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REAL, PSYCHOANALYTIC CLINIC AND CARDIAC SURGERY IN THE CONTEXT OF THE COVID-19 PANDEMIC

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ABSTRACT. Cardiovascular disease is among the leading causes of morbidity and mortality worldwide. Surgical intervention poses a threat to life, and when the heart is involved, the emotional burden on the patient must be considered due to the symbolism associated with the organ. In psychoanalytic clinical practice, after experiencing heart disease, some psychological effects manifest in the body as anguish, causing intense suffering. Currently, in addition to suffering caused by heart disease, there is uncertainty regarding the risk of COVID-19 contamination. This article aimed to present a clinical case and discuss the advent of the Real in clinical practice with a cardiac surgery patient in a hospital during the COVID-19 pandemic, by articulating it with psychoanalytic theory. To achieve this objective, we used a method of constructing a clinical case in psychoanalysis to convey the unique experience of treatment and generate knowledge about the process and potential interventions. In conclusion, the pandemic added suffering to the experience of cardiovascular patients, as it placed them in the face of radical ignorance, which made it difficult to construct any meaning that could alleviate anguish.

Keywords: Psychoanalysis; COVID-19; cardiac surgery.

REAL, CLÍNICA PSICANALÍTICA E CIRURGIA CARDÍACA NO CONTEXTO PANDÊMICO DA COVID-19

RESUMO. As doenças cardiovasculares estão entre as principais causas de morbimortalidade no mundo. A intervenção cirúrgica representa uma ameaça à vida e, quando envolve o coração, deve-se considerar a carga emocional para o sujeito em virtude da simbologia associada ao órgão. Na clínica psicanalítica é possível constatar que, após adoecer do coração, algumas ressonâncias psíquicas são expressas no corpo sob a forma de angústia e causam intenso sofrimento. No momento atual, soma-se ao sofrimento pelo adoecimento cardíaco, a incerteza quanto aos riscos de contaminação pela Covid-19. O presente artigo visa apresentar um caso clínico articulando-o à teoria psicanalítica com o objetivo de discutir o advento do Real na prática clínica com paciente de cirurgia cardíaca no contexto da pandemia de Covid-19 em um hospital. A fim de atingir o objetivo pretendido, utilizou-se o método da construção de caso clínico em psicanálise com a finalidade de transmitir a experiência singular do tratamento e produzir conhecimento sobre o processo em questão e as possibilidades de intervenção. Conclui-se que a pandemia da Covid-19 agregou sofrimento à experiência dos pacientes cardiovasculares, visto que colocou os

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sujeitos diante de um não saber radical, dificultando qualquer construção de sentido que pudesse aplacar a angústia vivenciada.

Palavras-chaves: Psicanálise; Covid-19; cirurgia cardíaca.

REAL, CLÍNICA PSICOANALÍTICA Y CIRUGÍA CARDÍACA EN EL CONTEXTO PANDÉMICO DE COVID-19

RESUMEN. Las enfermedades cardiovasculares se encuentran entre las principales causas de morbilidad y mortalidad en el mundo. La intervención quirúrgica representa una amenaza para la vida y, cuando se trata del corazón, hay que tener en consideración la carga emocional debido a la simbología asociada al órgano. En la práctica clínica psicoanalítica se puede constatar que, tras la enfermedad cardiaca, algunas resonancias psíquicas se expresan en el cuerpo en forma de angustia y provocan intenso sufrimiento. Actualmente, la incertidumbre de los riesgos de contaminación por Covid-19 se suma al sufrimiento causado por las cardiopatías. Este artículo tiene como objetivo presentar un caso clínico articulándolo con la teoría psicoanalítica para discutir el advenimiento de lo Real en la práctica clínica con un paciente de cirugía cardíaca en el contexto de la pandemia del Covid-19 en un hospital. Para lograr el objetivo previsto, se utilizó el método de construcción de casos clínicos en psicoanálisis con el propósito de transmitir la experiencia singular del tratamiento y producir conocimiento sobre el proceso en cuestión y las posibilidades de intervención. Se concluye que la pandemia de Covid-19 añadió sufrimiento a la experiencia de los pacientes cardiovasculares, ya que los situó ante un desconocimiento radical, dificultando cualquier construcción de sentido que pudiera aplacar la angustia experimentada.

Palabras-Clave: Psicoanálisis; Covid-19; cirugía cardíaca.

Introduction

Cardiovascular diseases are the leading cause of morbidity and mortality worldwide (World Health Organization [WHO], 2017). These diseases are characterized as multifactorial and incurable, with manifestations that have psychosocial impacts and require significant financial resources from the public health system. Several medical procedures are available to treat the affected individual. Among these procedures is surgery, which is indicated when an organ fails to function properly and cannot respond to drug therapies or less invasive interventions alone. One question that arises concerns comprehensive care for the patient.

Studies have shown that patients display a variety of emotional reactions after receiving news of the need for a surgical procedure to treat cardiac involvement. The most prevalent feeling during the preoperative period is fear, which can be attributed to the possibility of death, anesthesia, loss of control, and anticipation of pain. The immediate postoperative period commonly triggers feelings of despair, especially when associated with awakening from anesthesia, causing feelings of estrangement and accentuating the experience of a lack of control over one's body. Anxiety and depressed mood are perceived in a variable manner throughout hospitalization (Quintana & Kalil, 2012; Wottrich et al., 2013; Borges Junior et al., 2020; Moura et al., 2020).

Furthermore, the emotional burden on individuals with heart disease must be considered due to the symbolism associated with the organ. The heart is considered the

seat of emotions and has acquired a metaphorical meaning as a symbol of life. It pulses and beats to keep the organism alive by ensuring blood circulation, as well as love and its resonances. In this way, the heart plays a central role in the social imagination, shaping the experiences of those who suffer from heart disease (Monteiro, 2007). Heart disease and the need for surgery can have several consequences, one of which is the experience of bodily fragmentation.

From a Lacanian psychoanalytic perspective, the status of the body is expansive and involves a construction based on the relationship with the Other as a drive-body. This construction is based on the tripartite division of the Real, the Symbolic, and the Imaginary: the body articulated to jouissance, the body marked by the signifier, and the body image, respectively. Recognizing that humans are born premature and therefore totally dependent on others to survive highlights the importance of otherness for the constitution of subjectivity and corporeality (Aires, 2017).

Moretto (2006) reveals three dimensions of the body: the flesh-body, which corresponds to the remainder that resists the incorporation of the signifier; the organism-body, which refers to anatomy (the biological body); and the drive-body, which represents the subjective dimension, covered by fantasy and words. According to the author, medicine is responsible for treating the flesh-organism dyad. In turn, the psychoanalyst treats the erogenous body, which is "[...] the body woven by sexuality and language" (Priszkulnik, 2000 apud Moretto, 2006, p. 102). To the extent that illness highlights the imperfection of the body, it becomes a sign of the vulnerability and temporality of the flesh. Thus, manipulating the body re-enacts primary experiences of fragmentation, weakening the body's unity.

The disclosure of the medical diagnosis and therapeutic proposals for treatment can have significant consequences for the subject. The patient's perception of their health-disease process is directly correlated with their coping mechanism. Moretto (2019) posits that illness constitutes a disruptive event, compelling patients to reorganize their lives to confront the unprecedented challenges that arise from their encounter with the Real. Confronting the need for surgery can throw the patient into a state of helplessness, creating a rupture in the significant anchoring that provided them with psychic stability. A time without words is often experienced, during which the subject is immersed in affects that remain disconnected from the significant chain. This places the subject before the advent of the Real. Soler (2018) defines the advent of the Real as anything that is impossible to avoid and emerges as unprecedented, whether a continuation of the expected or a surprise. Thus, we can consider the COVID-19 pandemic as this impossible-to-avoid phenomenon that invaded the world in the form of a virus, as it has disrupted the meaning of life and intensified the experience of malaise (Birman, 2020; Izcovich, 2020).

The concept of the Real is associated with the triad of the Real, the Symbolic, and the Imaginary (RSI), which are records of human reality. Lacan coined the term "the Real" to designate that which is outside of meaning and, therefore, ungraspable by the symbolic. The symbolic corresponds to equivocality because it has the same structure as language. The Imaginary, in turn, refers to an image without the mediation of words and univocal meaning. In this sense, we can understand the Real as the absence of meaning. It refers to the impossible (Gorog & Oliveira, 2019) and the contingent (Cruglak, 2001) and appeals to the subject in a distinct way.

The Real 'ex-sists'[4] the symbolic, as evidenced by the bodily experience of anguish and the compulsion to repeat. According to Freud (1996b), anguish has a signaling and displeasing character. In the face of accumulated excitement, the psyche is unable to discharge itself through representation. In turn, Lacan[5] states that anguish is an affect that does not deceive; "[...] it highlights the insufficiency of language by not allowing itself to be apprehended or clarified by the signifier [...] " (Aires, 2014, p. 52). From this perspective, anguish is a sign of jouissance[6], governed by something beyond the pleasure principle.

When an event occurs in the body, the subject must deal with the contingency, demanding psychic reorganization to construct meanings and find a response to the event. Symptoms of heart disease, such as dyspnea, angina, and edema, point to the imminent risk of death, making it difficult to reduce the fantasy of annihilation. The disease makes living with the possibility of finitude inevitable. In culture, the signifier "death" has many meanings. However, when faced with the imminence of death, these meanings are emptied, and death appears inexpressible to each subject. Therefore, death itself would be the real, the impossible to symbolize, and illness would present itself as the contingency that disturbs the subject. This explains why patients have difficulty talking about this content during the hospitalization process (Silveira, 2015).

The subjective experience of imminent death is currently present in two ways during hospitalization. First, the risks of the surgical procedure are compounded by the risk of SARSCoV-2 contamination, which causes the disease known as COVID-19. Studies reveal the clinical impact of cardiovascular risk factors and the prevalence of heart disease before illness caused by SARS-CoV-2. These studies indicate that heart disease worsens the clinical process and prognosis (Nascimento et al., 2020). Patients with heart disease who contract SARSCoV-2 experience a more severe clinical course, with a higher frequency of respiratory failure and mortality. This can intensify these individuals' anxiety about death during hospitalization.

The new scenario imposes health recommendations for physical isolation, and the hospital environment is even more hostile and impersonal. Displaced from their status as subjects and without the presence of their socio-affective network to accompany them during the hospitalization process, patients have been experiencing a state of permanent tension, which intensifies their suffering and sense of loss.

The scarcity of studies linking the pandemic and heart disease poses the challenge of improving knowledge about the possibilities of intervention by psychoanalytic clinics in a health emergency context. In this sense, this article aimed to present a clinical case and link it to psychoanalytic theory to discuss the advent of the Real in clinical practice with a cardiac surgery patient in a hospital during the pandemic.

[4] In the 1974-1975 seminar, entitled *RSI*, Lacan uses the term ex-sistence to refer to that which makes a hole in each of the registers in the presentation of the Borromean knot. He then situates ex-sistence in its relation to the real, as that which remains outside symbolic apprehension, a non-symbolizable remainder.

[5] Lacan (2005) formalizes the concept of anxiety in a seminar dedicated to the topic in 1962-1963, when he presents it as a central affect of the analytical experience in its relationship with desire, the Other, and lack.

[6] According to Braunstein (2007), the term jouissance should be understood as 'the satisfaction of a drive', but not of each and every drive, but rather "[...] of a very specific drive, the death drive" (p. 60).

Methodological path

Study design

This research began with the experience of the Multidisciplinary Health Residency Program at a university hospital. This qualitative, retrospective clinical study is based on secondary data obtained from the review of a patient's medical records from the cardiology ward during the first quarter of the COVID-19 pandemic. The study also analyzed documentary records produced by the resident during psychological monitoring. Due to their confidential nature, the documentary records, which are information resulting from the provision of psychological services, cannot be shared with the multidisciplinary team in electronic medical records, as per the guidance outlined in Resolution 001 of the Federal Council of Psychology (CFP) (2009).

A clinical case was constructed to discuss psychological management strategies with a patient experiencing intense psychological distress due to the need for cardiac surgery. This method transmits unique knowledge about the subject in question. It involves reorganizing the patient's narratives to expand knowledge of psychic functioning and highlight the particularity of human suffering, its forms of subjectivation, coping strategies, and the psychologist's interventions in treatment (Dias & Moretto, 2017; Figueiredo, 2004). This method is characterized as a "[...] means of investigation, intervention, production of knowledge, and transmission" (Moretto, 2019, p. 130). Priority is given to the patient's subjective experiences and the professional's interventions to facilitate the transition from history to clinical case (Figueiredo, 2004).

According to Dunker and Ravanello (2017), case construction is a powerful instrument for transmitting psychoanalytic discourse. It allows us to sustain the specificity of the singular that exists in suffering, to the detriment of the tendency toward generalism and the discourse of reproducibility in health institutions. Transmitting the clinical experience of treatment allows for the transition from private to public testimony of psychoanalysis.

Place of study

This study was conducted in a cardiology ward of a highly complex hospital in the Brazilian Unified Health System (SUS) in the state of Bahia. Patients admitted to this ward are referred from the state regulatory system or the hospital outpatient clinic. The unit currently has 19 active beds for clinical and/or surgical patients, whose care is shared by a multidisciplinary team. Clinical patients have acute cardiovascular diseases and are hospitalized for clinical care. Surgical patients are admitted to undergo procedures such as myocardial revascularization, valve replacement, and pacemaker implantation, among others.

Participant

During the screening in the hospital's cardiology ward, patients requiring psychological support during their hospitalization were identified. Of the monitored cases, one patient was selected based on the following criteria: having a cardiovascular disease, being eligible for a surgical procedure, having been seen by the on-site psychologist, having experienced illness due to SARS-CoV-2 infection, and presenting a report of psychological distress related to the illness/hospitalization process.

Ethical aspects

The study complies with the guidelines established by Resolution 466 of December 12, 2012, which regulates research involving human beings. It was submitted to the Research Ethics Committee of the hospital in question and was approved according to substantiated opinion 4.392.432. The documentary records resulting from the provision of psychological services comply with the Federal Council of Psychology's Resolution 001/2009. The regulations indicated in Article 16 of the Code of Professional Ethics of Psychologists were followed regarding research and activities aimed at producing knowledge and developing technologies. Additionally, the ethical orientation of psychoanalysis regarding the importance of ending treatment to begin constructing the case was observed.

As this study is retrospective and based on secondary data and a review of medical records, the risks are considered low and will not cause harm to the participant. The only hypothetical risks are breach of confidentiality and secrecy. The researchers are committed to ensuring that the material is stored under restricted access and that the participants' identities are preserved by modifying data that could compromise their anonymity.

Results and discussions

Gabriel (fictitious name) is a patient who is being admitted for the 15th time. The main symptoms that led him to seek specialized help this time were chest pain, cough, and dyspnea. After a previous hospitalization in a hospital unit without a cardiology team, he was referred to this hospital for a diagnostic investigation of acute myocardial infarction (AMI). Following his admission, cardiac catheterization revealed coronary artery disease (CAD), indicating the need for myocardial revascularization.

A few days after admission, Gabriel presented with anosmia, or loss of smell. This led the healthcare team to suspect SARS-CoV-2 contamination, and the hospital initiated the COVID-19 protocol. In this hospital, which functioned as a backup unit during the pandemic and did not provide referral services for suspected cases of SARS-CoV-2, the protocol for suspected patients includes requesting a PCR swab test and a chest X-ray. Patients are immediately transferred to a care ward for suspected cases. When the diagnosis is confirmed, patients are referred to a reference hospital. This happened to Gabriel when his test confirmed the suspicion of SARS-CoV-2 infection.

Thirty days later, Gabriel returns to the hospital and is admitted to the cardiology ward for the revascularization procedure. After the screening carried out in this ward, he met with the psychologist. On that day, Gabriel reported his repeated hospitalizations for surgeries and recalled the period of hospitalization in the reference hospital for COVID-19. He described the experience as horrible, associating it with extreme isolation and a fear of death. He suspected that he had become infected at the first hospital and joked that he had infected about 40 people there. He also mentioned his belief that he had infected five people during his first stay at the specialty hospital. I only glanced at his speech in a questioning tone to make it easier for him to continue speaking, although I recognized his fantasy of infection.

Gabriel pointed out a difference between his previous hospitalizations and this one. He said that he had never been so distressed and that, no matter how hard he tried, he could not stop feeling distressed. The distress is located in the body and is associated with Gabriel's behavior of holding his chest. "[...] it's something here [...]," demonstrating the impossibility of naming the bodily experience. When I asked him what the difference was

between the hospitalizations, he said he was not sure. He pointed out that the hospital almost killed him “[...] because I was admitted with one problem and developed another.” What conquest was Gabriel talking about? He quickly told me that the hospital was a place where patients felt safe because they were there to be cured. However, the pandemic has made hospitals dangerous places where people enter with one disease and die from another.

Gabriel experienced radical helplessness in the face of the risk of death when his appeal to the Other went unanswered. As Soler (2018) warns us, death is one of the names for the Real. The novelty of the virus pointed to the limits of scientific knowledge and updated this experience of helplessness. In the face of pain and suffering, the subject finds no response in any other instance of alterity[7] as a form of protection against the risk of death. It is the symptomatic and subjective productions that gain relevance in the subject’s fight against the invisible enemy (Birman, 2020).

Gabriel told me again about his previous surgeries in an attempt to make sense of his current experience. In one of his accounts, he described himself as an ‘almost doctor’ and explained that he started his medical degree at a young age. He loved it, but due to his difficult financial situation, he soon found it difficult to continue. He needed to work to support himself and was unable to dedicate himself exclusively to the course. He finished the first year and then dropped out to work. He maintained friendships with his classmates who are now ‘great doctors’ in various specialties. “I learned a lot during my hospitalizations, it helped me a lot [...]” and he concluded: “[...] I have firsthand knowledge.” The impotence of desire could only manifest itself in the symbolic-imaginary constructions that fueled his fantasy. He constantly changed the therapeutic regimens of medications, justifying it by saying that he had studied medicine. For this reason, he believed he could also prescribe medications to acquaintances in his social circle.

An incident left a gap in his knowledge. He said he took medication for hypertension, and his doctor had prescribed enalapril for long-term use. One day, he woke up with symptoms, so he checked his blood pressure, which was still high. He decided to switch to losartan on his own and noticed that his symptoms had subsided. However, after a few days, he started bleeding from his nose and mouth, so he decided to see a doctor friend. During the consultation, he learned that ‘it was the blood pressure medication’. The doctor told him that he should not have changed medications and that his body could no longer handle it. After this incident, he became ‘disgusted with losartan’ and decided to follow the instructions. However, he continued his speech saying: “[...] I do a lot of things, I don’t depend on a doctor.” This statement illustrates the ambivalence patients often experience regarding medical knowledge.

He desired the knowledge that the medical discourse engendered, but he could not bear that it was embodied in the figure of the Other. For this reason, he rejected the role imposed by medical discourse. By changing his medication regimen or prescribing medicine to acquaintances, Gabriel enjoyed the authority he had previously renounced when he could no longer pursue his desire to study medicine. During his hospitalization, his ambivalence became excessive. He was hostile toward the nursing team but maintained a complacent relationship with the doctors in charge. He justified his attitude by stating that many “illiterate” people are admitted to this hospital, and the professionals believe that everyone is

[7]Persons or figures that can fulfill the function of the Other for the subject when he or she is in a state of helplessness, given that the subject cannot find an answer to the situation he or she is in (Birman, 2020).

uninformed. However, they “were disappointed” in him because “their diploma means nothing” to him. He demanded a different role in his treatment because he is not a “layman.”

For a long time, he questioned the hospital routine. He discussed the scheduling of medications, cleanliness, and the condition of the cabinets. Regarding medications, he discussed beliefs associated with their use. He believed that he should take the medications at the times established before his admission. In turn, the nursing team said that the patient was not at home and had to ‘follow’ the times they determined. As Silveira (2015, p. 39) warns, “[...] health professionals sometimes align themselves with the discourse of the master, sometimes with that of the university [...],” which makes individualized management difficult. The master’s discourse emphasizes control and obedience of subjects, endowing them with “[...] an almost religious power, which he must assert” (p. 40). In the university discourse, power is also a product, but it is based on scientific knowledge. This operation removes the subject from the scene, disregarding the knowledge of the person who falls ill.

Gabriel vehemently rejected the role of object of care that the institution had assigned to him. I realized it was important to address the patient’s concerns about his treatment. Despite understanding the need to adhere to the plan’s timeframe, I asked the team if a change could be made without harming the patient. Questioning certainty promoted a break with the absolute knowledge and power that had been established through the protocolization of the practice. This intervention resulted in a rectification in the work process, where the effect was to include the patient there, where the master’s discourse foreclosed him. The medication schedule could be reviewed and rearrangements were proposed ‘with’ the patient, and not ‘for’ the patient. Being listened to also changed the patient’s relationship with some members of the nursing team, indicating an assumption of knowledge in the new relationship.

During clinical supervision, I was warned at a certain point that the patient’s position in the transference relationship with me had changed. Gabriel began to question why I had not gone to see him and the length of the sessions. His demand was not addressed to me but was rather a protest that I should go see him. The tone of his expression was one of complaint. According to Miller (n.d.), the analyst occupies the position of “the Other of the demand [...]” (p. 7) and must endure “[...] all the historical figures of the Other of the demand for the subject” (p. 7) until a shift occurs that allows for the symbolic establishment of the transference. Initially, I responded to his requests for care by making myself available to listen to him. However, his demanding position imposed a requirement on others to respond to his demands rather than allowing for a subjective division that questioned his participation in that suffering. It was necessary to break through the empty, demanding discourse. To this end, the practitioner sought to operate from the scansion of the sessions at the point where her speech revealed an uncomplicated rationalization that prevented free association and, consequently, unconscious production.

With the doctors, Gabriel enjoyed the position of being different because he had been ‘recommended’ by a neurosurgeon friend. The doctors themselves had informed him of the recommendation, so he believed he would receive special care. Sometimes, he questioned why the surgeon had not yet come to speak with him. He said that the “surgeon’s presence gave him a lot of security.” He said he prayed to ask ‘God’ to give his doctor ‘strength’ so that everything would go well. It is important to emphasize that Gabriel allowed himself to be an object in the presence of the surgeon, attributing importance and knowledge to the doctor. It is no coincidence that he asked God to give strength to his doctor, who, in his imagination, could guarantee his continued life.

His friend, a neurosurgeon, had already assured him that the doctors at this hospital were competent, yet he anxiously awaited the cardiac surgeon's visit to give him 'anchorage' and the 'desire' to go to the operating table right away. Soler (2018, p. 45) states, "[...] that vital danger, the risk to life, far from frightening, fascinates, arouses a strange attraction, as if there were a taste for vital danger." A patient's experiences with illness point to a drive toward death. Freud (1996a) characterizes this phenomenon as a manifestation of the death drive, highlighting that the object of the drive can be anyone who helps it reach its goal. This object does not have to be foreign to the subject and can be part of the body.

The death drive (Freud, 1996a), or what Freud (1996a) referred to as what is beyond the pleasure principle, can be understood as a tendency for beings to return to an inorganic state. This propensity subjects the individual to compulsive repetition, which arouses unpleasant sensations in the psyche and causes suffering. Braunstein (2007) emphasizes that the concept of the death drive transcends the biological tendency to return to the inanimate at the energetic level. According to Braunstein, the death drive is, above all, "[…] something that approaches a will to destroy" (p. 62). He also affirms that jouissance is an attempt to satisfy the drive because "[…] the drive leaves a balance of dissatisfaction that stimulates repetition" (p. 63). In this case, the body becomes a field for jouissance outside of meaning—a body at the service of the death drive. The ability to discuss this experience of satisfaction and pain elevates jouissance to a different level, as "[…] the word takes jouissance out of the body and gives jouissance a different body, a body of discourse" (p. 74).

The following consultations were marked by discourse about the risk of death. When talking about the surgery, the most repeated signifiers were 'threatened' and 'decreed,' demonstrating the extent of his lack of control. He spoke about the 'figures' that 'chased' him, especially when he was alone. He had never seen anything like them, they had shadowy shapes. These visions began when the surgery was 'decreed' and were intended to 'confuse' his mind and make him make the 'wrong decision'. It was possible to assume that his illusory perception emerged in an attempt to border the advent of the Real. Although the visions accentuated his anguish, he could make them disappear by simply closing his eyes and calling on the name of God. Making the visions disappear made the possibility of death disappear. In this context, I make the signifier 'wrong decision' resonate, because it is with this speech that Gabriel transitions from the place of object to that of author. Initially, Gabriel maintained a complaining discourse about his organic illnesses, positioning himself in the place of the victim. He believed that he was not responsible for his illnesses. Conversely, in his relationships with others, he adopted an arrogant stance as a defense mechanism against the vulnerability he felt when confronted with the inability to anchor himself in the family's position of knowledge.

Asking the question "Why am I so afraid now?" revealed a shift in the patient's subjective position. When this question is directed to the psychoanalytic practitioner, the transference of knowledge begins. At this point, the patient assumes that the practitioner has the answer to his suffering. According to Wachsberger (1994), the analytic discourse is based on managing transference. The psychoanalytic practitioner must ensure that the "[...] gap in the Other" (p. 30) remains open to stimulate the analysand's desire to know. This lack of meaning allows entry into the analytic process. It could be assumed that the COVID-19 disease placed the subject even more radically before the contingency, making them highlight an important difference in this hospitalization. Getting sick was all too familiar to him/her, but the pandemic brought strangeness due to the Real that was brought into play. As a result, fear emerged, and when it became enigmatic, it awakened his desire to know.

This made him question his responsibility for his suffering. His relationship with food provides clues about his role in the illness.

The issue of food became the focus of the manifested content. He stated that his son worked with healthy foods, but that he was a "stubborn old man." Since his wife's death, he had taken over the household chores. His apartment was immaculate and looked like a "woman's apartment," because he was "strict." His only "sin" was his love of "good food" with lots of seasoning and salt. He preferred fatty meats and believed that he had neglected his health because of this preference. He knew that in the "new phase," he would need to "watch what he ate" due to the dietary recommendations. He developed a desire to learn. He wanted to learn how to prepare healthy meals and planned to count on his son's help. As an afterthought, he realized that he needed to talk to the nutritionist to find out what his diet would be like after he was discharged. Thus, Gabriel began to take joint responsibility for his self-care process. His desire to learn indicates a subjective change, leading to a change in how he experiences his role as a patient. Previously, when recounting his life story, the compulsive repetition of illnesses, always with surgical treatments, gained relevance. In hindsight, he was able to dislodge jouissance from the flesh because analytical listening allows one "[...] to treat jouissance, displace it, and put it into words" (Braunstein, 2007, p. 40).

During the immediate postoperative period, he appeared frightened by his heartbeat and blood pressure. He kept looking at the monitoring devices and me, but he did not say anything. During the time I spent at his bedside, only the sound of the devices broke the silence. Frightened, he said to me: "[...] do you see that?" I replied that I did not see anything and asked him to tell me what he saw. He tried to identify what he saw, making the devices an extension of his own body. His heartbeat could be seen with the naked eye, but he signaled this change by pointing to the device: "Look, my heart has been racing since yesterday, and my blood pressure is very high." He asked if this type of reaction was normal, concluding that it was the "[...] new heart adapting; when you exchange something old for something new, there is always a difference." His fragmented image was perceived through erogenous sensations caused by the invasion of the drains. He spoke of parts of his body that were always linked to the signifier "agonized." He felt "agonized" because the urinary catheter had not been removed, the medications were not "controlling" his heartbeat and blood pressure, and he could not go to the bathroom or take a shower. These symptoms were unbearable because they reminded him of death and impotence, and could not be symbolized.

For Silveira (2015), the inability to process an experience perceived as an invasion reveals its traumatic nature. According to the author, the Real cannot be elaborated on; however, the subject can "[...] introduce signifiers into the Real of the experience" (p. 36). This operation allows one to "[...] tie what is not elaborable in the core of the unconscious" (p. 38), so that the Real stops invading psychic reality. Therefore, I had, a priori, to remain silent when encountering the Real, as mobilized by the patient's perceived sensations, which revealed the body's fragility. The listening space, sustained by presence, gave rise to signifiers that enabled some elaboration in the face of suffering.

The return to the ward was marked by a hopeful discourse about the treatment. Controlling the symptoms evoked a sense of triumph. When discussing the surgery, he said: "[...] another task accomplished in life." When talking about his plans, he expressed a desire to reinvest in social ties and chart new paths. He wanted to make inventions around his health-disease process that included 'some changes' in his daily routine. These changes indicated a shift in his subjective position, since he wanted to 'get out of this old vibe of

illness and such' to enter a 'new phase.' His discourse indicated a shift in his source of satisfaction, allowing him to respond from a less mortifying place. In this sense, the treatment produced creative solutions based on the redistribution of the subject's modes of jouissance, enabling a greater investment in life-affirming strategies.

Final considerations

This research emerged from concerns that arose from listening to the narratives of patients with cardiovascular diseases in a university hospital during the first quarter of the SARSCoV-2 pandemic with psychoanalytic guidance. After health recommendations for isolation and social distancing were established as the only forms of protection against SARS-CoV-2 contamination, discursive repetition emerged during consultations. This repetition pointed to the impossibility of finding words to alleviate the experienced anguish. The suffering experienced in the hospital presented as an unbearable inability to express an experience.

Cardiovascular diseases and the need for surgical intervention put patients in a state of uncertainty, making the treatment process painful. However, the possibility of becoming infected in the treatment environment exacerbates the emotional experience of helplessness during hospitalization. Once a symbol of healing, the hospital becomes a dangerous place to die. In light of this, we propose reflecting on the advent of the Real in psychoanalytic clinics with cardiac surgery patients in the context of the pandemic. Through our work in the cardiology unit, we were able to hear narratives about heart diseases associated with the risk of contracting SARS-CoV-2, which confirmed the hypothesis of previous studies on this topic. These studies addressed the psychological overload experienced by cardiac patients due to the symbolism of the organ, which is now compounded by the fear of contagion.

Psychoanalysis, based on the notion of the unconscious, assumes that one cannot know everything else. This unknown represents the source of endless possibilities for change. However, this state of not knowing can also be a source of anguish, which creates fear and uncertainty. Becoming ill during a time when the limitations of scientific knowledge are evident in the face of an unprecedented pandemic and when one cannot rely on significant figures in one's life owing to social isolation can have devastating effects. These narratives point to the worst and diminish hope for treatment and recovery. Anguish, chained for the certainty of death, has taken many forms and sometimes becomes unbearable. However, creative solutions can emerge.

The decision to present a clinical case demonstrates the complexity of subjective experiences associated with organic illness. Even in the face of collective anguish caused by the ineffable nature of the pandemic, it has been argued that the solutions found by the subject are always unique, as demonstrated by the presented case. In the face of the Real, suffering reveals not only pain, but also forms of satisfaction with which the subject wants nothing to do.

It is concluded that the advent of the Real during the pandemic has established a time without words, demonstrating the limits of symbolic resources in responding to it. This subjective time, which cannot be represented or accounted for, highlights the fragility and suffering of humans. Thus, subjects had to deal with a timeless experience in which sustaining the fantasy of immortality and the illusion of control over life became impossible. Therefore, retreating is not an option for psychoanalytic practice in tertiary care. Instead, a

listening space was created for patients, allowing time for processing the inevitable suffering that arises from encountering the Real.

References

Aires, S. (2014). Corpo e afeto: considerações lacanianas. *Revista Diálogos Possíveis, 13*(02), 43-55. https://www.academia.edu/25854540/CORPO_E_AFETO_CONSIDERA%C3%87 %C3%95ES_LACANIANAS

Aires, S. (2017). A doidignidade das palavras: Lacan e a clínica das psicoses. In C. G. Burgarelli. *Padecer do significante: a questão do sujeito* (cap. 7, pp. 95-114). Mercado das Letras.

Birman, J. (2020). *O trauma na pandemia do coronavírus: suas dimensões políticas, sociais, econômicas, ecológicas, culturais, éticas e científicas* (1a ed.). Afiliada.

Borges Junior, D. P., Oliveira, G. K. C., & Vasconcelos, A. C. P. (2020). Contribuições da psicanálise à atuação na clínica cardiológica. *Mudanças, 28*(2), 27-31. http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S0104-32692020000200004&lng=pt&tlng=pt

Braunstein, N. (2007). Os gozos distintos. In N. Braunstein. *Gozo* (1a ed., cap. 02, pp. 55109). Escuta.

Conselho Federal de Psicologia [CFP]. (2005). *Resolução nº 010/2005. Código de* ética profissional do psicólogo*, XIII Plenário*. http://site.cfp.org.br/wp-content/uploads/2012/07/codigo-de-etica-psicologia.pdf

Conselho Federal de Psicologia [CFP]. (2009). *Resolução nº 001/2009*. https://site.cfp.org.br/wp-content/uploads/2009/04/resolucao2009_01.pdf

Cruglak, C. (2001). *Clínica da identificação*. Companhia de Freud.

Dias, E. C., & Moretto, M. L. T. (2017). *A construção do caso clínico como via de transmissão da psicanálise nas instituições de saúde*. Blucher.

Dunker, C. I. L., & Ravanello, T. (2017). Gênero e forma literária: considerações sobre a estrutura ficcional dos casos clínicos em psicanálise. *Cadernos de Psicanálise, 39*(36), 87-102. http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1413-62952017000100 005&lng=pt&tlng=pt.

Figueiredo, A. C. (2004). A construção do caso clínico: uma contribuição da psicanálise à psicopatologia e à saúde mental. *Revista Latinoamericana de Psicopatologia Fundamental, 7*(1), 75-86. https://dx.doi.org/10.1590/1415-47142004001006

Freud, S. (1996a). Além do princípio do prazer. In S. Freud. *Obras psicológicas completas de Sigmund Freud: edição standard brasileira* (2a ed., Vol. XVII). Imago. Trabalho original publicado em 1920.

Freud, S. (1996b). Inibição, sintoma e angústia. In S. Freud. *Obras psicológicas completas de Sigmund Freud: edição standard brasileira* (2a ed., Vol. XVII). Imago. Trabalho original publicado em 1926.

Gorog, J.-J., & Oliveira, C. (2019). O que é o Real para Lacan? *Stylus,* (38), 23-33. http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1676-157X2019000100002&lng=pt&tlng=pt

Izcovich, L. (2020). O corpo na psicanálise. In *Psicanálise e pandemia. Fórum do Campo Lacaniano – MS* (pp. 49-79). Aller.

Lacan, J. (1974-1975). *O seminário, livro 22: Real, simbólico, imaginário*. Inédito.

Lacan, J. (2005). *O seminário, livro 10: a angústia (1962-1963)*. Zahar.

Miller, J-A. (n.d.). *Como iniciamos a análise. Campo Freudiano*. Mimeo.

Monteiro, M. P. (2007). Psicanálise e cardiologia: um (en)contro impossível ou um (en)canto possível?. *Cógito*, *8*, 9-13. http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1519-94792007000100002&lng=pt&tlng=pt

Moretto, M. L. T. (2006). *O psicanalista num programa de transplante de fígado: a experiência do outro em si* [Tese de doutorado]. Universidade de São Paulo. https://doi.org/10.11606/T.47.2018.tde-06122018-144620

Moretto, M. L. T. (2019). Na vertente clínica: a abordagem psicanalítica do sofrimento nas instituições de saúde. In *A abordagem psicanalítica do sofrimento nas instituições de saúde* (1a ed., cap. 4, pp. 57-73). Zagodoni.

Moura, F. F., Zimmer, M., Tavares, M. G., Almeida, G. B., & Santos, D. B. (2020). Prevalência de sintomas de transtornos mentais comuns em pacientes internados em um Hospital Geral do Sul do Brasil. *Revista da SBPH*, *23*(2), 139-148. http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1516-08582020000200013&lng=pt&tlng=pt

Nascimento, P., Cardoso, M., & Neves, A. (2020). Principais desfechos fatais em indivíduos cardiopatas acometidos por COVID-19. *Enfermagem em Foco, 11*(2. esp). doi: https://doi.org/10.21675/2357-707X.2020.v11.n2.ESP.3676

Organização Mundial da Saúde [OMS]. (2017). *Doenças cardiovasculares*. https://www.paho.org/bra/index.php?option=com_content&view=article&id=5253:doencas-cardiovasculares&Itemid=1096

Organização Mundial da Saúde [OMS]. (2020). *Coronavírus*. https://www.who.int/es/health-topics/coronavirus/coronavirus

Quintana, J. F., & Kalil, R. A. K. (2012). Cirurgia cardíaca: manifestações psicológicas do paciente no pré e pós-operatório. *Psicologia Hospitalar, 10*(2), 17-32. http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1677-74092012000200003&lng=pt&tlng=pt

Resolução nº 466, de 12 de dezembro de 2012. (2013, 13 de junho). Dispõe sobre diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. *Diário Oficial da República Federativa do Brasil*. http://bit.ly/1mTMIS3

Silveira, D. B. (2015). *Incidências do Real em um hospital de cardiologia: apontamentos a partir de uma experiência* [Dissertação de mestrado]. Universidade do estado do Rio de Janeiro.

Soler, C. (2018). *Adventos do Real: da angústia ao sintoma* (1a ed., Elisabeth Saporiti, trad.). Aller.

Wachsberger, H. (1994). Função das entrevistas preliminares. In *Clínica lacaniana. Casos clínicos do campo freudiano* (pp. 26-31). Jorge Zahar. Trabalho original publicado em 1989.

Wottrich, S. H., Quintana, A. M., Camargo, V. P., Quadros, C. O. P., & Naujorks, A. A. (2013). Significados e vivências mediante a indicação cirúrgica para pacientes cardíacos. *Psicologia em Estudo, 18*(4), 609-619. https://doi.org/10.1590/S1413-7372201300 0400004

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