

Listening to the Personal “Inner Language” of Patients with Head and Neck Cancer

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Abstract

Background: Recurrent head and neck cancer (rHNC) still carries a poor prognosis. There is no generally accepted standard treatment protocol for this condition, and most patients succumb to the disease after 18 months. What often goes unexamined is the “personal listening language” (PLL) and emotional background of these patients, which favors addictive alcohol and tobacco behavior and is strongly correlated to a broad range of psychosocial problems that become exacerbated over time.

Objective: The study aimed to describe the PLL of patients with head and neck cancer. To that end, we conducted a retrospective study of data collected through an open-ended questionnaire applied individually to each patient who freely wanted to participate. This study aimed to better study the patients’ emotional state, insofar as the “emotion” for these patients is the feeling of fear of dying, of helplessness, guilt that generates internal and external disorganization in the patient’s life, causing depression, despair and distress for many. That accounts for the search for their Personal Listening language, which is the expression of their uniqueness and peculiar way to understand their existence, that is, an existential semantics of the individual patient.

Justification for using the PLL: This PLL was important because it allowed patients to speak with a professional psychologist who heard and listened to them in their mental and physical pain, involving fear, loneliness, guilt, and to express their anguish and suffering. “Emotion” for these patients is the feeling of fear of dying, of helplessness, a guilt, which generates internal and external disorganization in the patient’s life, causing depression, despair and grief to many. The patient who suffers, who is in distress and upset by his/her situation needs medical and psychological assistance, a holistic treatment. The psychological support through the LPP in patients with head and neck cancer allows them to overcome emotional issues and have serenity vis-à-vis the illness.

Methodology: This study started in July 2009 and finished in December 2010. 124 patients were treated during a total of 191 sessions of psychological support. This doctorate student from the university was available two afternoons a week at the clinic on a voluntary basis for patients who wanted this service. An open-ended questionnaire was given to the each patient, which allowed the consented participation of patients in the care during our meeting. The responses, which shall be kept for three years, were recorded and included their personal data, the hospital’s HR and the number of care. Patients answered openly and felt welcomed and grateful for the benefits they experienced, which allowed them to better cope with their situation and have a professional who heard them in their emotional and psychological distress. Responses were grouped and written down.

After these visits, because we realized that the statements of the patients were positive about the LLP, we decided to request the Ethics Committee of Escola Paulista de Medicina - UNIFESP, approval to conduct the Retrospective Study, which was approved CEP No. 0291/11. The collected material allowed us to write in order to be able to collaborate in the awakening of increased public health attention and care to these patients who suffer from loneliness, are distressed and need to be heard and listened and offer them quality of life during their illness and support to their suffering and emotional distress, something mostly forgotten.

Results and conclusions: The findings revealed the psychological benefit of this type of listening for rHNC patients in coping with their illness and suffering, as well as for improving the quality of their emotional life.

We could see that PLL, through the psychological support to patients with head and neck cancer, according to their own speeches, made them thankful that they found a point of reference to talk about their psychic pain and suffering. It was observed that although they are experiencing a disease that leads them to the finiteness of life, this listening allowed them to endure and cope with the situation in a more serene manner, motivating them to live a better quality of life, taking care of themselves, learning the importance of food, family interactions and overcoming anxiety, distress, fear of living alone. The PLL encouraged not only an internal well-being but also a new meaning to their lives, a return to spirituality in their beliefs and an analysis of their history, now that they were more organized within, awakened to live with a better quality of life in the days they have left.

Keywords: Recurrent head and neck cancer; Personal (inner) listening language; Psychology; Stress; Oncology

Introduction

Among malignant tumors of the upper aerodigestive tract, squamous cell carcinoma of the head and neck is one of the most common malignancies, with approximately 500,000 projected cases per year [1]. In Brazil, it is estimated that 35,000 new cases occur each year, and 19 cases of oral cancer are diagnosed per 100,000 inhabitants - the second highest incidence of oral cancer in the world, after India [2]. Approximately half of all patients affected by head and neck cancer

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(HNC) experience recurrence of the disease within five years after treatment, according to the INCA [3]. HNC survival rates are very low for patients who experience a relapse: most die within the first year, usually with severe functional and aesthetic problems.

Psychological problems suffered by rHNC patients are often overlooked by the public hospital system. Patients with HNC often experience a strong component of depression, anxiety, which can manifest as the inability to abandon harmful vices, such as smoking and alcohol, which caused the onset of their disease. According to An et al. [4], who studied patients in a smoking cessation program, those with clinically-proven components of depression had less success in quitting. The authors concluded that the more severe the depression, the greater the difficulty of abandoning harmful habits such as smoking.

Assuming the existence of a basic emotional component in patients with rHNC, we sought to access this "sick" emotional state through outpatient psychological support in order to "listen to their personal language," and thus be able to better prepare them to cope with their disease. Safra [5] defined this "listening to personal language" as the way in which the uniqueness of a human being is reflected in their personal style, which derives from their peculiar way of interpreting their existence and the borrowing of words, images and actions, in existential personal semantics.

The possibility of researching "personal language listening" [PLL] in patients with HNC presents an important aspect that is often overlooked in patients with recurrent disease. Often, the survival rate of these patients is around 15-22% over five years, according to Sercarz et al. [6], who studied this specific target population.

This paradox was evident when we began a series of interviews with cancer patients in the Outpatient Oncology Clinic at the Federal University of São Paulo. We conducted these interviews in order to better know them and understand how we could support them during their treatment at the institution. We serve 123 cancer patients with similar mental, cultural, and economic conditions. Of this total, 33 patients presented with rHNC. Despite their difficulties in speech articulation, we realized the importance of PLL as a mechanism to facilitate the therapist in preparing them to deal with their individual fears, anxieties, and suffering.

During the treatment of these patients, we observed the expression of their individuality and their language to be a peculiar way of interpreting their existence, assigning a personal, existential, semantic meaning to words, images, and actions. This would be what we call a certain essence of the speech, to be recognized by the therapist, and this translates into the PLL of a patient undergoing a stressful situation. According to Ballone and Moura [7], stress amounts to the overall change in an organism to adapt to a new situation, which may cause varying degrees of discomfort depending on its individual characteristics. According to Mello and Fiks [8] and Selye [9], stress has the function of adjustment. Patients with cancer often face a need to adapt not only to the consequences of the disease but also to treatment. When commenting on anxiety in cancer patients, these authors assert that Posttraumatic Stress Disorder [PTSD] may be present, especially vis-à-vis the diagnosis of cancer, surgery, chemotherapy, and other medical procedures.

Melo and Fiks [8] describe that "the traumatic event can have an intense psychological distress or physiological reactivity, causing

emotional and social isolation", as one patient expressed in our research: "If I knew the consequences, I would not have had surgery." Through these words he conveys the great impact of the sequelae, even though they arose from procedures necessary to contain the disease.

In our early days of listening to these patients, we observed that even in an anticipatory environment they appeared dull, dejected, with a frightened presentation and difficulty focusing, but they slowly familiarized. During the sessions, those with difficulty speaking would offer a wave or positive gesture to show some intimacy and greater composure. As a result, we believed that we could stimulate insight in patients with rHNC, preparing them to face their mortality and initiate awareness of their death.

Selye [9] cites three successive stages of adaptation-related stress:

- a) Alarm reaction phase, known as "shock," when the body cannot maintain equilibrium by itself;
- b) Adaptation or resistance phase, composed of a set of specific adaptive which cannot be maintained for long;
- c) Exhaustion or depletion phase: this is when limitations in the adaptation mechanisms and energy reserves are exceeded. This is the most serious stage, which can lead to the patient's death.

Brief dynamic psychotherapy [BDP] has shown the importance of professional accompaniment of patients, providing them with support to help contain the impact of the news of the cancer. In this situation, the function of BDP is to provide patients with support and PLL in relation to their physical and psychic pain, allowing them to discover a new meaning for their life. With this we can facilitate the individual patients' adaptation to the new situation, thereby providing them with a better quality of life.

According to Uchitel [10], traumas do not arise from events, but from memories and associations which act traumatically, forming complex ramifications and associations that generate further aggression in the present. The trauma thus does not speak but "acts", being a repetition of perceptions without words. Seligman-Silva [11] reported that trauma can lead to the failure to receive an event, and thus cause a "wound in memory." Consequently, patients should always be well provided with support and care, especially by the multi-disciplinary professional team that accompanies them during treatment.

As for the experience lived by the patient, Braga [12] states that it should be evaluated from the existential perspective, and that the trauma affecting the patient can only be properly accessed by professionals such as doctors, psychologists, and psychiatrists who listen to the personal story of the "patient, his subjective life." The author also comments that careful examination of the words used by the patient is fundamental to understanding the psychological impact and the psychological representation caused. In this regard, clinical experience shows that patients suffering from a psychological impact usually take on attitudes of resilience, anger, and/or acceptance.

In "Illness as a Metaphor," Sontag [13] mentioned that instead of analyzing the disease, a therapist should focus on punitive or sentimental fantasies engendered about the situation, leading us to rethink the disease as an individual psychological expression. In outpatient care for patients with rHNC, we could identify the emotional phases they passed through, and how each demanded special attention from health

professionals. In this context, a situation particular to patients with rHNC is introduced to us through the patient's PLL.

According to Green [14], the stress process starts from the information provided and perceived, which can cause psychological reactions that generate stress and feelings of loss, arising either from the situation itself or the environment. According to Mello et al. [15] the essential feature of PTSD is the development of specific symptoms following exposure to an external stressor, especially the experience of the risk of death (Criterion A).

Methodology

We used the qualitative method, given the fact that this study was developed in the field of health and illness. This method symbolizes the phenomena in health, taking into account the existential, clinical and psychic attitudes of the patient and the illness. From the responses collected and recorded by this professional because many patients could not write or read. Through Brief Dynamic Psychotherapy we sought to carefully listen to the language and make interventions of psychological support as needed for each patient individually taking into account their existential problems.

This retrospective study evaluated data from the medical records of 123 patients examined in the Oncology Outpatient Clinic at the Federal University of São Paulo (a total of 193 sessions), from July 2009 to December 2010, after approval by this institution's Ethics and Research Committee. Of this total, we identified 33 patients with recurrent cancer of the oral cavity [n = 18] and oropharynx [n = 15]. We collected sociodemographic data and conducted a psychological assessment based on an initial five-part questionnaire completed by all patients. We developed the following "categories of speech" for the study.

- 1 - How they received the news about the disease.
- 2 - Psychopathologies expressed.
- 3 - Taboos and prejudices about the disease.
- 4 - Relationship with family.
- 5 - Impact of Psychological Intervention.
- 6 - Perception of the meeting with and care by the psychotherapist.

An analysis of responses to the questionnaire was compiled using the clinical-qualitative methodology for observation and description of the results. From this analysis, we created our support plan through BDP sessions.

Demographic characteristics of the sample

This study involved 105 men and 18 women from different Brazilian cities. Most patients were in the age group between 50 and 60 years. Most were part of the working classes B and C, with complete primary education.

Of these, 15 patients with an etiology of rHNC in the oral cavity and oropharynx were selected. The choice of this sample was based on the similarity of the biological behavior and the aesthetic and functional disorders of the tumors.

Categories of speech

We analyzed the following categories according to the discourse examined in the patient assessments.

How did you receive the news of the disease? Some phrases spoken by patients on receiving the news:

I don't even think about reality, I feel a lot of anger and rage, I get nervous, I carry a lot of sorrows inside me, I felt sad, depressed and not accepted, I was shaken and upset, "I felt embarrassed and trapped, useless, and prostrate, I feel guilty. Through my bad habits, I suffer in silence, I was shocked, terrified, cried a lot, had difficulty accepting."

"Now I accept it better than in the beginning. I try to feel tranquility and serenity, but in the beginning it was very difficult. This disease has led me to take stock of life. I try to deal with it normally and be positive in life."

"I wonder, why must I go through this disease? What did I do? I did not deserve this, why me?"

Expressed psychopathologies: Patients were anxious and distressed, experiencing feelings of guilt, despair, some apathy, anhedonia, irritability, isolation, sadness, worry, anger, and nervousness.

Some phrases that exemplify this category

"It is better to die, I am always sad, I feel depressed, discouraged. I have no right to complain about pain and suffering, it is a suffering I need to experience alone."

"I don't feed myself because I want to die, no one cares for me, I'm alone all day and I cannot prepare food."

"I didn't take care of myself during my life and so I feel guilty, without any right to talk about it."

"They tell me that all I did was smoke and drink and that now I must endure the consequences, it is too hard to hear this from my family."

Taboos and prejudices about the disease: Some typical phrases expressed in this category

"I do not know why this happened to me. I think God is punishing me, perhaps to correct something in my life. I have so much anger and hatred from past situations that it all emerged in this disease. Now I just have to accept it and that takes humility, resignation, that's how I feel."

"Why did this happen to me? After a life of struggle, dedicated to caring for others, and now this happens to me now that I can finally rest?"

As reflected in the above statements, the body over the course of biological history has been marked by the impression that "being" sick was the same as being "possessed" by a psychic and/or physical evil, a disharmony, a moral evil that recalls the stories cited in times of plague, Spanish flu, leprosy, cholera, syphilis, tuberculosis, cancer, leprosy, and AIDS; diseases seen as a curse, misfortune, taboo, a mysterious evil or transgression. In her essay, Sontag [13] referred to "being sick" as an experience akin to gaining a new citizenship. In other words, it is like feeling cruelly and secretly invaded by a disease that does not ask permission: it is cancer. This disease is seen as a demonic gravity that blocks and atrophies bodily functions so that the body shrinks and acts treacherously, as stated by Reich [16].

We observed that some patients with rHNC also understand the disease as a punishment for something left undone, through ideas of condemnation for something from the past, for not having been

careful, for drinking or smoking. These thoughts come from the reflection of their historical culture and possibly some personal beliefs about the past.

Relationship with family: While most expressed being well taken care of and supported in their illness, many also expressed

"I feel well taken care of and they support me in everything, I have everything I need and the whole family is present."

"I do not feel understood, I must make my own food because no one does that, I feel lonely in this struggle, the children don't visit me, it's very sad,"

"I have to do all the housework, otherwise when my wife comes she will tell me off. That is painful, there are days when I simply can't do it."

"I cannot speak about the disease because if I say something they point out situations in my past that hurt, so I shut up and suffer alone, I have no one to talk to"; "they want me to feed myself well but I feel such pain and they don't understand"; "friends all moved away, they are afraid to catch the disease from me, I feel despised, rejected by friends—this is the biggest pain. I would like to live with some of my children to take care of me."

The family is the social space in which patients can express their feelings, especially their troubles, the source of sickness, sadness, and grief. These patients expressed the perception of being cared for, supported, and monitored even if silently by the family. Others complained about a lack of care, some neglect, and indifference. They complained that the loss of friends because of the disease "caused" evident suffering, insofar as they did not understand the reason for this distance when they most needed friendship and support.

Impact of psychological intervention: Some patients have been fortunate enough to be able to rely on specialized psychological care. Those reported the following

"I liked having someone to talk to, because at home I can't talk about all that I feel and suffer, because they suffer even more with me and it makes me exhausted." "I wondered if I should come and talk, because psychologists are for crazy people, but I took courage and came and I realized that this is not the case. It is important to have a professional who will listen to us"; "it has relieved stress."

Patients expressed the importance of being able to express their suffering and emotions. The time and space of the visits proved to be facilitators of a bond and changes in thinking regarding this existential situation, and also served as facilitators to confront the disease and motivation to continue living with quality of life.

How did you perceive the meeting with and care by the psychotherapist? When asked how they viewed the meeting and exchange with the psychotherapist, patients expressed

"After I talked about this I felt better and better every day. I returned to say that after I spoke, my mind changed. It helped me a lot, I did not say to anyone what I said here in this room."

"After talking, I felt relieved, lighter, it made me feel comfortable and quiet, it was fruitful. Her words help lift the mood. I do not usually cry, but here I cried, and that was good." "I could vent."

"I thought about not talking, but I liked it and it was good for me. It was different than I thought."

"I loved to talk, I do not know what you did for me to talk so calmly."

The priority of the intervention is to reduce the impact of the disease and resulting treatment, enabling a new coping dynamic by stabilizing the adaptive processes surrounding the "disease vs. treatment" binomial, and in doing so attempt to diminish the emotional rupture experienced by patients facing recurrent disease in the head and neck. This is amply demonstrated in the descriptions of listening to patients.

Discussion

The testimonies highlighted above illustrate the various stages and attitudes that patients experience in the disease-death situation, as well described by Elisabeth Kübler-Ross [17], who outlines the defense mechanism against diseases with risk of death. In the phase termed "denial," the patient refuses the diagnosis, cushioning its impact. When denial is no longer possible, it is replaced by feelings of rebellion and resentment. In the "negotiation" phase, patients try to obtain healing through negotiations and divine bargains. "Depression" is the phase of internalization, which sees the emergence of lamentations, complaints, indifference, and a tendency towards self-isolation. The "acceptance" stage shows contemplation of the approaching end with a degree of quiet expectation. Servan-Schreiber [18] points out that "a positive denial is one where patients care for their health and follow medical prescriptions; conversely, anything that undermines the will to live diminishes the capacity for healing."

The retrospective study conducted at the Outpatient Oncology Clinic of UNIFESP aimed to better study the emotional side of these patients through PLL, to enable integration of the health process and an understanding of finality. This disease can cause a feeling of "uselessness that affects the sense of dignity and affective aspect," says Servan-Schreiber [18]. These observations are consistent with the patients' emotional expressions transcribed above. In this retrospective study we have observed the importance of PLL; qualified listening has allowed patients to confront themselves and change their way of looking at the reality of the disease.

The retrospective study shows patients better at this confronting and more motivated to care for themselves in the words of Winnicott [19], "holding" (caring for oneself, keeping oneself). In the context of health, he explains that "the main work that is done is that in the nature of integrating the experience, made possible through support in human relationships, but a professional one a form of holding."

These patients put their confidence in psychological care to express the multiple emotional aspects that affect them. The existential dimension of these HNC patients is fragile, and in the face of this psychic fact Ayres [20] proposes that "There is an excess of scientific technology and little art in contemporary medicine much techno science because of little art, or little art because of too much technoscience," and that today, "technoscience embodies medical art, shapes it, expresses it. The medical art, in turn, calls on technoscience, feeds from it, is transfigured into it". This leads us to question of how health is fostered and its humanization. The author concludes that we must not limit medical art to assisting only the creation and manipulation of objects.

The routine intersperses the different relationships of the family and work environment, which often provides emotional release, as postulated by Kisse [21]. The author states that "cancer patients have a typical tendency to meet their emotional problems and conflicts,"

which leads to a "reduction in the output of emotional release." These patients have difficulty expressing their emotions, especially anger, and with hurt feelings they isolate themselves and use the mechanism of avoidance in interpersonal relationships; silence as a way of dwelling on what was injured. This creates an emotional tension, not allowing the patients to express themselves due to long-held feelings of repression, fear, guilt, and lack of self worth. Sontag [13] describes that according to the mythology of cancer, "the disease in the former mode was caused by a constant repression of violent feelings." Likewise: "the person who is dying of cancer is portrayed as devoid of any ability to autotranscendence, humiliated by fear and physical pain," and ends up taking a position of resilience, as noted by Kotliarenko et al. [22], resilience being the effective confrontation of the circumstances and severely stressful and cumulative life events.

According to Trichopoulos et al. [23] cancer patients have a history of struggle, suffering, and material, spiritual, emotional and socioeconomic hardship beginning early and continuing throughout life, associated with a struggle for personal and family achievements, and sometimes accompanied by frustration. From an early age they are marked by a lack of affection, rejection, and abandonment, and they grow up with a feeling of being unworthy of affection, and as a consequence lead a life of continuous psychic distress. Vis-à-vis this emotional reality of the illness, Hofmann [24] defended that the concept of disease can exist without a general theory of health.

Coddo [25] points out the importance of the humanities and the importance of understanding "how human beings construct themselves, their childhood, sexuality, pleasure, suffering, politics, economics, and finally the unconscious, from which stems 'the mystery.'" He also teaches us that when the human beings speak about "psychological distress, they are talking about a kind of split between subjectivity and objectivity, such as a divorce between self and world, between self and other."

Ayres [26] adds: It seems to me that the live intersubjectivity of the moment of care allows an escape from the 'desubjectivizing' objectification exactly because therein an exchange occurs, a relational space that goes beyond the technological. It relies on technology, but is not subordinate to it, subverts it. It is established from within and around the universals it expresses, but charges them to the limits. The 'carnal' co-presence of an assistant and an assisted inexorably brings into play a kind of knowledge that is distinct from the universality of the art and science, but also differs from the free exercise of creative subjectivity of a producer of artifacts.

The importance of the humanized relationship in encounters with sick people, the emotional listening and the refuge, will allow them to understand the place they are in, which is found internally, encouraging them to face the current preparation of accepting and caring for themselves with less suffering. In other words, their potential place with respect to the social world will depend on the confidence that they will have awakened in them a motivation for living, even with the awareness of finality.

Among the stages of acceptance of the disease, Becker [27], writing about the denial of death, notes: "it does not matter whether the system of heroism in a culture is frankly magical, religious and primitive or secular, scientific and civilized." It is, regardless, a system of mythic heroes, in which people strive to acquire a basic sense of value, of being special in the cosmos, useful for creating, constant in meaning.

The denial mechanism is a defense against the loss of identity and integration of oneself, which generates profound anguish. Becker [27] adds that death anxiety is the characteristic anxiety trait, the most intense anguish of man. Rank, [28] the Austrian psychologist, points out that when we speak of guilt, "consciousness of guilt is only an expression of his will denial, not of creative accomplishment of will, which makes one truly guilty." The same author points out that "will and guilt are the two complementary sides of one and the same phenomenon." and adds,

"I think the guilt feeling occupies a special position among the emotions, as a boundary phenomenon between the pronounced painful affects that separate and the more pleasurable feelings that unite. It is related to the painful separating affects of anxiety and hate. But in its relation to gratitude and devotion, which may extend to self-sacrifice, it belongs to the strongest uniting feelings we know. As the guilt-feeling occupies the boundary line between the painful and pleasurable, between the severing and uniting feelings, it is also the most important representative of the relation between inner and outer, I and Thou, the Self and the World."

Rank [28] further explains: Man's acceptance of his dependence on nature is more honest, while freedom-ideology, beyond a certain point, presumes the negation of that dependence and is therefore, also in a deeper sense, dishonest. This fundamental dishonesty towards nature then comes out as consciousness of guilt, which we see active in every process of art the more strongly man feels his freedom and independence, the more intense on the other hand is the consciousness of guilt, which appears in the individual partly restrictive, partly creative.

Rank [28] also adds that "the body is a gateway to restore the house; the house-body is the psychic, whose virtue is authentic because only the authentic bears in itself the emotional. The house-body is what maintains the life of the relationship in the family, which opens in a growing, abundant manner and reaches the social, the world of relationships. It is what allows the vast human exchanges and enrichment of life." That is, it maintains interpersonal relationships as an outlet for the expression of emotions, which prevents illness, isolation, avoidance and stress.

Psycho-oncology aims to improve the quality of life of patients. It creates the psychological conditions for coping with the emotional difficulties and pain awakened by the disease. Frankl [29] notes the value of attitude, which means assuming unavoidable suffering, and "that while human beings suffer, the soul lives on."

According to Mello, [30] "cancer is a disease linked to the whole person of the patient; it should be a reflection of his/her personal relationships, family and social life". Reed and Jacobsen [31] prioritize "the way in which psychological states affect the transformation of normal cells into malignant ones, the impact of cancer and the psychological treatment aiming at an emotional adjustment, the role of social support in cancer, the impact of cancer and its long-term treatment, the psychiatrist's and psychotherapist's roles in reducing side effects." According to Groddeck, cited by Lazlo [32] "the sick man himself creates himself, his illness," and as formulated by Karl Menninger, "illness is in part what the world has done to its victim, but in larger part it is what the victim has done with his world, and with himself." And yet cancer was seen as failure, as an attribute of losers in

life. Then Sontag [13] conducted a thorough investigation of the moral and political meanings attributed to the central diseases of the modern world, dispelling the interpretations and irrationalism with respect to the understanding of this disease.

Sontag wrote *Illness as Metaphor* [13] when she found that people suffering from cancer were stigmatized. She describes:

Disease is not a metaphor and that the most truthful way of regarding illness - and the healthiest way of being ill, is one most purified of, most resistant to metaphorical thinking with which this realm was painted. And that cancer transforms the body, understood as a disease caused by the habits of the individual and that reveals something about him (p.3)

Morris [33] adds: "My goal is to introduce an encounter between physician and patient with knowledge, empathy, and a commitment to personally discuss the results." In this manner the care of a patient throughout the illness can continue to become more humane in government institutions, integrating bio-psycho-social-spiritual aspects and the whole human being in search of quality of life while these patients struggle between life and mortality. Soares da Costa [33] comments that the Social Sciences focus on issues of collective and public health, highlighting the person, body, and disease, and that the construction of the individual, body, and feelings is linked to health disorders. He adds that in the field of medical sciences social anthropology plays an important role in ensuring the construction of solutions to remedy the social demands of public health. The plurality of disciplines anthropology, philosophy, sociology, psychology, and history connected to theoretical and methodological approaches are fostering care for the human being, which also includes a focus on bioethics.

Results and Conclusion

The authors of this paper conclude that the public health demand for care of oncology patients with rHNC appears to be of paramount importance, because the "outpatient setting" requires a different approach than psychotherapy, and requires from the mental health professional an attitude of flexibility and welcoming in order to outline the difficulties of these individuals. This enables interaction with the rest of the medical staff, facilitating the each patient's unique personal listening language, which in turn recognizes the importance of specific psychological support.

We could see the benefits of the outpatient setting from patients' accounts, as well as the expressed psychopathology typical of such a framework. The classic "disease taboos," such as ideas of condemnation or divine punishment, also emerged. In this internalization the patients were also able to perceive family relationships presented in different ways, whether supportive relationships or silent caring attitudes, expressions of contempt and neglect, and delegating responsibility for the disease to the patient.

It became evident from these listening and interventions through Brief Dynamic Psychotherapy that these patients need to be heard and listened to in their uniqueness as an ethical recognition in the field of health and illness, respecting their beliefs and spirituality that are always present in the disease situation as a way of overcoming, accepting and coping with the situation. Their speech showed the great extent to which this psychological support service promoted their

quality of life, overcame their anguish, and helped them find meaning in their lives and their existential reality - as already described in the categories of speech in which they described their anguish at the news, their pathologies, the preconceptions about the disease, the relationship with the family, the impact of the psychological intervention and how they saw the meeting with the psychotherapist. It was possible to observe the various phases in which the patients were, i.e., anger, bargaining, denial, acceptance. The presence of a professional is indispensable for these phases to be developed and to provide the patient with emotional support.

Limits of this Work

It is important to emphasize that because this work is a retrospective study of medical records, it requires a qualitative study using samples of good informants through the interview method.

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