Carmack, et al., 2004; Lagana, et al., 2005; Gershenson, et al., 2007; Donovan, et al., 2007; Stead, et al., 2007; Lindau, et al., 2007; Liavaag, et al., 2008; Cleary, et al., 2011) [in Abbott-Anderson & Kwekkeboom, 2012]. The loss of sexual satisfaction and libido is partially influenced by the sickness of the sexual partner (Maughan, et al., 2002; in Izycki, et al., 2016).

Research conducted by Perz, et al., in Australia (2013), described the construction of post-cancer sex and intimacy (Q methodology research design, respondents: gynecological cancer sufferers, their partners, and health workers). Results showed that there were three factors solution provided the best conceptual fit for the perspectives regarding intimacy and sexuality post-cancer, namely: 1) communication (dispelling myths about sex and intimacy), 2) valuing sexuality across the cancer journey, and 3) intimacy beyond sex. Communication is central to the acceptance of a range of satisfying sexual and intimate practices post-cancer. Renegotiation of sex and intimacy useful for development of alternative sexual practices for normalizing the sex experience after cancer. QOL and relationship satisfaction may be achieved through communication and non-genital intimacy.

Perz, et al., continued their study in 2014 towards 657 people with cancer across a range of sexual and non-sexual cancers, and 148 partners. The majority reported reductions in sexual functioning after cancer across cancer type, for both groups. Physical QOL was a predictor for men and women with cancer, and for male partners. Dyadic sexual communication was a predictor for women with cancer, and for men and women partners. Mental QOL and depression were also predictors for women with cancer, and the lower self-sacrifice subscale of self-silencing a predictor for men with cancer.

By knowing various study results, it is important to analyze deeper the predictors of sexual satisfaction among people with cancer, especially women. Study findings will be important for developing a strategic intervention targetting women living with cancer and their sexual partners in order to achieve higher sexual satisfaction and more effective couple communication.

RESEARCH METHODOLOGY

Quantitative research paradigm applied in this study. This was a retrospective study because the instrument recalled the memory

of study respondents. The study design was cross-sectional which portrait the studied phenomenon at one time observation without continuous follow-up. This cross-sectional study involved 35 women living with cancer in two congested communities in Surabaya, Indonesia: Pucangsewu and Pacar Keling areas. The data of cancer patients were kindly provided by respectable Public Health centre in both areas. Door to door data collection was done in January-March 2023.

The sexual satisfaction questionnaire (Nomejko & Dolinska-Zygmunt, 2014) was used to collect the data of sexual satisfaction. This instrument consisted of 10 items in four-point Likert scale format to differentiate individual response, ranging from 1 (disagree) to 4 (agree). There were more negative items (number 1, 3, 5, 7, 8, and 9) than positive items (number 2, 4, 6, and 10) in this instrument. This instrument was proved to be valid and reliable with r = 0.438 – 0.752 and Chronbach's Alpha = 0.810, respectively.

Total score was ranging from 10 to 40. There were three categories made to ease the data presentation in result section based on the total score, namely: 1) low (10-20), sufficient (21-30), and 3) high (31-40). This category was not intended for statistical analysis purposes. The data scale was interval. Normality and linearity tests were conducted before regression test was used to determine the significant predictors of sexual satisfaction. Descriptive statistic was used to generate the value of Mean and Standard Deviation (SD) of measured variable.

This study protocol has been reviewed by Faculty of Medicine, Widya Mandala Surabaya Catholic University, with ethical clearance registered certificate of 082/WM12/KEPK/DOSEN/T/2020. Informed consent was given to all respondents before study participation. The ethical principle of study in human subject was implemented according to Helsinki agreement.

RESEARCH RESULT

Table 1. Demography Characteristic

Characteristics	Frequency (F)	Percentage (%)
Age (years old):		
1. Early adulthood (26-35)	2	5.71
2. Late adulthood (36-45)	4	11.43
3. Pre-elderly (46-55)	8	22.86
4. Elderly (56-65)	13	37.14
5. Old age (>65)	8	22.86
Education level:		
1. Elementary school	9	25.71
2. Secondary school	8	22.86
3. High school	13	37.14
4. Higher education	5	14.29
Marital status:		
1. Single	4	11.43
2. Married	19	54.29

3. Widowed	10	28.57
4. Separated	2	5.71
Occupation:		
1. Full-time	1	2.86
2. Part-time	3	8.57
3. Retired	5	14.29
4. Housewives	17	48.57
5. Jobless	9	25.71

In this study, there were 35 women living with cancer participated. The majority was married elderly female being housewife with sufficient educational background by graduating from high school. Table 1 explains about the demography characteristic of study respondents in details.

Table 2. Cancer-Related Information

Characteristics	Frequency (F)	Percentage (%)
Cancer diagnosis:		
1. Breast cancer	21	60.00
2. Cervical cancer	1	2.86
3. Endometrial cancer	2	5.71
4. Ovarian cancer	3	8.57
5. Others	8	22.86
Cancer stadium:		
1. 1	4	11.43
2. 2	12	34.29
3. 3	9	25.71
4. 4	1	2.86
5. No idea	9	25.71
Stage of survivorship:		
1. Acute (<1 year)	3	8.57
2. Short-term (1-5 years)	18	51.43
3. Long-term (>5 years)	14	40.00
Therapy:		
1. Surgical	10	28.57
2. Chemotherapy	17	48.57
3. Radiotherapy	5	14.29
4. Medication	2	5.71
5. None	1	2.86
Sexual-related complaint:		
1. None	35	100

Table 2 shows that most respondents were short-term survivor of 2nd stage breast cancer treated with chemotherapy. Surprisingly, 100% respondents had no complaint related to sexual aspect. Descriptive statistic showed that Mean of sexual satisfaction was 30.34 (sufficient level) with SD 5.78. Sexual satisfaction was sufficient in women living with cancer who had none sexual-related complaint. Frequency analysis showed that most respondents had sufficient sexual satisfaction (n=18 or 51.4%), followed by high satisfaction (n=14 or 40%), and the least was low satisfaction (n=3 or 8.6%).

Table 3. Sexual Satisfaction Sub-Variables*

Item	Sub-variables	Disgaree		Agree	
		F	%	F	%
1 (-)	Sexual life disconcert	0	0	18	51.4
2 (+)	Source of pleasure	3	8.6	11	31.4
3 (-)	Sex-generated negative emotions	1	2.9	15	42.9
4 (+)	Perceived sexual attractiveness	3	8.6	7	20.0
5 (-)	Perceived poor sexual partner	2	5.7	22	62.9
6 (+)	Absence of sexual life problem	10	28.6	10	28.6
7 (-)	Sexual life intense thought	3	8.6	14	40.0
8 (-)	Sexual life frustration	1	2.9	22	62.9
9 (-)	Afraid of sexual partner dissatisfaction	3	8.6	15	42.9
10 (+)	Sexual life fulfillment	8	22.9	12	34.3

***Middle-range scale (score 2 and 3) was not presented.**

Table 3 explains about the result of frequency analysis of each item in the instrument in details. Frequency analysis towards each item in the instrument showed that most respondents agreed to the negative items, especially item 5 about perceived poor sexual partner and item 8 about sexual life frustration (@62.9% for each). Meanwhile from the positive side, most respondents agreed to item 10 about sexual life fulfillment (34.3%).

Table 4. Predictors of Sexual Satisfaction

Item	Sub-variables	p-Value	R^2 or Nagelkerke	Influences (%)
1	Sexual life disconcert	0.001	0.430	43.0
2	Source of pleasure	0.001	0.434	43.4
3	Sex-generated negative emotions	0.087	---	---
4	Perceived sexual attractiveness	0.000	0.369	36.9
5	Perceived poor sexual partner	0.007	0.255	25.5
6	Absence of sexual life problem	0.000	0.443	44.3
7	Sexual life intense thought	0.000	0.491	49.1
8	Sexual life frustration	0.003	0.361	36.1
9	Afraid of sexual partner dissatisfaction	0.000	0.509	50.9
10	Sexual life fulfillment	0.036	0.158	15.8

Table 4 shows that sex-generated negative emotions were the only sub-variable of sexual satisfaction which could not predict sexual satisfaction significantly (p=0.087). Item 9 about afraid of sexual partner dissatisfaction was proved to be the strongest predictor of sexual satisfaction (p=0.000). It was accounted for 50.9% variances of sexual satisfaction in this population (R^2=0.509).

DISCUSSION

Most study respondents were short-term survivor of 2nd stage breast cancer treated with chemotherapy. Stage 2 breast cancer is characterized by the presence of cancer cells in a breast and/or in the lymph nodes near a breast, further defined as stage 2A and 2B depending on other factors. The survival rates are strong for both stages: 98% for stage 2A and 95.6% for 2B (Giuliano et al., 2017).

By being a short-term survivor, most respondents have been struggling with cancer main-adjuvant therapies and physical-psychological symptoms related to cancer and its therapies for almost five years. The total suffering is frequently happened (Tejawinata, 2012). Sexual complaints are related to physical suffering due to gynecological complaints, and also related to psychological suffering due to the perceived threat towards couple relationship-harmony. Sexual concerns result in significant emotional distress, including sadness/depression, issues related to personal appearance, stigma, and negative impacts on personal relationships (Boswell & Dizon, 2015).

Surprisingly, 100% respondents reported no complain related to sexual aspect. This study findings are relieving at some point. Normally, breast cancer survivors treated with chemotherapy reported worse gynecological symptoms (Soldera et al., 2018). Chemotherapy can have a large effect in altering a woman's sexual health and function and it is among the most detrimental to sexual function (Boswell & Dizon, 2015). Chemotherapy appears to have the greatest influence on the development of sexual complaints which include but are not limited to changes in sexual desire, arousal, orgasmic intensity and latency, debilitating vaginal dryness and painful intercourse (Krychman & Millheiser, 2013). Previous chemotherapy could predict high level of reproductive concerns among breast cancer patients (Ljungman et al., 2018).

The absence of sexual complaint leads to the sufficient level of sexual satisfaction among respondents. If physical complaint is not the cause of the lowering sexual satisfaction among respondents, meaning there are other factors potentially play more important roles with higher influence, psychological or social-related causes for instance. According to the Basson model of female sexual functioning, the importance of psychological and mental health in the concept of female sexuality is proposed by intimacy, desire, arousal, orgasm, and satisfaction which were all part of a propagating circle-separate, inter-related, and all equally important (Basson et al., 2010). Other than that, there is a possibility that the sufficient level of sexual satisfaction was driven by the sufficient level of sexual needs among respondents, as sexual needs were associated with sexual and relationship satisfaction (Geue et al., 2015).

Satisfaction is only one of the domain of sexual functioning in females, in which there are multiple factors may play important roles, such as: the partner status, overall healh, comorbidities, intimacy, and the roles individual play (Boswell & Dizon, 2015). For instance, a study towards breast cancer patients showed that impaired sexuality may cause by sexual and psychological distress, difficulties in identifying feelings, externally oriented thinking, negative emotions related to sexuality, and more rigid cognition towards peculiar aspects of sexuality, e.g. failure disengage-

ment thougts and age-related beliefs (Nimbi et al., 2022).

Most respondents were elderly (56-65 years old) in which most women had menopaused. Elderly women with chronic disease like cancer experience reduced sexual capacity and desire result in negative impact on the quality of elderly's sexual life. Chronic disease may influence sexual expressions and responses which adversely affect one's mood and energy so that can cause depression and grief, as well as loss of self-confidence, self-esteem, and self-concept in elderly. The factors affecting sexuality of an elderly with chronic disease include cultural and mythical beliefs about age and illnesses, fear, and embarrass of changed physical appearance (Khoei et al., 2016).

Education can improve women's educability, knowledge, and attitudes towards sexual issues, thereby increasing their sexual satisfaction (Bayat et al., 2023). There is still various preposition about whether education level influences sexual satisfaction or not, especially in cancerous women. A study towards 270 married women in reproductive age showed that education level was not significantly associated with sexual satisfaction, in which higher formal education level did not bring better sexual function or higher sexual life satisfaction (Abdoly & Pourmousavi, 2013). While another secondary study showed that education was the most effective predictor of women's sexual satisfaction in stable conditions without sexual dysfunction and mental health problems (Bayat et al., 2023). There is a possibility if the sufficient level of sexual satisfaction found in this study was influenced by the sufficient level of respondents' formal education level which is high-school graduated in majority.

Most respondents were married women. Marital status ensures the stability of sexual partner availability. In living with chronic disease, the spouse's support even given higher meaning, especially in emotional support domain. Sexual satisfaction had a direct association with marital status through direct effect of marital quality in women (Sheikhan et al., 2019). Sexual satisfaction is in steady decline after one year of marriage, and intercourse frequency, partner's specific sexual skills, passion decline, health status, intimacy in couple communication, and conflict style take some parts in it (Schmiedeberg & Schroder, 2016). Marriage/ relationship duration was not identified in this study.

Most respondents were housewives. In cervical cancer survivors, occupation was associated with sexual function (Yin et al., 2016). Women who work have financial independence and more self-confidence leading to satisfaction in sexual life more than housewives as a result of earning money, while women with no income like housewives feel less sexiness leading to less sexual activity and sexual satisfaction (Shahhosseini et al., 2014).

Results showed that sex-generated negative emotions could not predict sexual satisfaction significantly. This finding is consistent with study of Yoo et al. (2013) who found that emotional intimacy did not appear to have a significant influence on sexual satisfaction. Oppositely, emotional bound between couples or emotional intimacy is a considerable trait with a significant effect on women's sexual satisfaction (Khoei et al., 2015). Emotion is an important aspect potentially determining sexual satisfaction because of its association with relationship

satisfaction. Especially when the worsening of sexual life is determined by negative emotions (Eleuteri et al., 2022).

Results also showed that the strongest predictor of sexual satisfaction in women living with cancer is being afraid of sexual partner dissatisfaction. A study towards 1,009 midlife heterosexual couples showed that partners' reports of frequent kissing, cuddling, and caressing; frequent recent sexual activity; attaching importance to one's own and one's partner's orgasm; better sexual functioning; and greater relationship happiness contributed significantly to predicting and understanding individuals' sexual satisfaction (Fisher et al., 2014). Both men and women tended to be accurate in perceiving their partners' levels of sexual satisfaction, but women neither over- nor underestimated their partners' sexual satisfaction (Fallis et al., 2014). Perception bias is atenuated by sexual communication quality, but when the quality is poor then better emotion recognition ability will be associated with less perception bias (Fallis et a., 2014). Therefore, the openness in couple communication needs to be promoted to avoid perception bias in partner's sexual satisfaction.

Perceived poor sexual partner is also a significant predictor of sexual satisfaction, which may lead to the afraid feeling of sexual partner dissatisfaction. This negative thought or perception may be induced by perceived low level of sexual skills. Actually, sexual skills can be learned. There is a significant effect of sexual skills training program on sexual satisfaction and intimacy (Moghaddam et al., 2020). The lessons in it may give positive views toward sexual issues result in realistic and positive sexual expectations, healthier sexual behaviors and self-expressions, increased sexual knowledge which leads to more sexual satisfaction and intimacy in sexual relationship.

Some significant predictors found in this study are related to a negative thought towards sexual life. There are three-related-sub-variables which were proved to be a significant predictor of sesual satisfaction, namely: disconcert, frustration, and intense thought similar to worriness/anxiety. Someone who hold more negative self-perceptions may be more likely to be affected by intrusive and negative thoughts during sex which then impair their sexual satisfaction (Lafortune et al., 2022). Sexual satisfaction is a highly subjective experience, depending on the individual hierarchy of essential criteria, and should be assessed as a separate dimension from sexual functioning (Rogowska et al., 2022). There is a possibility that the study respondents put sexual satisfaction in the highest criteria of their sexual or marital relationship priority but having negative self-perception.

Sexual frustration is similar to sexual distress resulted from sexual inactivity or dissatisfaction. It is a natural response in which the sexual expectation and needs are imbalance or there is an incompatibility or diferent sexual expectations between individual and the partner, which is normal in adults. It involves a psychological and/or biological responses to having an unsatisfied sexual desire (Lankford, 2021). Its characteristics are dissatisfaction, stress about sexual encounters, anxiety, anger, and even depression due to unmet sexual needs.

From the positive side, some respondents still feel that they are sexually attractive at some point. Perceived sexual attractiveness is a

significant predictor of sexual satisfaction in this population. Gynecological cancer patients report lower self-esteem and attractiveness (Izycki et al., 2016). A study towards midlife women averagely aged 58 years old, relatively similar to most study respondents, found that feeling attractive was an important reason for sexual activity (Thomas et al., 2019). Breast cancer survivors were most concerned with changes in how their bodies worked sexually (Crowley et al., 2016). Changes in appearance, especially breast changes due to breast cancer, impaired women's body image impacted their sexual satisfaction. Therefore, body image may influence the feeling of attractiveness, sexual activity, and sexual satisfaction in the end. Women who felt confident with their body reported better sexual satisfaction, even in the face of bodily changes related to aging process or chronic disease (Thomas et al., 2019). For respondents with negative body image perception, it is necessary to be empowered by her spouse or health care professionals to ensure positive sexuality.

Sex as a source of pleasure is a significant predictor of sexual satisfaction in this population. Sexual pleasure is the physical and/or psychological satisfaction and enjoyment derived from solitary or shared erotic experiences, including thoughts, dreams and autoeroticism (Gruskin et al., 2019). Pleasure is a crucial component of sexual satisfaction and that sexual satisfaction derives from positive sexual experience (Pascoal et al., 2014). Couples with a committed relationship like marriage usually have the highest sexual pleasure compared to couples with emotionally-involved relationship or just a hookup (Milstein et al., 2020). Sexual activity is less pleasurable and associated with greater cost for heterosexual women even though they do not differ in the capacity for sexual pleasure compared to men (Laan et al., 2021). Men and women differ in their experience of sexual pleasure.It is even harder in women with serious gynecological illness like cancer. It is important to keep sexual pleasure alive as long as the body permits.

Absence of sexual life problem is also a significant predictor of sexual satisfaction in women living with cancer. It is related to perceived problem absence in marital or couple relationship with her spouse. It is more than just a personal sexual problem induced by gynecologycal cancer, but closer to the problem arise in couple sexual relationship. Sexual satisfaction was bidirectionally associated with marital satisfaction and sex frequency especially in the first 4-5 years of marriage (McNulty et al., 2016). Among individuals reporting sex in the past year, problems with sexual response were common but self-reported distress about sex lives was much less common (Mitchell et al., 2013). It could be common also if women living with cancer perceived absence or none self-reported distress about sex lives.

Last but not least, sexual life fulfillment is the significant predictor of sexual satisfaction too. The fulfillment of sexual sphere and harmony in sexual relation may increase individual’s satisfaction with sexual life important for an optimum psychological wellbeing (Chernyavska et al., 2022). Sexual satisfaction may well depend on the ability to feel sexual desire and to fulfill it through sexual activity (Dosch et al., 2016). Cancer may interfere sexual activity due to organic dysfunction, but if couples could maintain a good relationship or sexual harmony, high sexual

satisfaction is not impossible after cancer.

This study is not without limitation. The nature of cross-sectional design which is not involving follow up aspect may not detect the changes in sexual satisfaction overtime. It is needed to continuosly assess this aspect in the field setting to assure early detection and management of sexual problems in women living with cancer. Nurse is placed in the front gate of the health care delivery system to better acknowledge sexual needs of cancer patients, something which is sometimes difficult to talk openly about. In order to achieve a high sexual satisfaction after cancer, nurse may modify the significant predictors in this study among women living with cancer.

CONCLUSION

Sexual satisfaction is sufficient in women living with cancer who have none sexual-related complaint. It is predicted strongly by the afraid feeling of sexual partner dissatisfaction. Other than that, sexual satisfaction is also may be predicted by various determinants, such as: sexual life disconcert, perceived poor sexual partner, sexual life intense thought, sexual life frustration, sex as a source of pleasure, perceived sexual attractiveness, absence of sexual life problem, and sexual life fulfillment. Sex-generated negative emotions cannot predict sexual satisfaction significantly in women living with cancer.

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