ESSAY

Psychic risk: a psychoanalytic approach to identifying subjective changes in patients assisted in a hospital complex

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ABSTRACT

This paper proposes an analysis, based on psychoanalytic theory, of the "psychological risk" instrument used by the multidisciplinary team of a prestigious hospital complex to collect information and identify possible subjective changes in patients treated in the institution. This tool is used to identify and refer patients to mental health services for psychological follow-up and monitoring. The objective was to recognize the specificity of the tool called "psychological risk", its possibilities and scope, as another option to listen to patients in distress. The use of the tool has reinforced the importance of a prior assessment of the patient, contributing significantly to the elaboration of a care plan and interventions aimed at providing quality psychological assistance during the illness process.

Keywords: Psychoanalysis, Hospital care, Patient care team.

INTRODUCTION

The present study proposes an examination of the "psychic risk" instrument used in a private and philanthropic hospital complex, by the multidisciplinary team, based on Lacanian psychoanalytic theory. This tool aims to gather information and potentially identify subjective alterations that may complicate treatment and quality of life during the illness process. With patient-centered care in mind, focusing on their demands and referrals, the team can more effectively direct psychological interventions to minimize suffering, thus providing quality care and attention deemed significant for the individual during treatment.

Through a structured model, the team is trained to actively listen to the patient's narratives during the illness process, ensuring that their perceptions inform the completion of the instrument accurately. Data collection involves a compassionate examination of each patient's daily life to identify any need for broadening the scope of care to address emotional issues possibly triggered or exacerbated during treatment, such as sleep quality, fear, medication adherence, among others. The instrument is administered by the nursing team, and its findings are shared with other members of the multidisciplinary team to prompt specific care alerts. It is noteworthy that the team's identifications and their relevance for enhancing the patient's experience within the institution are regularly discussed with the mental health team and disseminated to the rest of the staff.

This screening protocol was established with the aim of identifying, acknowledging, guiding, and treating potential emotional alterations stemming from diagnosis and treatment, both in the general hospital and in oncology units. As a result of this instrument, the mental health team emphasized the importance of psycholog-

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ical interventions in this context of significant organic fragility, as they enable the healthcare team to better understand psychological suffering and broaden perspectives on intervention and care.

Study design and sample

This is a theoretical-reflective essay on the "psychic risk" instrument, a screening process implemented institutionally to assess hospitalized patients in inpatient units and oncology treatment. Patients attending imaging units and elective consultations are not within the scope of this evaluation.

This study presents the author's reflective analysis of the importance of a psychoanalytic approach to hospitalized patients. As it did not involve any direct data collection, ethical approval from a research ethics committee was not required.

Description of the "psychological risk" screening instrument

Anticipating that a hospitalized patient, and/or one diagnosed with cancer, will experience distress is essentially one of the tasks of the healthcare team. The purpose of the described instrument is precisely to identify distress more quickly and enable interventions.

In order to achieve a more active and early response, the instrument was institutionally implemented, consisting of screening, assessment, treatment, and follow-up stages. This process allows for the early detection of warning signs so that the mental health team can intervene promptly and increase patient care.

Within the hospital complex mentioned, specific procedures and internal workflows were developed to ensure that the process proceeded as designed. Thus, a screening tool was constructed for all patients, emphasizing primarily the communication of screening results to the healthcare team, as well as facilitating interaction between the patient and the team based on instrument-derived data. Regarding its validation, it should be noted that it is an ongoing internal process of science and research, following the steps of a methodological study. Therefore, it is considered that the instrument is under development, aiming for its validation.

The careful daily evaluations through enhanced listening, the actions of the trained team in response to patient verbalizations, and referral to other services as necessary have proven crucial for the success of the instrument's objective. However, this is a collaborative effort involving the entire care network. Initially, it involves physicians, nurses, nursing technicians, psychologists, pharmacists, physiotherapists, and nutritionists, but it is not limited to these professionals and also includes all support teams. Thus, a culture of differentiated listening is established in response to symptoms presented by the patient, caregiver, or family member, whether expressed verbally or through behavior, gesture, or glance. The strengthening of multidisciplinarity in patient care forms the basis for the functioning of the instrument under study.

The flow of the screening instrument[1] begins with a classification applied daily by the nurse responsible for the patient's care on that day, at the time of admission and within the scheduled reassessment routine in the units. Thus, the nurse fills out the

instrument based on information reported by the patient, triggering alerts in the system with necessary care for the activated psychic risk in that case. Based on risk criteria, the classification is defined as: not detected, mild, moderate, severe, and very severe. Undetected or mild risks are monitored by the healthcare team. In other cases, the mental health service is activated: psychology, for assessment, and if necessary, psychiatry. In addition to alerting the mental health team, the flow guides other teams as a whole regarding care and possible interventions to be performed for the management of each case.

However, the "psychic risk" screening instrument aims to establish an early look and assess the possibilities of psychological risk by objectively identifying subjective and contextual characteristics (e.g., issues related to medication effects).

Among the relevant information for filling out the risk assessment, we have: psychiatric history, addiction, behavior changes, mood changes, psychomotor agitation, persistent thoughts about illness, significant decrease in social interactions, difficulty adhering to treatment, mental confusion, verbalization of disinvestment in life, difficulty in relationships with family, and the team's concern with the case.

Initially, as the system is fed with reports and observations about each case, a score appears, and based on that score, an alert is generated for the nursing staff, directing actions of both the psychology unit team and other teams responsible for additional care to be provided. Thus, the psychologist assesses the initially heard and referred risk situation from the team, discussing and guiding care on measures necessary for the psychological safety and quality of care in treating patients with psychological or psychiatric risk.

Staff training

To standardize the completion of the instrument, training sessions are conducted by the psychology team and the institution's development and education team. The psychology team actively participates to foster the necessary listening sensitivity for the proper data completion.

There is an annual fixed training calendar specifically designed for the entire team, including both clinical and administrative sectors, considering that all contribute to the continuum of care. Moreover, through the analysis of collected data, it is possible to identify the need to expand educational processes for teams and anticipate annual training sessions.

During these training sessions, the entire team is instructed on the importance of communication to broaden the scope of care, the criteria to be activated, completion of responses in the system, actions of each team in response to detected risks, and the workflows for activation and handling by the specialized staff team.

An analytical listening

In accordance with Lacan's teachings, "Every word always has something beyond it, sustains many functions, involves many meanings. Behind what a discourse says, there is what it wants to say, and behind what it wants to say, there is yet another wanting to say, and nothing will ever be exhausted"[2:275].

Contemplating the functioning of each subject brings to light everything related to subjective constitution, everything that, in some way, interfered in the life of that subject from their constitution to the present moment. Their capacity to create future expectations regarding life is also directly related to all of this. The real and the symbolic, entwined by an imaginary seeking consistency, enable the subjective dimension to become the protagonist through the elevation of listening beyond mere verbal expression.

The oncologic patient, torn by the diagnosis in their plans and life perspectives, finds themselves facing impossibilities, previously idealized, now taking shape as reality in that moment. They seek the healthcare institution with the aim of healing, and in the face of this Real, incessantly unwriteable, the imaginary, in a sudden fall, unravels.

The unveiling of the lack imposes itself. The wall of castration is erected. Plans made disorganize. Idealized families disintegrate or reshape themselves. Arrangements and reinventions are permitted and often facilitated by the illness.

The body speaks. The ailing body screams, even in silence. However, for an analytical listening to be possible, addressing and listening to the suffering beyond the organic are necessary.

The prospect of linking a psychological screening, objective and formatted, to fundamentally subjective psychoanalytic interventions demands this listening. The words strung together in discourse assume the level of work. The subject's speech says a lot about them, but it is the directed listening guiding the work that makes it possible, in the face of the body's impossibility, for therapeutic management to be specific in this context.

Again, in Lacan's words: "(...) psychoanalysis, standard or not, is the treatment expected from a psychoanalyst"[3:331].

It is in the discourse chain, in the very text of the discourse, that analytical listening takes place. Even if the preliminary listening performed by the rest of the team is not truly analytical listening, it is from the initial words spoken by each subject that the demand is addressed and can be acknowledged by the analyst. This acknowledgment is the first moment of clinical practice, and it is in the relationship with the analyst that it becomes possible to speak of the body as the support for illness, of the Real, beyond the symptom, beyond what is said.

The initial strangeness of the screening, considered something devoid of singularity, dissipates when it is possible to perceive that the interdisciplinary focus opens space for subjectivity, and the word is privileged. Thus, the subject of the unconscious, pulsating in words through anxiety, manifests in pain and medication effects.

The instrument guides the patient to the psychoanalyst, and from there, the transfer, the engine of the work, allows this suffering to be imbued with meaning, as the word reaches the symbolic. It is in this significant path that subjective resizing, in the face of illness, becomes possible.

It is based on what was initially heard by the entire team that the patient arrives for follow-up. However, it is in the pursuit of the subject's enunciation that the work is constructed. The statement reports

the suffering, but it is in the textuality of the enunciation, in the search and listening to what is said, that there is the possibility of constructing this work, where the limit of the Real constantly overlaps with the reach of words.

In other words, it is from listening to the statement, what is said, that the patient goes to the analyst, but the work is done in the enunciation, in the search for that saying that reports the truth of the subject. Thus, the truth, always halfway, needs the "said" to appear, but it will only truly come about in the listening of the "unsaid" by the analyst.

The application of the "psychic risk" instrument in the hospital institution aims for the complete discourse, the manifest content. Nevertheless, it is also through this manifest content that the analysand reaches the consulting rooms, for psychoanalysis in intention, so that the latency of the semblance of saying, as a path to the proximity of the Real already in play, can be worked on.

Perhaps the importance of the instrument for psychoanalysis in its extension lies therein, as Lacan tells us: "Thus, the said does not go without the saying"[4:451].

Even if the work goes beyond what is heard by the team, it is in this statement, this saying, that the subject appears, and the work is made possible. It announces and enunciates the subject of the unconscious in suffering, but it is an effect of saying.

Returning to the beginning, to conclude, the goal of this work is to analyze the "psychic risk" screening instrument from a psychoanalytic perspective. Although meaning is only possible at the end of the signifying chain, and the transference continues even if the work with the patient ends, either due to the end of cancer treatment or death, the place of the analyst remains the same, namely, as the place of emptiness, of the gap, the place of the dead.

Thus, it is in the half-truth of the suffering subject that analytical listening can play its role, questioning what is known about that subject, assumed by the team, and intervening interdisciplinarily in each case. In this singularity without protocols, analytical theory performs its function, breaking established words that constitute a priori knowledge. However, this does not happen at first, but, as is inherent and fundamental to the work of analysis, only later.

Limitations

As a limitation, it should be considered that this study did not include measures of clinical analysis or validation of the instrument, as such analyses were not within the scope of the research. This limitation emphasizes the importance of complementing the investigation with other methodologies in order to obtain a more comprehensive and accurate understanding of the practical utility of the instrument in question.

FINAL CONSIDERATIONS

The screening instrument, based on the words expressed by the patient to the multidisciplinary healthcare team, highlights fundamental contents for activating psychology during the process of illness and oncological treatment. It is possible to emphasize defense mechanisms, family dynamics, and the relationship between

the patient and their body, which is updated with organic illness. In the face of the risk screening instrument, the power of words is authenticated in the team's listening.

It is important to note that some of the criteria addressed in the instrument, when identified by the care team, could go unnoticed in institutions that do not have a systematized process for determining "psychic risk". Facilitating the application process of the instrument in alerting the entire team determines the path of support and quality care for the patient.

Therefore, screening for psychic risk provides direction for psychology in guiding what is heard, as well as aligning, with the entire team, the necessary support for the patient at that moment. Furthermore, regarding analytical listening, the adoption of psychic risk assessment reinforces, within the institution, the idea of singularity, reminding everyone who listens that each word speaks volumes about the subject and their suffering, and that even in silence, they can speak of themselves.

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