The Sexual and Emotional Life Experiences Reported by Brazilian Men with Head and Neck Cancer at a Public University Hospital: A Qualitative Study

Ricardo Souza Evangelista Sant’Ana¹ · João Paulo Zerbinati² · Maria Eufrasia de Faria³ · Carmen Silvia Passos Lima³ · Christine Maheu⁴ · Egberto Ribeiro Turato³,⁵

Accepted: 20 February 2022 / Published online: 31 March 2022 © The Author(s) 2022

Abstract
This study explored the sexual and emotional experiences of male patients with head and neck cancer. This study utilized a clinical-qualitative method. Twelve patients with head and neck cancer were recruited to participate in the research through in-depth semi-directed interviews with open-ended questions recorded. Data was collected at the radiotherapy of a Brazilian hospital. All patients demonstrated negative impacts on the dynamics of affective and sexual relationships caused by a serious disease. Data revealed that impacts mainly affect “The felt/lived body”, and “The affective-sexual body”. Requiring, then, an “Elaboration of the grief of the bodily and sexual changes”. Considering, evaluating and proposing care for a sexual and emotional aspects of patients with head and neck cancer is essential for the creation and implementation of comprehensive health measures, especially in terms of quality of life for patients.

Keywords Head and neck cancer · Sexuality · Sexual health · Qualitative study

Introduction
Head and neck squamous cell carcinoma (HNSCC) is the fifth most common malignant neoplasm worldwide, with about 780,000 new cases diagnosed per year [1]. The tumors occur mainly in oral, oropharyngeal, pharyngeal and laryngeal cavities [2] and are more prevalent in middle-aged men. The highest rates of oral cavity tumors occur in Pakistan, Brazil, India, and France [3, 4]. The main risk factors for HNSCC are the continuous and...
excessive consumption of alcohol and tobacco and/or becoming infected with the Epstein Barr virus [1, 5].

The anatomical location of HNSCC as well as treatment with resections, radiotherapy (RT), and chemotherapy (CT), leads to facial deformities and functional abnormalities that affect eating, sleeping, and communication. The end result may have a profound effect on patients’ self-image and social interactions that provide them with joy and a sense of well-being [6–10].

HNSCC affect the patient physically and psychologically with their irreversible effects and the scars left on the body. The perception of someone’s body as different from that of others and their own—and the image they have intrinsically—can generate in patients with HNSCC shock, anguish, frustration, strangeness, and a feeling of worthlessness with wide social, subjective, and relational repercussions [10–12].

Therefore, patients with HNSCC view their body as visibly vulnerable and limited. In addition, the progression of tumors may lead to impairments in sexual function, affecting patients’ quality of life [13–17].

Sexuality is essential to individuals’ well-being and quality of life [18]. However, sexuality goes beyond partnerships and the joining of sex organs during intercourse. As well, it is not limited to the genitals as any part of the body may give sexual pleasure. In biomedical training, there is a more targeted approach to the anatomophysiopathology of the problem, addressing issues such as decreased libido, erectile dysfunction, impact on sexual relations, including psychosocial and psycho-affective aspects of sexuality [8].

When it comes to cancer care, sexual health should be a focus for health professionals as it affects patient management and treatment. Oncology teams should not shy away from discussions about sexuality and cancer during the treatment. When an issue is detected—either by psychosocial or physiological conditions, circumstances, or reasons—appropriate referrals, procedures and treatment must be provided [19].

The American Society of Clinical Oncology (ASCO) published practical guidelines on sexuality and cancer in 2017. Regarding this topic, Barbera et al. [20], proposed ways to manage patients’ sexual dysfunctions resulting from specific cancer problems or treatment. However, the recommendations did not sufficiently address patients’ emotional state in terms of sexuality, and emphasized actions that are more clinical, technical and medicinal, such as the use of prostheses and drugs [21].

The National Comprehensive Cancer Network (NCCN) also published a document for health care professionals with recommendations for patients whose sexual dysfunction were due to cancer or antineoplastic treatment [22]. Again, identifying and managing emotional challenges associated with sexual dysfunction in HNSCC patients is not addressed.

Currently, there are few studies that address the problems related to the sexual and emotional health of patients with HNSCC from a qualitative perspective [11, 23]. Emotional, psychological and sexual demands are listed in the literature as an unmet need for health support to patients with head and neck cancer [24]. This gap in scientific knowledge justifies and reaffirms the importance of this work.

The definition of sexuality in this study will mainly refer to the work of Winnicott [25, 26] about the psychosomatic relationship, which is characterized by the deep relationships a person establishes with their body, the world, and other people. When mentioning the word body, there is an immediate tendency to minimize it as purely biological. Indeed, the body represented in the psyche and the biological body are inseparable entities. Therefore, the body is the subject itself, and the expression of its subjectivity consists of its way of life, habits, pleasures, dislikes, and psychological path, all of which characterize a person in relation to their experiences and are components that influence their identity.
The aim of this study is to examine the emotional significance of sexual experiences based on reports from male patients with head and neck cancer receiving CT and RT at a Brazilian Public University hospital and as part of their support service.

Methods

The Clinical Qualitative Research Methodology [27] was used which enables us to understand the sexual and emotional experiences of patients with head and neck cancer. A fundamental part of this methodological structure is the interviewee’s discourse [28]. In this case, a scientific investigation is carried out based on the meaning that the respondent attributes to the experiences, assuming that this is an efficient way of learning and inferring results that reveal the nexus of meanings.

Setting

This research was carried out at the RT outpatient service in a tertiary university hospital in southeastern Brazil. To this end, it relies on a multi-professional and interdisciplinary team, and it also promotes teaching, research and further education. The initial stage in the clinical qualitative research is acculturation, through which the researcher establishes a direct relationship with the population to be studied.

These initial aims were to learn the routine of the service, the ideas, the micro culture present in these settings, and the thoughts, actions, and discourses that have been established in this daily life. The information gathered in this stage (the perceptions of the researcher and the reports of dialogues with the professionals or patients) were recorded in a field diary and used to formulate the questions initially proposed for the interviews.

Participants

The selection of the sample was intentional. This study had 12 participants who were selected and invited to participate in the study according to the data in their medical records. The inclusion criteria were: (1) male HNSCC patients who were undergoing outpatient treatment with RT and/or CT; (2) over 18 years of age; (3) three weeks after RT; (4) after the first application of CT; and (5) adequate mental and cognitive health for the interview.

The sample was based on the criterion of theoretical information saturation. This criterion consists of the perception, on the part of the researcher, that the information has started to present patterns of repetition, with limited new relevance and no increase in the nexus of meaning, and that the information already obtained is enough to answer the research problem [29]. It is worth mentioning that the moment of saturation is also validated by the advisor and members of the research team of which the researcher was part.

Procedures

Data collection started when the researcher, the team of health care professionals, and the patient began to open up more naturally and spontaneously on a day-to-day basis. The process took place in three stages: (1) The researcher initially approached the patient, who
was waiting in the outpatient clinic for the application of RT; (2) The researcher spoke to the patient, explaining the research proposal and seeking to create a bond; (3) If the patient accepted to take part in the research, further contact was scheduled, normally when he would return to the RT clinic.

The interview audio was recorded using a smartphone. Other observations and reactions made by participants during the interviews were recorded in a research diary. The interviews were usually conducted after a patient’s RT session, as they said they were more available, less worried, and less tense, which provided favorable conditions for a more spontaneous and effective interview. They took place in a suitable location—an outpatient room where their clinical treatment took place. Data collection was carried out from July 2018 to November 2018 by the first author of this article.

Data Collection

Data collection was based on individual semi-structured interviews with in-depth open questions, with the expectation those interviewees would speak as openly as possible about their experiences relating to sexuality. The script touched on topics related to treatment and everyday social, affective, family, and sexual life.

Data Analysis

Data were analyzed using the Clinical-Qualitative Content Analysis [30]. This method is specially adapted to deal with the subjective requirements of the clinical-care relationship. Additionally, the method makes the researcher the main research instrument throughout the process of the study, and the reports of research subjects about their experiences in health contexts is the important content to be analyzed.

Data analysis followed the seven steps described in the Clinical-Qualitative Content Analysis: (1) editing of the material: transcription of recorded interviews and convergence with material recorded in the field diary; (2) free-floating reading of the collected material: reading of material while suspending directed attention; (3) comments and impressions; (4) subcategorization and categorization: group and name significant speech within the same theme; (5) discussion with academic peers about the analyzed material; (6) definition of categories and refinement of categories based on content analysis; and (7) validation of the analyzed material together with peers.

The collected data were interpreted from the psychodynamic approach, seeking the study participants’ subjective perspective, and understanding beyond what is merely spoken and described in the interview.

Ethics Considerations

The interviews were carried out with the patients’ agreement and only after signing the Informed Consent Form. Informed consent was obtained from all individual participants included in the study. The study was approved by the Research Ethics Committee under the Certificate Number of Presentation for Ethical Appreciation: 79822717.0000.5404.
Results

Participants

The 12 study participants, aged between 48 and 65 years, had tumors in their pharynx or oral cavity, and were undergoing CT and/or RT. Most patients were heavy drinkers and smokers. All patients reported incomplete or complete elementary education (Table 1).

Interviews

Sessions ranged from 36 to 110 min (mean 62 min). From the analysis of the interviews, four categories were listed: (1) The felt/lived body; (2) The affective-sexual body revisited; (3) Elaboration of the struggle of the body with the new beginning, and; (4) Health care in the sexual and emotional aspect. Table 2 summarizes the categories and their respective descriptions/characteristics as well as the subcategories that emerged from each category. In the presentation of the results, excerpts of the interviews that deal with the representative and significant content of their affective, sexual and emotional experiences have been highlighted.

The Felt/Lived Body

This category deals with the unveiling of the body from the perspective of what is perceived and felt, the idiosyncrasy of the body as a structure that is related to reality and events that cause changes in both objective and subjective experiences. These are movements that bring physical, occupational, and behavioral changes, and also alterations in the concept of pleasure in the interrelation of the body with the world. These changes are the subcategories that were listed in the interviews and which will be the subject of discussion.

Table 1 Characteristics of the 12 male patients with head and neck carcinoma

| Patients | Age | Civil status | Drinker | Smoker | Diagnostic          | Section | Treatment |
|----------|-----|--------------|---------|--------|---------------------|---------|-----------|
| E1       | 56  | Unmarried    | Yes     | Yes    | Pharyngeal SCC      | RT/CT   | 07S/4B    |
| E2       | 48  | Married      | Yes     | Yes    | Pharyngeal SCC      | RT/CT   | 21S/1B    |
| E3       | 63  | Married      | Yes     | Yes    | Pharyngeal SCC      | RT/CT   | 03S/2B    |
| E4       | 51  | Married      | Yes     | Yes    | Oral cavity SCC     | RT/CT   | 21S/1B    |
| E5       | 55  | Separated    | Yes     | Yes    | Oral cavity SCC     | RT/CT   | 30S/1B    |
| E7       | 55  | Widower      | Yes     | Yes    | Pharyngeal SCC      | RT/CT   | 5S/2B     |
| E8       | 55  | Divorced     | Yes     | Yes    | Pharyngeal SCC      | RT/CT   | 21S/3B    |
| E9       | 50  | Married      | Yes     | Yes    | Pharyngeal SCC      | RT/CT   | 16S/1B    |
| E10      | 52  | Married      | Yes     | Yes    | Pharyngeal SCC      | RT/CT   | 21S/1B    |
| E11      | 43  | Unmarried    | No      | Yes    | Oral cavity SCC     | RT/CT   | 4S/4B     |
| E12      | 63  | Married      | No      | No     | Pharyngeal SCC      | RT/Surgery | 5S/3B |

SCC squamous cell carcinoma, RT radiotherapy, CT chemotherapy, S section, B Block
Table 2  Categories and subcategories of the 12 male patients with head and neck carcinoma

| Category                                           | Characteristic/description                                                                 | Subcategories                                                                 |
|----------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| 1. The felt/lived body                             | Shows the meaning attributed to the body and how it is perceived from the changes caused by the cancer diagnosis and treatment | Physical and occupational changes; Behavioral changes in the interaction of the body with the world |
| 2. The affective-sexual body revisited: advances in the affective-sexual representation of the hitherto known body/subject but which, with the disease, changes | Advances in the affective-sexual representation of the hitherto known body/subject but which, with the disease, changes and becomes strange | Body representation of the head and neck; Affective and/or sexual relationship; Sexual conflict; The strange “new” body |
| 3. Elaboration of the grief of the bodily and sexual changes | Understands aspects of the adaptation to the new reality with the body which appears     | Not applied                                                                   |
| 4. Health care in the sexual and emotional aspect   | Deals with the demand for care in the emotional and sexual aspect                          | Not applied                                                                   |
Physical and Occupational Changes

The body does not just consist of biological features but is intrinsically linked to human existence. Thus, neither the biological nor the existential aspect can be considered the original one as they are interdependent. Along the path of life, the human being will encounter inevitable incidents, obstacles and complications that may also affect their objective body, like a cancer.

“Now the problem is my mouth, my tongue, to talk, to eat. I can only eat mashed food, you know! Talking, no way! Speaking’s changed! After I operated my tongue, a lot has changed!” (E4).

“So, I felt a change in my body, it seems that it is getting older, it’s indisposed, the pain hurts a lot” (E6).

“My face has changed, understand? I was a little stronger, a little more robust, right?! Then it fell, my appearance changed, and I got thinner, I looked older” (E11).

Behavioral Changes in the Interrelationship of the Body with the World

Facing reality causes a lot of anguish and in some cases, it also triggers changes that lead to significant transformations. In other words, being confronted with a life-threatening risk may lead to the patient taking better care of their health, body, and themselves.

“I smoked four packs, then two, now it’s dropped to two cigarettes a day, I don’t drink anymore, after I started here at the hospital” (E1).

“You don’t feel like eating, it’s serious” (E2).

“I didn’t drool, I was normal, now I’m not normal anymore, right?! Then it “split”, you know?” (E4).

“I have no desire because I stopped drinking, so the only fun I had was going to the bar, chatting. So, we went out for a drink, and then I was already drunk and high. Now I stay at home” (E11).

“And now it has taken some of my taste away, right?! I can’t taste anything anymore, and then the pains come, ok!” (E12).

The Affective-Sexual Body Revisited

The category of the affective-sexual body shows the modification and demand for redefining the body based on the disease. The physical anatomical toll that the patient experiences results in the establishment of new readings of oneself. In view of these findings, the following subcategories emerged: Bodily representation of the head and neck; Affective and/or sexual relationships; Sexual conflict; and the Strange “new” body.

Bodily Representation of the Head and Neck

These experiences produced significant elements that reverberate in the patient’s life.

“My head is the feature that the person sees, for example, before any of this was here. My face was never beautiful, but it was never that ugly either! Today, I don’t
know, someone looks at me like that and says, “Look who I married”” (E2). “The disease finished with my appearance, the sexual part, unfortunately, my head doesn’t help, I don’t know. You have to adapt” (E9).

**Affective and/or Sexual Relationships**

More than ever, the support of a partner, family, or someone close is indispensable especially for those who are seriously ill with a condition that may impact intimate or personal relationships.

“Before my disease we already lived in separate homes, we lived in separate houses, and it was more united, but then the disease came. She said: “You are not going to be here alone…” So, I came here again, I had the surgery and now I went back to my house again” (E2).

“Every now and then we hug each other, one takes the other’s hand. But no closeness, let’s get close to God, let’s have this treatment and it’s over, you know?!” (E3).

“I feel horny, but I’m a little thin because of this, it gets in the way, I always feel like it, but the problem you have this, and there are times when I lose interest” (E8).

“Oh, family, they are more attentive! Be more careful, thank God. They take part in the treatment, they come more when I go to chemotherapy but not when I have radiotherapy, no one comes, everything is quiet. But when it is the part when the body has chemotherapy there’s a companion! Someone from the family” (E12).

“I lost a lot of weight, it’s not just the sex you don’t want, you don’t want anything, I wasn’t even hungry” (E10).

**Sexual Conflict**

In this subcategory, the condition of illness triggers a change in the patient’s sexual conduct. These reinterpretations/reflections about their sexual behavior are brought up, judged, and scrutinized. The patient is faced with certain dilemmas regarding their sexual behavior.

“Because I’m going to explain something to you, in this good time I had I went after fa*s, you know? Good things fa*s, got it? I liked a fa*, they were like magnets, I went after these shits, I forgot women and went after fa*s, then I got it and said: I’ll give up these fuc**ng fa*s too” (E11).

**The Strange “New” Body**

Sexuality remains an important part of people’s lives, and its importance can be identified in the participants’ statements below. The negative impact on patients’ sexuality and relationships due to bodily changes and the treatment itself requires efforts on the part of the patients to be able to adapt to them.

“The desire to have sex has not decreased, but it doesn’t work anymore. Sex itself is really good, this tongue thing there, that’s no good” (E1).

“Kissing is difficult because of the way almost half of my tongue is loose, but the rest is all good” (E4).

“Yes, there is an erection, but not the same as before” (E5).
Elaboration of the Grief of the Bodily and Sexual Changes

Grief can be related to death, separation—any disruptions in a patient’s life and their daily reality. Patients who survive HNSCC confront a reality that they fear and view as uncertain. In order to continue their lives, HNSCC survivors need to give new meaning to the traumatic experience they have had as a result of the disease and being ill in order to return to life and live with quality of life.

“Ah, everything is good in life, it is marvelous, before it was terrible, now with the ideal treatment it’s great” (E1).

“After, I want to travel because I didn’t enjoy anything in my life” (E3).

“I have a piece of land, I want to build a house for myself, take care of my children, go back to work, which I really want to do” (E4).

Their statements show a lot of hope; the participants make plans for the future, with the intention of pursuing unfulfilled dreams, ideas, and projects. Moreover, they emphasize being productive again at work, being with their family, and partaking in leisure activities.

Health Care in Terms of Sexual, Affective, and Emotional Factors

This category deals with the importance attributed to the treatment of patients with HNSCC, especially in terms of attention and specialized care for sexual, affective, and emotional health.

“So, I think that if there was a sexologist, something could be done about it because it’s a taboo to say that at the time we get premature ejaculation. If there were a sexologist, the person would get better faster. I think it helps a lot in the treatment. I didn’t say anything, but I’m speaking now. Do you understand?! But I think there has to be a doctor to talk about sex to the patients, there are a lot of people suffering like I did because you see the person, you can’t, and it’s been a year, understand? Today everything is great” (E10).

“There is chemotherapy that I had, and it breaks you, but I think it would help a lot if there was a person to ask, what are you asking now, a doctor, I don’t know. To see if it changes because the person is broken, many things, especially with this thing that I ended up with” (E1).

“I think it’s important to talk about sex. Is important because you’re with someone” (E8).

Discussion

Sexuality can be understood as affective, sexual and/or bonding achievements. It demarcates the attachment of human beings to their own physical and emotional development [25].

Winnicott [25, 26] starts from a point of view of the stages of human development and of the subjective and affective constitution in this process. The somatic, in the Winnicottian proposal, would be an individual’s conquest before the constitution of his life, of his integrality and psychosomatic unity.

For Winnicott, there is no opposition between body and mind, but between soma and psyche. There is, in this perspective, an initial instinctual tendency of the human baby to
unite the mind in the body. This trend takes place from the care received from the environment. The achievement of integration refers to the possibility of being. The body, the skin, becomes the boundary between self and non-self. The psyche begins to live in soma and an individual’s psychosomatic life begins.

His proposal interacts with the Merleau-Ponty’s phenomenology [31] and your principle of corporeality. Corporeality in Merleau-Ponty [31] is understood as a fundamental element to understand the experience of being in the world: the body is the subject itself. The world exists only insofar as it becomes effective on a sensitive, real, physical level although this existence is not reducible to sensitive data since body and mind are inseparable.

The body is not reduced to sexuality as it is a reflection of each person’s worldly existence, which also includes sexuality. Sexuality is the bridge for emotional-sexual contact [25] above all, for the experiences in intimate relationships, including those with family and sexual partner.

In this sense, the body that becomes ill affects the subject’s mind. Situations such as the presence or imminence of a serious pathology like HNSCC cause many changes. Physical, psychological, and occupational changes have major impacts on the life of patients with HNSCC [10, 17]. These changes caused by the disease invade the person’s subjective element and reveal their limitations. The patient regresses to a stage where they are more dependent and need greater care in order to develop physically and emotionally [25]. This stage is like that of the care needed by a baby, child, or elderly person. These traits of the regressive process can be observed in interviews E6 and E11.

The diagnosis and treatment of patients with HNSCC also results in changes in behavior and pleasure in the interrelation of the body with the world. These changes reach their thoughts and feelings about their body and themselves in various ways. Being aware of or taking up potentially risky behaviors for one’s own body and oneself, such as excessive alcohol and tobacco consumption [32, 33], can arouses anguish in HNSCC patients.

Participant E4 considers himself abnormal based on the change to his physical body. Participants E2 and E12 mention changes related to the taste of food, the absence of the desire to eat, and how the body perceives certain sensations. For participant E11, the impact was how their social relationships suddenly changed and how they felt deprived of them. These are also a source of pleasure that, although not sexual in nature, are part of the broadest concept of sexuality, which includes the affective experiences that result from the relationship between the body and the mind, between the subject and their body, and also affective elements resulting from the constitutive process of their subjectivity with the other and the environment which they are part of [34].

Physical appearance, or the way in which the bodily representation of the head and neck are described by the patient with HNSCC, tends to be reflected in their personal relationships. Intimate relationships have a powerful force in structuring and organizing people’s lives. The meaning attributed by the patient during their experience with the health-disease process will shape and influence new arrangements and views of life [27].

With the experience of a disease such as an HNSCC, the patient’s fantasies, emotional and sexual demands intensify [16, 24, 35]. This densely charged emotional experience can hinder the elaborative process of their closest affective relationships, as identified in the statements of participants E2 and E9.

Affective bonds, whether sexual, erotic, or those of love, knowledge and recognition, help the person in their mental organization process. In addition, they motivate the patient, especially those with HNSCC, due to the complexity and implications of this disease, to face the treatment. Considering that the disease leads the patient to a state of regression, it
requires those around them, including caregivers and health professionals, to provide delicate and subtle care \[36–38\].

The period of cancer treatment can bring to mind certain moments of the patient’s life, moments observed in the light of considerable reflection \[6, 39\]. The emotional requirements that arise in this period are related to the patient’s experiences, which have generated many numbers of conflicts, and which, until then, were not seen to be of great importance or concern \[34\].

**Sexual conflict** is present in the statement of participant E11, who reports his trajectory of sexual behavior, with an ambiguous discourse in relation to same-sex eroticism, which is latent in the patient. The contradiction and conflict in terms of his own sexual relations disturb him. He resorts to aversive feelings to ward off this desire, which is present in his sexuality.

This conflict, as well as other anxieties and affective and sexual reflexes, must receive some kind of qualitative intervention, as an attentive and welcoming listening of the multidisciplinary team and, perhaps, referral to the mental health team. In any case, paying attention to affective and sexual demands are important to take care of and elaborate on the anxieties, anxiety, stresses, sadness and other affective and emotional symptoms present from the disease \[39, 40\]. Demands that when not heard can negatively interfere with the patient’s quality of life and prognosis \[24\].

Change is an invitation to the new and fresh rearrangements based on the alterations to one’s life, including those experiences which bring pleasure. Facing this strange ”new” body is a great challenge. Some people find it difficult to change their own habits and customs. There are confrontations of all kinds, especially in dealing with already established affective-sexual relationships \[17, 24\]. The need to reinvent and rediscover new pleasurable practices is fundamental in order to improve quality of life, as well as keeping hope present \[41, 42\].

For male patients, when they become ill, is important to understand the difficulties and resistance in terms of self-care which are also related to the construction of masculinity \[43\]. The hegemonic model of masculinity is marked by physical strength and distance from everything that can be related to the feminine. Thus, men have difficulty in approaching elements such as affectivity, emotion, and care, and this can have a negative effect on the care for one’s own body, resulting in greater vulnerability to diseases and a lower adherence to treatment. Clinical aspects also found in other works \[44, 45\].

For the real elaboration of grief, a process of de-idealization is necessary \[46\], accepting powerlessness and imperfections, including facial deformations. The return to everyday life and adapting to the new reality \[34, 47\] requires creating new possibilities based on the recognition of losses \[48\]. An atmosphere of trust in which it is possible to explore such ideas must be established \[43\].

In view of the way in which patients with HNSCC are affected, is essential to produce and create a “new beginning” \[34\], which should also be supported by the specialized health team to help these patients recover their health and quality of life \[49\].

**Sexual, affective and emotional health care** is essential in assisting patients in the process of creating psychological mechanisms to face the challenges and emotions that arise from illness \[45\]. The specialized care intervention of the mental health team involves the adoption of active and qualitative listening, as well as the use of dialogue. Talking has its intervention role and legitimacy, and is effective as well as functional, as pointed out by patients E1, E8 and E10.

The conversation must touch on the patient’s sexuality as a relational phenomenon that includes both his internal world—thoughts, fantasies, desires, fears, anxieties—and the
external world—people, environment, work, marriage, and family [24, 39]. It is necessary to find moments to talk about the issues that affect patients with HNSCC, clarifying and helping them to dispel certain fears through real knowledge about the disease. Ignorance and the lack of meaning associated with emotional overload are risk factors for emotional traumas and mental illness [50].

An oncology health team must therefore be prepared to deal with emotions and the various questions that result from illness [42, 45, 51]. The team must also have sufficient technical knowledge to help the patient transform their emotional anxieties, allowing them to support, integrate, and address this moment [52].

Ultimately, data revealed that impacts mainly affect the felt/lived body, and the affective-sexual body. Requiring, then, an elaboration of the grief of the bodily and sexual changes and a special Health care in the sexual and emotional aspect.

The data demonstrate the need for the entire health team to be attentive to perceive, validity and care of emotional demands the HNSCC patient [53]. Creating spaces for attentive and qualified listening to sexual, effective and emotional aspects are positive factors which can contribute to a greater sense of well-being, emotional and psychological health, increased life expectancy and comfort in the face of physical, emotional and sexual changes [37, 54]. Finally, a possible psychosomatic integration [25, 26].

Conclusions and Recommendations

The findings of this study showed the importance to address the issue of sexuality with male patients with head and neck cancer, especially because it is not a subject addressed by oncology teams, usually. Diagnosis and treatment may trigger latent conflicts and questions about sexuality. Investment in these patients’ affective and sexual health care may help to reduce the traumatic experiences that emerge during the cancer treatment.

Addressing sexuality, which affects the dynamics of these patients’ daily relationships in different contexts and moments of their lives, is of great value when it comes to improving the quality of life, and sex life, of those with a serious disease such as HNSCC. This can be done by the mental health team, as well as by social workers, doctors, and specialized nursing staff, according to the severity of the demand. The bond between a patient and a health professional is essential to understanding the patient’s particularities and necessities before and during the diagnosis and treatment of HNSCC.

In conclusion, this study enhanced our understanding on the association among emotional support, coping style, perceived bodily, sexual and emotional changes, and psychological distress in head and neck cancer patients. Effective strategies focusing on the sexual and emotional dimensions are needed for head and neck cancer survivor man, being able to guarantee their quality of life, and sex life.

Author Contributions Conceptualization: Ricardo Souza Evangelista Sant’Ana, Egberto R. Turato; Methodology: Ricardo Souza Evangelista Sant’Ana, Egberto R. Turato; Formal analysis and investigation: Ricardo Souza Evangelista Sant’Ana, João Paulo Zerbinati, Maria Eufrasia de Faria, Carmen Silvia Passos Lima; Writing—original draft preparation: Ricardo Souza Evangelista Sant’Ana, João Paulo Zerbinati, Maria Eufrasia de Faria, Carmen Silvia Passos Lima; Writing—review and editing: Christine Maheu, Egberto R. Turato; Supervision: Egberto R. Turato.
**Funding**  Open Access funding provided thanks to the Hospital Sírio-Libanês, a philanthropic institution in health, research and education.

**Declaration**

**Competing Interest**  The authors have not disclosed any competing interests.

**Open Access**  This article is licensed under a Creative Commons Attribution 4.0 International License, which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if changes were made. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article’s Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit http://creativecommons.org/licenses/by/4.0/.

**References**

1. Ferlay, J., Colombet, M., Soerjomataram, I., Mathers, C., Parkin, D.M., Piñeros, M., Znaor, A., Bray, F.: Estimating the global cancer incidence and mortality in 2018: GLOBOCAN sources and methods. Int. J. Cancer 144(8), 1941–1953 (2018). https://doi.org/10.1002/ijc.31937
2. Buzaid, A.C., Maluf, A.C., Lima, C.M.R.: Manual de Oncologia Clínica do Brasil - Tumores Sólidos, 14ª. Ed. Dendrix, ed. São Paulo (2016)
3. Muzzatti, B., Giovannini, L., Flaiban, C., Annunziata, M.: Sexuality and intimacy after cancer: an exploratory survey at 5 years or more since treatment completion. G Ital. Med. Lav Ergon. 34(2 Suppl B), B12–B16 (2012)
4. Gupta, B., Johnson, N.W., Kumar, N.: Global epidemiology of head and neck cancers: a continuing challenge. Oncology 91(1), 13–23 (2016). https://doi.org/10.1159/000446117
5. De Vita, V.T., Lawrence, T.S., Rosenberg, A.S.: Cancer: Principles & Practice of Oncology. BL Books. Wolters Kluwer, Philadelphia (2015)
6. Muzzin, L.J., Anderson, N.J., Figueredo, A.T., Gudelis, S.O.: The experience of cancer. Soc. Sci. Med. 38(9), 1201–1208 (1994). https://doi.org/10.1016/0277-9536(94)90185-6
7. Fleury, H.J., Pantaroto, H.S.C., Abdo, C.H.N. Sexualidade em oncologia. Diagn. Tratamento. 16(2), 86–90. (2011). BL Books
8. Carvalho, E.S.S., Paiva, M.S., Aparicio, E.C., Rodrigues, G.R.S.: Trayectorias afectivo-sexuales de personas con heridas crónicas en las piernas: aspectos en la escucha terapéutica. Rev. Gaúcha Enferm 34(3), 163–170 (2013). https://doi.org/10.1590/S1983-14472013000300021
9. Nayak, S.G., Pai, M.S., George, L.S.: Self-image of the patients with head and neck cancer: a mixed method research. Indian J. Palliat. Care 22(3), 331–334 (2016). https://doi.org/10.4103/0973-1075.185050
10. Caldin, L.N., Medina, L.A.C., Silva, R.A., Barros, L.M., Lima, M.M.S., Melo,G.A.A., Galindo Neto, N.M., Caetano, J.: Self-concept and role function in patients with head and neck cancer. Acta. Paul. Enferm. 34, eAPE00892. (2021). https://doi.org/10.37689/acta-ape/2021AO00892
11. Low, C., Fullarton, M., Parkinson, E., O’Brien, K., Jackson, S., Lowe, D., Rogers, S.: Issues of intimacy and sexual dysfunction following major head and neck cancer treatment. Oral Oncol. 45(10), 898–903 (2009). https://doi.org/10.1016/j.oraloncology.2009.03.014
12. Isaksson, J., Salander, P., Lillienhorn, S., Laurell, G.: Living an everyday life with head and neck cancer 2–2.5 years post-diagnosis—a qualitative prospective study of 56 patients. Sc. Sci. Med. 154, 54–61 (2016). https://doi.org/10.1016/j.soscimed.2016.02.031
13. Gritz, E.R., Carmack, C.L., de Moor, C., Coscarelli, A., Schacherer, C.W., Meyers, E.G., Abemayor, E.: First year after head and neck cancer: quality of life. J. Clin. Oncol. 17(1), 352–360 (1999). https://doi.org/10.1200/JCO.1999.17.1.1352
14. Crossley, M.: ‘Let me explain’: narrative emplotment and one patient’s experience of oral cancer. Soc. Sci. Med. 56(3), 439–438 (2003). https://doi.org/10.1016/s0277-9536(01)00362-8
15. Lambrecht, M., Mercier, C., Geussens, Y., Nuyts, S.: The effect of a supersaturated calcium phosphate mouth rinse on the development of oral mucositis in head and neck cancer patients treated with
(chemo)radiation: a single-center, randomized, prospective study of a calcium phosphate mouth rinse + standard of care versus standard of care. Support. Care Cancer 21(10), 2663–2670 (2013). https://doi.org/10.1007/s00520-013-1829-0
16. Grattan, K., Kubrak, C., Caine, V., O’Connell, D.A., Olson, K.: Experiences of head and neck cancer patients in middle adulthood: consequences and coping. Glob Qual. Nurs. Res. 5 (2018). https://doi.org/10.1177/233339618760337
17. Lima, E.N., Ferreira, I.B., Lajolo, P., Paiva, E., Maia, Y.C.P., Pena, G.G.: Health-related quality of life became worse in short-term during treatment in head and neck cancer patients: a prospective study. Health Qual. Life Outcomes 18(307) (2020). https://doi.org/10.1186/s12955-020-01543-5
18. World Health Organization. Sexual health. http://www.who.int/topics/sexual_health/en/ (2017). Accessed 30 Sept 2021
19. Schover, L.R.: Sexual quality of life in men and women after cancer. Climacteric 31, 1–5 (2018). https://doi.org/10.1080/13697137.2018.1526893
20. Barbera, L., Zwaal, C., Elterman, D., McPherson, K., Wolfman, W., Katz, A., Matthew, A.: Interventions to address sexual problems in people with cancer. Curr. Oncol. 24(3), 192–200 (2017). Doi:https://doi.org/10.1002/cam4.1497
21. McCarter, K., Baker, A.L., Britton, B., Wolfenden, L., Warrten, C., Bauer, J., Halpin, S.A., Carter, G., Beck, A.K., Leigh, L., Oldmeadow, C.: Smoking, drinking, and depression: comorbidity in head and neck cancer patients undergoing radiotherapy. Cancer Med. 7(6), 2382–2390 (2018). Doi:https://doi.org/10.1002/cam4.10146
22. Denlinger, C.S., Sanft, T., Baker, K.S., Baxi, S., Broderick, G., Demark-Wahnefried, W., Friedman, D.L., Goldman, M., Hudson, M., Khakpour, N., King, A., Koura, D., Kvale, E., Lally, R.M., Langbaum, T.S., Melisko, M., Montoya, J.G., Mooney, K., Mosleh, J.J., McMillian, N.R.: Clinical practice guidelines in oncology. J. Natl. Compr. Cancer Netw. 15(9), 1140–1163 (2017). https://doi.org/10.6004/jnccn.2017.0146
23. Hoole, J., Kanatas, A.N., Mitchell, D.A.: Psychosexual therapy and education in patients treated for cancer of the head and neck. Br. J. Oral Maxillofac. Surg. 53(7), 601–606 (2015). Doi:https://doi.org/10.1016/j.bjoms.2015.04.022
24. Airoldi, M., Ostellino, O., Raimondo, L., Pecorari, G., Franco, P., Rampino, M., Succi, G., Denegri, M., Tosi, C., Botto, R., Torta, R., Ieraci, V.: Unmet needs in head and neck cancer patients: unmet needs, emotional disorders, and pain. J. Clin. Oncol. 35(15) (2017). https://doi.org/10.1200/JCO.2017.35.15_suppl.e17501
25. Winnicott, D.W.: Maturational Processes and Facilitating Environment. Karnac Books, London (1990)
26. Winnicott, D.W.: Psycho-Analytic Explorations. Karnac Books, London (2010)
27. Turato, E.R.: Tratado da metodologia da pesquisa clínico-qualitativa: construção teórico-epistemológica, discussão comparada e aplicação nas áreas da saúde e humanas, 6th edn. Vozes, Petrópolis (2013)
28. Faria-Schützer, D.B., Surita, F.G.C., Alves, V.L.P., Vieira, C.M., Turato, E.R.: Emotional experiences of obese women with adequate gestational weight variation: a qualitative study. PLoS One 10(11), e0141879 (2015). https://doi.org/10.1371/journal.pone.0141879
29. Fontanella, B.J., Luchesi, B.M., Saidel, M.G., Ricas, J., Turato, E.R., Melo, D.G.: Sampling in qualitative research: a proposal for procedures to detect theoretical saturation. Cad. Saúde Pública 27(2), 388–394 (2011). https://doi.org/10.1590/S0102-311X2011000200002
30. Faria-Schützer, D.B., Surita, F.G., Alves, V.L.P., Bastos, R.A., Campos, C.J.G., Turato, E.R.: Seven steps for qualitative treatment in health research: the clinical-qualitative content analysis. Ciência Saúde Colet 26(01), 265–274 (2021). https://doi.org/10.1590/141381232020261.07622019
31. Merleau-Ponty, M.: Phenomenology of Perception. Taylor & Francis Group, New York (2005) BL Books.
32. Freedman, N.D., Schatzkin, A., Leitzmann, M.F., Hollenbeck, A.R., Abnet, C.C.: Alcohol and head and neck cancer risk in a prospective study. Br. J. Cancer 96, 1469–1474 (2007). https://doi.org/10.1038/sj.bjc.6603713
33. Argiris, A., Karamouzis, M.V., Raben, D., Ferris, R.L.: Head and neck cancer. Lancet 371(9625), 1695–709 (2008). https://doi.org/10.1016/S0140-6736(08)60728-X
34. Balint, A.: Primary love and psycho-analytic technique. Karnac. BL Books, London (1994)
35. Krychman, M.L., Amsterdam, A., Carter, J., Castiel, M., DeAngelis, L.: Brain cancer and sexual health: a case report. Palliat. Support Care 2(3), 315–318 (2004). https://doi.org/10.1017/S1478951504040404
36. O’Brien, K., Roe, B., Low, C., Deyn, L., Rogers, S.: An exploration of the perceived changes in intimacy of patients’ relationships following head and neck cancer. J. Clin. Nurs. 21, 17–18 (2012). Doi:https://doi.org/10.1111/j.1365-2702.2012.04162.x
37. Castro, E.K., Bianchini, D., Peuker, A.C., Romeiro, F.B.: Communication in oncology: a qualitative analysis based on psychoanalysis. Psicol. Estud. 21(2), 349–358 (2016). https://doi.org/10.4025/psicolestud.v21i2.29707
38. Humphris, G.: Psychological management for head and neck cancer patients: United Kingdom National Multidisciplinary Guidelines. J. Laryngol. Otol. 130(2), S45–S48 (2016). https://doi.org/10.1017/S0022215116000426
39. Kvale, K., Synnes, O.: Understanding cancer patients’ reflections on good nursing care in light of Antonovsky’s theory. Eur. J. Oncol. Nurs. Dec. 17(6), 814–819 (2013). https://doi.org/10.1016/j.ejon.2013.07.003
40. Dekker, J., Karchoud, J., Braamse, A.M.J., Buiting, H., Konings, I.R.H.M., Linde, M.E., Schuurhui zen, C.S.E.W., Sprangers, M.A.G., Beeke man, A.T.F., Verheul, H.M.W.: Clinical management of emotions in patients with cancer: introducing the approach “emotional support and case finding.” Transl. Behav. Med. 10(6), 1399–1405 (2020). https://doi.org/10.1093/tbm/ibaa115
41. Li, P., Guo, Y.J., Tang, Q., Yang, L.: Effectiveness of nursing intervention for increasing hope in patients with cancer: a meta-analysis. Ver. Latino-Am Enfermagem 26 (2018). https://doi.org/10.1590/1518-8345.1920.2937
42. Corn, B.W., Feldman, D.B., Wexler, I.: The science of hope. Lancet Oncol. 21(9), e452–e459 (2020). https://doi.org/10.1016/s1470-2045(20)30210-2
43. Figueiredo, L.C.: Trust: the experience of confidence in the psychoanalytic treatment and in the cultural space. Ver. Bras. Psicanal. 41(3), 69–87 (2017). http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S0486-641X2007000300008&lng=pt&nrm=iso
44. Teixeira, D.B.S., Crus, S.P.L.: Health care for the human: analysis of its strength is search for the health services. Rev. Cuba. Enf. 32(4) (2016). https://www.medigraphic.com/cgi-bin/resumenI.cgi?D ARTICULO=76501
45. Ichikura, K., Yamashita, A., Sugimoto, T., Kishimoto, S., Matsushima, E.: Persistence of psychological distress and correlated factors among patients with head and neck cancer. Palliat. Support Care 14(1), 42–51 (2016). https://doi.org/10.1017/S1478951515000711
46. Kupermann, D.: Humor, de-idealization and sublimation in psychoanalysis. Psicol. Clín. 22(01), 193–207 (2010). http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S0103-566520100010012&lng=en&nrm=iso
47. Honorato, N.P., Abumusse, L.V.M., Coqueiro, D.P., Citero, V.A.: Personality traits, anger and psychiatric symptoms related to quality of life in patients with newly diagnosed digestive system cancer. Arq. Gastroenterol. 54(2), 156–162 (2017). https://doi.org/10.1590/s0004-2803.201700000-04
48. Winnicott, D.W.: Holding and interpretation: fragment of an analysis. Karnac Books, London (1991)
49. Melo Filho, M.R., Rocha, B.A., Pires, M.B.O., Fonseca, E.S., Freitas, E.M., Martelli Junior, H., Santos, F.B.: Quality of life of patients with head and neck cancer. Braz. J. Otorhinolaryngol. 79(1), 82–88 (2013). https://doi.org/10.5935/1808-8694.20130014
50. Wu, Y.S., Lin, P.Y., Chien, C.Y., Fang, F.M., Chiu, N.M., Hung, C.F., Lee, Y., Chong, M.Y.: Anxiety and depression in patients with head and neck cancer: 6-month follow-up study. Neuropsychiatr. Dis. Treat. 27(12), 1029–1036 (2016). https://doi.org/10.2147/NDT.S103203
51. Salander, P., Isaksson, J., Granström, B., Laurell, G.: Motives that head and neck cancer patients have for contacting a specialist nurse: an empirical study. J. Clin. Nurs. 25, 21–22 (2016). https://doi.org/10.1111/jocn.13283
52. Bianchini, D., Peuker, A.C., Romeiro, F.B., Castro, E.K.: Communication in oncology: a qualitative analysis based on psychoanalysis. Psicol. Estud. 21(2), 349–358 (2016). Doi:https://doi.org/10.4025/psicolestud.v21i2.29707
53. Rigoni, L., Bruhn, R.F., Cicco, R., Kanda, J.L., Matos, L.L.: Quality of life impairment in patients with head and neck cancer and their caregivers: a comparative study. Braz. J. Otorhinolaryngol. 82(6), 680–686 (2016). https://doi.org/10.1016/j.bjorl.2015.12.012
54. Dreifuss-Kattan, E.: Cancer and Creativity: A Psychoanalytic Guide to Therapeutic Transformation. Routledge, England (2018)

Publisher’s Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.
Authors and Affiliations

Ricardo Souza Evangelista Sant’Ana1 · João Paulo Zerbinati2 · Maria Eufrasia de Faria3 · Carmen Silvia Passos Lima3 · Christine Maheu4 · Egberto Ribeiro Turato3,5

Ricardo Souza Evangelista Sant’Ana  
enf.rses@gmail.com

João Paulo Zerbinati  
jpzerbinati@usp.br

Maria Eufrasia de Faria  
mariaeufrasiab@gmail.com

Carmen Silvia Passos Lima  
carmenl@fcm.unicamp.br

Christine Maheu  
christine.maheu@mcgill.ca

1 University of São Paulo at Ribeirão Preto College of Nursing, Ribeirão Preto, São Paulo, Brazil
2 Faculty of Philosophy, Sciences and Letters at Ribeirão Preto, University of São Paulo, Ribeirão Preto, São Paulo, Brazil
3 School of Medical Sciences University of Campinas, Campinas, São Paulo, Brazil
4 School of Nursing, McGill University, Montréal, QC, Canada
5 Cidade Universitária “Zeferino Vaz”, R. Tessália Vieira de Camargo 126, Barão Geraldo, Campinas, São Paulo, Brazil