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Experiences and influences of grief processing in the treatment of an individual with spinal cord injury

Vivências e influências da elaboração do luto no tratamento da pessoa que sofreu traumatismo raquimedular

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Abstract

Objective

The study reports a case of a person who suffered a spinal cord injury called Trauma Raquio Medular. The question was answered: can the grief of the patient, his/her family and the professionals contribute or hinder treatment and rehabilitation?

Method

The medical records of a patient treated at an Emergency Hospital were analyzed. The analyses will be based on psychological theories about grief with complements from psychoanalysis, seeking to report from the psychologist's perspective the experiences of grief in hospital treatment.

Results

This clinical case was chosen due to the complex history in biopsychosocial aspects of the patient. The body in its fragility can be modified by traumatic situations, such as: amputations, spinal and head injuries, among others. From the bodily changes, grief can be experienced.

Conclusion

Understanding the grief process can provide more effective and humanized care, with a view to returning to the territory.

Keywords: Grief; Hospital psychology service; Patient care team; Spinal cord injuries.

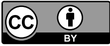
Resumo

Objetivo

O estudo relata um caso de uma pessoa que sofreu uma lesão na coluna denominado Trauma Raquio Medular. Respondeu se: o luto do paciente, de sua família e dos profissionais, pode contribuir ou dificultar no tratamento e reabilitação.

Método

Foi analisado o prontuário de um paciente atendido em um hospital de Urgência e Emergência. As análises serão a partir de teorias da psicologia sobre o luto com complementos da psicanálise, buscando relatar pelo olhar do psicólogo as vivências do luto no tratamento hospitalar.



Resultados

A escolha desse caso clínico deu-se pela história complexa em aspectos biopsicossociais do paciente. O corpo em sua fragilidade pode ser modificado por situações traumáticas, tais como: amputações, lesões na coluna e na cabeça, entre outros. A partir das alterações corporais pode se vivenciar lutos;

Conclusão

A compreensão do processo de luto pode proporcionar um cuidado mais eficaz e humanizado, tendo em vista o retorno para o território.

Palavras-chave: *Luto; Psicologia hospitalar; Equipe de assistência ao paciente; Traumatismos da medula espinal.*

Since the emergence and development of the human species, it has been known that humans are marked by finitude, as well as by the fragility of their bodies, which may be subject to violations of various kinds. Freud (1930), in *Civilization and Its Discontents*, states that there are three sources of suffering: the power of nature, the fragility of the body, and the inadequacy of the regulations governing human ties within the family, the state, and society.

The body, in its organic fragility, can be traversed and altered, for example, through various forms of amputation, spinal and traumatic brain injuries, among others. Following a traumatic event, individuals are sometimes directed, either by their own means or by others, to a public or private healthcare institution. This study will focus on a case report of a patient who suffered spinal injuries and was referred to an Emergency Hospital. This hospital handles a large demand of patients who have suffered trauma from various mechanisms.

Based on the research of Vasco e Franco (2017), it can be stated that in both Brazil and globally, the highest rates of spinal cord injuries are due to traumatic etiologies, whereby individuals compress or fracture the spine through motor vehicle accidents, natural disasters, Gunshot Wounds (GSWs) and Stabbing Wounds (SWs), falls, diving into shallow waters, among others.

When treating an individual with Spinal Cord Injury (SCI), one can observe numerous psychological, physiological, and social impacts, among other changes, stemming from this body-altering traumatic event (Melo, 2009). This study examines the experience of grief during the hospitalization period of a person with SCI, focusing on the bodily changes imposed by the trauma. The stages of grief are analyzed to understand their impact on trauma processing, treatment, and rehabilitation, with insights drawn from the observations and contributions of the hospital psychologist.

Sigmund Freud (1917[1915]/1996), in *Mourning and Melancholia*, describes mourning as the loss of a beloved family member or an abstraction occupying that role, such as one's country, an idea, an object, freedom, among others. Freud further asserts that mourning will be overcome after a period of time, during which the individual finds new "objects of love".

Based on Freud's theory of mourning, the body, lost and altered due to SCI, can be considered one of the beloved objects that undergoes the process of mourning. Thus, this study seeks to investigate the experience of mourning in an individual who has suffered SCI and to determine whether the intersecting experiences within the hospital setting may influence treatment, recovery, and coping.

Considering the unique experience of mourning for a body altered by spinal trauma, this study intends to analyze and associate the hospital psychologist's observations regarding the experiences of the patient, the family, and their interactions with the healthcare team, in light of psychological theories on grief with psychoanalytic contributions.

Another important factor to consider in the context of mourning for individuals with SCI is the role of the healthcare team. According to the Ministério da Saúde (2013), the multidisciplinary team should aim to support both the patient's mental and physical health, as well as to guide individuals toward a fulfilling life, social inclusion, and the development of autonomy. Thus, guiding the patient and family through the stages of grief may help the healthcare professional identify the patient's potential strengths and encourage them to improve their Activities of Daily Living (ADLs).

This study will address the hypothesis that the mourning experienced by the patient, their family, and the healthcare team may either support or hinder the individual's rehabilitation and recovery process, considering the influence mourning may have on their journey through hospitalization and eventual reintegration into the community and society.

As this is a single case report, based on the medical record of a patient who has been discharged, risks are minimal. Data collection does not interfere with hospital service routines. Throughout the analysis and in the dissemination of final results, patient confidentiality was maintained, with only information relevant to the case included. Identifiable details such as skin color, race, ethnicity, sex, age, and location, among others, were anonymized. Confidentiality of the hospital/service where the research was conducted was also preserved.

The proposed research was submitted for evaluation by the Innovation and Research Coordination and approved by the Research of Fundação Hospitalar do Estado de Minas Gerais, following the institution's research project submission protocol. Considering that data collection was conducted through secondary sources and retrospectively, with a significant time gap since the patient's hospitalization, which consequently limits access to the patient, an exemption from the Informed Consent Form was granted.

Method

This is a single-case report investigating the medical records of an individual who experienced a Spinal Cord Injury and was treated at an Emergency Hospital in Belo Horizonte, Minas Gerais, Brazil, from March to July 2022. This clinical case was selected due to the patient's complex biopsychosocial history. Observations and analyses are grounded in psychological theories of mourning, with psychoanalytic insights, and aim to document, from the psychologist's perspective, the influences and experiences of mourning on hospital treatment.

Participants

Participants included a patient with Spinal Cord Injury treated in an Emergency Hospital, the healthcare team, and the patient's family.

Instruments

Content analysis of medical records, discourse analysis, and participant observation.

Procedures

Data from the medical record of the discharged patient were investigated to analyze the patient's treatment and recovery process.

Results

Based on this case report, it is possible to explore the hypothesis as to whether mourning may aid or hinder the hospital treatment process, as well as rehabilitation and discharge. In this case, it was observed that, at times, the stages of grief interfered with both the patient and the healthcare team. *However, when the feelings arising from the grieving process — in the patient, the family, and the team — are externalized and processed, they may help mitigate negative effects* (emphasis added).

It is important to note, following Cemin and Einsfeld (2022, citing Worden, 2013), that the experience of mourning is unique to everyone, and those who experience similar situations may develop various ways of coping with the experiences encountered. Therefore, further investigations are necessary to address this question.

From this single case report and literature on the topic, the importance of the multidisciplinary team is evident, as well as the relevance of the hospital psychologist's role in processing grief, as this may provoke multiple reactions in the patient, the family, and the healthcare professionals (Cemin & Einsfeld, 2022).

Discussion

This case concerns a patient, referred to here as B.A. for confidentiality, who was attended to by various hospital psychologists during the hospitalization period due to the distribution of the psychology team across hospital sectors. The patient experienced an extended hospitalization, marked by the challenges commonly faced by individuals with. According to the guidelines of the Hospital Israelita Albert Einstein (2012), SCI results in temporary or permanent changes in motor, sensory, and/or autonomic functions in affected individuals.

B.A. remained in the trauma hospital for four months before being transferred to a rehabilitation facility. The patient's life history is complex, with numerous social challenges that will be detailed throughout this report. According to Donicht et al. (2021), life stories involving traumatic events often include forms of suffering that are, at times, tied to situations of social vulnerability, potentially leading to an "invisibility syndrome" – a phenomenon that, in psychoanalytic terms, may be considered symptomatic.

B. A. is 28 years old, lives with his 22-year-old girlfriend, and is the father of an eleven-month-old daughter (at the time of hospital admission) and a five-year-old stepson (whom he regards as his son). B. A. has fourteen siblings, divorced parents, and a history of various family conflicts. He has no formal employment and performs occasional jobs as a construction assistant.

During a psychology consultation, B. A. reported having lived alone since the age of thirteen due to family conflicts. These experiences contributed to shaping aspects of his personality, at times influencing and hindering his hospital treatment and interactions with the healthcare team. The family environment is shaped by the experiences and relationships of its members. In this context, unique forms of organization, distinct realities, and ways of engaging with the world are constructed, shaped by beliefs and symptoms that are part of the individual's constitution (Romagnoli, 2004).

B. A. claimed that his main source of income was "the trafficking of illicit substances," which he described as his enterprise. This "work" was an inheritance from his father, who chose to pursue alternative financial ventures. The patient reported having started this work upon leaving home. According to Donicht et al. (2021), in certain social contexts and amid social invisibility, trafficking

is the "most valued profession" and, at times, the only option available to some individuals. For certain people, the use of illicit drugs may be as habitual as a morning cup of coffee.

What B. A. refers to as work was the direct cause of his trauma, as he became a victim of violence, suffering multiple gunshot wounds in front of his daughter and wife, at his home's doorstep. The perpetrator was an acquaintance, sent to "execute" him by one of B. A.'s trafficking "associates".

Research indicates that traumatic causes account for the highest rates of spinal cord injuries in Brazil and globally. Individuals frequently sustain these injuries from spinal compression or fracture due to motor vehicle accidents, natural disasters, gunshot wounds, stabbing wounds (SWs), falls, diving into shallow water, among other causes (Vasco & Franco, 2017).

Following the violent incident, the patient was assisted and transported by the Mobile Emergency Care Service to an Emergency and Trauma Hospital, where he was immediately admitted to the Intensive Care Unit (ICU). Here, the patient and his family had their first interactions with the psychology service, as well as with the medical and multidisciplinary teams. From this point, the psychology professional observed manifestations of grief as a consequence of the traumatic event, affecting both family members and the care team. Hospital psychology focuses on the psychological repercussions associated with hospitalization and illness (Silva, 2020).

The renowned theorist Elizabeth Kübler-Ross, recognized for her work on grief, death, and dying, developed concepts through her experiences with terminally ill patients. In her book *On Death and Dying*, Kübler-Ross associates grieving processes with a non-chronologically standardized oscillation between five stages of coping: denial and isolation, anger, bargaining, depression, and acceptance (Kübler-Ross, 1981).

Some ICU team members felt impacted by B. A.'s story, marked by violence and social vulnerability; they emphasized that the patient was "*young, had a life ahead of him, a young daughter; his life is at risk, and if he survives, he may become disabled*" (sic). The team expressed mixed feelings of grief, such as anger and sadness. They revisited personal stories, values, and biases, empathizing with B. A.'s mother's "position" and voicing indignation. In the book *Do Luto à Luta* (From Mourning to Struggle, free translation), grief is presented as a wound arising from the supremacy of reality, which confronts desire and dethrones narcissism; the self is displaced from its former sense of authority (Tavares, 2014).

In the case of the ICU team and B. A.'s story, the frustration regarding a patient's life can be identified as a result of the dethroning of the self. Such affectation, arising from idealizations or disillusionment regarding the life of an "other", which reflects one's own life, sometimes aided in care and at other times hindered the treatment process. Freud states in his work *On Narcissism* that individuals are unwilling to abandon their infantile narcissistic perfection. As they mature, they are impacted by disturbances from others and their own critical judgment of no longer possessing this perfection, which they then seek to recover through an ego ideal (Freud, 1914[1916]/1996).

Due to the need for Mechanical Ventilation (MV), the patient arrived intubated in the ICU, making an initial psychological approach unfeasible. Thus, the psychology team attended to the family alongside the medical team to clarify the patient's critical health status at that moment. Family support is essential in helping relatives cope with the situation, express their emotions, and understand ICU treatment processes (Silva, 2020).

The first family members present were the mother and two sisters (one of whom was very tearful and felt remorse over a recent conflict with the patient, during which she admitted to having, in anger, expressed a wish to see him dead). The distressed and shocked family members expressed mixed feelings of anguish, sadness, anger, fear, and remorse. According to Silva (2020),

the way in which a family reacts to the illness process can be influenced by various factors, including the individual's role within the family unit and their interpersonal history.

They recounted the patient's life story and disclosed his use of psychoactive substances, which was important information for the ICU team given its relevance to monitoring the patient's awakening after extubation and managing drug interactions to reduce withdrawal symptoms. Drug interactions associated with the use of illicit substances in ICU patients can be a significant concern, as these medications may produce adverse effects and amplify the effects of illicit substances, potentially leading to treatment complications such as hypertensive crises and overdose (Feitosa-Filho et al., 2008).

The psychologist on duty assumes the moderation function, carries out possible interventions, provides guidance on ICU schedules and procedures, and accompanies the family on their bedside visit. The moderation function relates to the ability to receive, process, contain, and transform disordered external information, facilitating its integration into the psyche. This function is associated with receiving and transforming emotional content (Fernandes, 2008).

The medical team identified the areas of the patient's body affected by GSWs, explaining that the spinal column was impacted in the Cervical 7 (C7) and Thoracic 1 (T1) regions. They outlined for the family the possible complications associated with such injuries, including a prognosis of tetraplegia (loss of movement in both upper and lower limbs), a prognosis that was to be reassessed and confirmed during the hospitalization period. The grieving process begins from the moment a fatal or potentially fatal diagnosis is received, stemming from the symbolic or actual losses that the diagnosis entails for the family or the individual (Franco & Polido, 2014).

The spinal cord is located within the spinal column and is part of the central nervous system, responsible for transmitting and receiving information through nerves throughout the body, connected to the brain. According to Vasco (2015, citing Lianza et al., 2007), the spinal cord functions as a regulatory center controlling motor skills, sensory input, and autonomic functions, including the bladder, respiration, thermal control, sexual activity, and bowel functions, among others.

The spine is physiologically subdivided into the Cervical, Thoracic, and Lumbar regions, with the impact of spinal cord injuries varying according to the specific location of the injury. Thus, as stated by Vasco (2015), the "*higher the injury (closer to the head), the greater the motor, sensory, or autonomic deficits*" (emphasis added). Following this logic, one could hypothesize that the greater the functional loss, the likely greater the psychological effort required to process the pain and adapt to the imposed losses.

Each individual perceives and experiences pain in a unique manner. Medeiros (2019) describes pain as the threshold between the organic and the psychological, between the Other and the relationship with the Self. The author identifies pain as a source of disorder within the individual, making it difficult to classify as solely physical or psychological. In individuals who have sustained SCI, physical pain may sometimes disappear due to a total or partial loss of sensitivity, leaving only psychological pain (Nasio, 1997).

In *The Book of Love and Pain*, the author presents psychological pain as a reaction to trauma – a defense mechanism, in which, following the disorganization caused by the traumatic situation, the individual struggles to rediscover themselves. Considering the grief experienced by individuals who have suffered trauma, it is possible to hypothesize that psychological pain is present as part of the process of the individual's psychological reorganization (Nasio, 1997).

The family may also experience grief alongside the individual as they adapt to the new condition they have been presented with. This grief will manifest uniquely in each family member.

It is possible to consider that each family member's previous experiences with the trauma survivor may influence the process of illness, treatment, recovery, and the individual's own grieving process (Cruz et al., 2021).

According to Vasco and Franco (2017), the family functions as an interconnecting institution, and thus family members may undergo the grieving and life-restructuring process together following the traumatic event. Adjustments may begin during the hospitalization period and continue after discharge, as the individual is no longer the same family member they once were and may have become more dependent.

B. A.'s relatives demonstrated a good understanding of the patient's health status and severity, initially showing coping through spirituality as a defense mechanism for psychological protection within the denial stage of grief. In the denial stage, individuals attempt to avoid confronting the reality of the event and its potential consequences. They may avoid thinking or speaking about the situation and often turn to other coping mechanisms, such as spirituality (Kübler-Ross, 1981).

The sister, who had initially expressed remorse upon admission, returned after visiting hours had ended, exhibiting heightened and congruent emotions in response to the situation. The family member channeled feelings of grief (anger) toward the hospital front desk staff, attempting to bypass visiting hour restrictions, even after receiving medical updates. In the anger stage, individuals often seek someone to blame and may become more confrontational, externalizing emotions and projecting them outward, accompanied by a sense of disbelief (Kübler-Ross, 1981).

In the days following, while the patient remained in the ICU, some siblings came during visiting hours, and the family frequently requested exceptions to the established daily visitation limits in the unit. This behavior suggests a family context with difficulties in following "laws" (rules), which may explain a symptom observed in B. A. that was inherited from this family dynamic, influencing the patient's treatment, rehabilitation, and subsequent grieving process. The speaking subject is inscribed in culture, and the castration of desire is a conditioning factor for normativity. The "law of the father", as formulated by Lacan, marks the individual and assigns him the conditions necessary for life in society (Lemos et al., 2015).

Over time, family visits became less frequent, with, at times, only B. A.'s mother being present, and on other occasions, no visitors whatsoever. This situation may be associated with the patient's family history, familial conflicts, as well as the denial stage of grief. The isolation of family members may represent one of the stages of grief associated with denial, as they seek distance, avoid communication, or refuse to confront certain situations (Kübler-Ross, 1981).

Over time, the patient's clinical condition stabilized, although they remained unable to breathe without mechanical ventilation. Consequently, the medical and multidisciplinary team proposed a Tracheostomy (TQT). A TQT is a surgical procedure in which an opening is made in the anterior wall of the trachea, creating a pathway to the external environment through a cannula that connects to the ventilator. This procedure is performed on patients with compromised airways or those requiring prolonged periods of mechanical ventilation (Medeiros, 2019).

The procedure for performing the TQT was explained to the family in the presence of the psychology team. The psychologist provided support to family members, who expressed concerns about the possibility that the patient might be unable to live without mechanical ventilation and the challenges they might face upon returning home with this device. They expressed sadness regarding B. A.'s weakened body and loss of autonomy. The pain of loss offers an opportunity to reassess values, reorganize life plans, and strive to accept what cannot be changed. The exchange of feelings can help facilitate the grieving process (Tavares, 2014).

B. A.'s mother appeared humble in her life context, demonstrating some cognitive difficulties and fluctuations in her understanding of the patient's health status. She believed that he would return to his previous life activities without any dependencies. The psychologist provided her with support and intervened to help the family reflect on the new life configuration imposed by the trauma, both for the patient and for the family members. Healthcare professionals may utilize resources that help alleviate suffering and potential destabilization caused by the situation experienced (Silva, 2020).

When faced with an imposed disability, the family tends to undergo adaptations and psychological confrontations, as well as logistical, financial, and social challenges, among others. At times, a family member may need to forgo personal, professional, and financial plans in order to adapt to the new context of dependence for the individual who suffered the trauma, thus experiencing grieving processes (Bossardi et al., 2021).

Upon hearing the news of the TQT, the patient's mother fluctuated between various feelings and stages of grief. She exhibited anxious behavior and began a bargaining process through spirituality, stating that if it was God's will, her son would recover, making promises and fasting for his improvement. Bargaining appears as a postponement of the inevitable, serving as an exchange that saves the patient from the cruel reality imposed on him and his family (Kübler-Ross, 1981).

Angry, B. A.'s mother directed self-blame, holding herself responsible for the patient's life history. As previously stated, in the anger stage, individuals seek someone to blame. The family member externalizes sadness over the situation and expresses acceptance, stating that she will care for her son in whatever condition he presents after his hospital discharge. The acceptance stage can occur slowly and gradually after the release of anger, sorrowful crying, and the communication of fears and fantasies (Kübler-Ross, 1981).

When addressing the characteristics of the grieving process, it is essential to consider haste as a symptom of contemporary society, noting that such a characteristic may predict anxiety and anguish for the individual who has suffered trauma, their family, and healthcare professionals. The grieving process involves reactions to a significant loss that destabilized the individual's functioning, and this process requires time for elaboration (Vasco & Franco, 2017).

After a few days, with the reduction in sedative medications, the patient began to awaken on mechanical ventilation, appearing somewhat confused and agitated, demonstrating anxiety, signs of withdrawal, crying, and a depressed mood. B. A. expressed to the psychologist feelings of fear, longing, pain, and discomfort related to immobilization. The patient then began the process of perceiving his body after the traumatic event. In his studies, Freud (1914[1915]/1996). Freud (1914[1915]) de 1996 discusses that some mental processes occur unconsciously until they reach consciousness through sensory organs, asserting that the unconscious is atemporal.

The hospital psychologist made the necessary interventions and discussed the case with the medical team, requesting a conversation with the patient about his condition of Respiratory Muscle Injury (RMI). The communication of his new condition was delivered by the on-call physician, without the presence of the psychology team. Building on Freud's formulation of the atemporality of the unconscious, Lacan also addresses time logically for understanding the unconscious. According to him, the subject undergoes the "instant of seeing", the "time for understanding", and the "moment of concluding" (Garcez & Cohen, 2011).

In Lacan's framework, the instant of seeing involves no subjectivization or reasoning; it is merely the acknowledgment of a fact. In the time for understanding, reasoning and hypotheses about what was observed emerge; and in the moment of concluding, there is a sense of urgency, a certainty about the fact (Garcez & Cohen, 2011).

In the days following the announcement of his imposed tetraplegia, the patient exhibited mood swings, a tendency to complain, and excessive demands on the nursing, physical therapy, and medical teams. The psychology team dedicated more time to this patient in response to such behavior. When one loses something, it is not just a single thing that is lost; often, good humor, patience, and common sense are lost alongside it, and sometimes even the will to live may go with the loss (Tavares, 2014).

Due to the TQT, the patient learned to produce a vocal sound with his tongue to call others, resembling a bird's chirping. Initially, this sound was well received by the team, but over time, it became aversive to the professionals due to the patient's excessive and constant requests, which at times sounded like commands. B. A. wanted to be heard! He sought acknowledgment as an individual; amid so many losses, words were what remained to him. In Freudian psychoanalysis, the subject emerges through language. Lacan postulates the subject of the unconscious as structured like a language and organized in three registers: the real, the symbolic, and the imaginary. The subject is influenced by an Other already embedded in language, with the subject as an effect of a signifier (Torezan & Aguiar, 2011).

On one weekend shift, the psychology team was called in due to the patient's incessant behavior in seeking attention and someone's presence at his side. In her work, Kübler-Ross presents human attitudes toward death and dying, pointing out that fear of finitude provokes anxiety (Kübler-Ross, 1981). In his imagination, B. A. may have believed that another person's presence would distance, if only for a moment, "the unwanted guest" (i.e., death) (Bandeira, 2012, p. 133).

During this same session, the patient demonstrated awareness and orientation regarding his bodily changes and was able to express anger about his RMI condition. The patient displayed irritability and impatience when his requests were not met.

He appeared to want his desires fulfilled immediately, many of which were denied by the team due to his current clinical condition. He seemed unwilling to accept explanations for the refusals of his requests, displaying an impatient, intolerant personality with a certain authoritarianism and difficulty in respecting "laws" (rules), similar to the aforementioned family behavior. In the anger stage, revolt emerges, sometimes directed outward, making it more challenging for family and healthcare staff to handle the patient (Kübler-Ross, 1981).

However, B. A. showed signs of psychological destabilization along with the reconstruction of his body perception. One of the interventions by the psychologist included a video call with the patient's wife and mother, aiming to relieve his distress and longing. In the bargaining stage, guilt and punishment may be internalized, and thus, negotiations can serve as temporary relief (Kübler-Ross, 1981). Given his background, B. A. expressed a fear of abandonment.

The following day, the patient was attended to at the team's request due to B. A.'s excessive, unceasing demands. The patient appeared lucid but anxious, complaining of tingling and cramps throughout his body. He expressed fears stemming from the hospitalization and the trauma-inducing event. Due to the patient's need for presence, the team considered implementing an extended visiting policy in the ICU. The family was contacted and given the relevant instructions. The family is generally viewed by the healthcare team as a partner in rehabilitation. The impact of spinal cord injury causes a drastic rupture between the patient's former and current life, confronting him with a severe, disabling, and unfamiliar condition that will require readjustment (Cruz et al., 2021).

In the phone call, the patient's wife expressed a request for a visit from B.A.'s father, who was in conflict with the patient and wished to reconcile with him. The psychologist emphasized that the visit should aim to calm the patient rather than increase his anxiety. The request was thus

conveyed to the patient, reinforcing that B. A.'s wishes would be respected. In psychoanalysis, the concept of the subject is defined as the subject of desire, driven by a sense of lack and shaped by the desire of an Other (Torezan & Aguiar, 2011).

Throughout the day, the hospital psychologist returned several times to the patient's bedside, noting his maladjustment to his new SCI condition, indicating he was in the denial stage of grief. This stage is common and can be healthy if experienced momentarily, given the painful and distressing situation (Kübler-Ross, 1981). In response to the situation, the matter was discussed with the medical team, and a follow-up conversation with the patient was requested to provide additional information and clarity regarding his health status. This situation reiterates the earlier point that the subject will need time to process grief.

The physical therapy team discussed the case with the psychology team to coordinate a multidisciplinary approach due to the need to wean the patient off MV. The physical therapist reported that the patient had been unable to remain off MV due to fear and anxiety. During psychological care, the patient expressed fear of death and attachment to the ventilator. Attachment tends to mitigate losses, as one clings to objects, people, and ideals. The Ego sustains this "attachment" by persisting in expectations and illusions, refusing to let go of what is no longer present, reinforcing idealized aspects while rejecting personal flaws (Tavares, 2014).

The psychology professional addressed the feelings expressed, and B. A. acknowledged his pain. Gradually, the interventions facilitated his disconnection from MV, allowing the team to plan his transfer to one of the hospital wards. Through conscious reflection, transformation occurs; the pursuit of acceptance involves acknowledging one's pain (Tavares, 2014).

B. A. expressed a desire to receive a visit from his father, leading to their reconciliation. The patient's father appeared fearful and struggled to understand that his son would no longer be able to walk due to the diagnosis of tetraplegia. The hospital psychologist provided support and conducted appropriate interventions with B. A.'s father, who was emotionally fragile and in denial, finding it difficult to remain at the bedside. After experiencing a cathartic release of anger and guilt (directed at himself and others), the family member was able to remain by the patient's side. According to a video by the Sociedade Brasileira de Psicanálise (SBP, Brazilian Society of Psychoanalysis) (Sociedade Brasileira de Psicanálise Integrativa, 2022), catharsis is a therapeutic process involving the release of emotions and psychic disturbances through verbal and bodily expressions.

B. A.'s transfer to one of the hospital wards occurred with the presence and support of his father. After the patient's arrival in the semi-intensive care unit, the psychologist notified the remaining family members about the patient's transfer and provided organizational instructions. This communication was necessary due to conflicts between the father and the rest of the family. Franco and Polido (2014) suggest that, in the context of anticipatory grief experienced by the family, there are both facilitating factors, such as a flexible family that adapts and adjusts roles, and complicating factors, such as dysfunctional relationship patterns that hinder communication and problem-solving.

While in the ward, the patient began to request news about his daughter, whom he identified as the source of meaning in his life and his motivation to continue "fighting" for rehabilitation. Sigmund Freud (1917[1915]/1996), in his work on mourning and melancholia, asserts that over time, an individual tends to gradually withdraw libidinal investment from the lost object and begins to invest in new love objects.

As days passed, the family, healthcare team, and patient came to understand that B. A.'s hospitalization was progressing toward a prolonged and chronic phase, with the patient frequently

oscillating through the stages of grief. According to Kübler-Ross (1981), in the grieving process, there is a non-linear oscillation through stages of coping. In the process of illness, there may be phases that the patient, family, and healthcare team experience.

Franco and Polido (2014) state that in the face of illness, the family will undergo phases in organizing their experience, as follows: the crisis phase (preceding diagnosis), where symptoms are interpreted, and the family unites to confront the unknown, grounded in their beliefs and functional dynamics. The chronic phase (the challenge of resuming a semblance of normal life), acute crises emerge, leading the patient and family to accept the changes as the pre-illness identity can no longer be relied upon. The final phase (inevitability of finitude) is the time for farewells, for addressing unresolved issues, and for fulfilling the last wishes of the ill patient.

With support from the Occupational Therapist (OT), the patient receives hand assistance to operate his cell phone independently, fostering greater autonomy and instilling hope for rehabilitation. According to the Ministério da Saúde (2013), the multidisciplinary team should aim to maintain both the individual's mental and physical health, as well as to guide them toward a fulfilling life, social inclusion, and the development of autonomy. Thus, guiding the patient and family through the stages of grief may help the healthcare professional identify the patient's potential strengths and encourage them to improve their activities of daily living.

At times, constant cell phone use interfered with the care process, while external factors and information unrelated to the hospital environment affected the patient's mood. The patient's mood could also become dysphoric or dysthymic, particularly following frustration with a professional or conflicts with family members.

At one point during hospitalization, the psychiatry team was consulted to address mood instability. Medication therapy was initiated, which, in the team's observation, helped the patient process grief less intensely. This combination of medication and daily psychotherapy supported other professionals' efforts, enabling the patient to more readily accept therapeutic interventions from various specialties. Tavares (2014) suggests that, rooted in citizenship as well as in every profession, each professional holds a therapeutic potential within; it is a comprehensive art that seeks to promote health, revitalizing and energizing life.

Throughout the patient's hospitalization in the wards, the psychology team was often called upon due to the patient's refusal of treatments, which hindered his rehabilitation. The patient oscillated through stages of grief, including isolation and denial, anger, and depression. Kübler-Ross (1981) distinguishes between two types of depression: preparatory, which is directed toward an objective, and reactive, which arises based on circumstance.

At one point, B. A. informed the physical therapy team and later the psychology team that despite his condition, he continued to manage his "business" through his cell phone and harbored plans for revenge due to discovered betrayals. The patient demonstrated a need to assert his wishes and rules, and at one point, threatened the medical team on one of the floors by showing a photo of weapons. For a person accustomed to control who suddenly loses it, anger may represent an attempt to regain that sense of control (Kübler-Ross, 1981).

B. A.'s treatment had extended to a three-month hospitalization, during which he exhibited impatience and expressed that the treatment seemed endless. In contemporary individuals shaped by capitalist discourse, a sense of urgency functions as a protective mechanism, helping them avoid confronting lack (Garcez & Cohen, 2011). The medical team felt intimidated by the threats and, due to the patient's state of denial and non-cooperation with the treatment, a transfer to a different ward was requested.

The transfer left the patient feeling frustrated once again due to the extended wait to see his daughter, whose visit was being arranged by the psychology service. During his psychological session, B. A. appeared tearful, expressed sadness, and vocalized his anxieties, once again displaying the depression stage. Alongside the multiple losses the patient experienced due to the trauma, he also had to grieve not being able to have his daughter nearby or witness her growth. Nasio (1997) describes anguish as a reaction to the threat of losing a loved one.

With the change of the ward, the psychology service communicated and handed over the case to the new team. The psychologist from the previous ward reported that, at certain times, the nursing team observed the patient tearful and attempting suicide using the cables of the vital signs monitor. At this point, an extended visit arrangement with the family was revisited; however, despite being a large family, they were unable to organize the visit. Dalgalarrondo (2008) indicates that it is very common for patients experiencing grief over significant losses to develop depressive syndromes and disorders, which are subdivided into: Recurrent depressive episode or phase, dysthymia, atypical depression, melancholic or endogenous depression, psychotic depression, depressive stupor, agitated or anxious depression, secondary or organic depression.

The patient appeared apathetic, unmotivated, with family contact limited to phone calls that were occasionally conflictual. He reported feeling abandoned, desperate, and hopeless. He reported suicidal ideation without specific plans, exhibited anguish regarding his condition and unhappiness, and showed signs of the isolation and depression stage of grief. According to the International Classification of Diseases (World Health Organization, 2021), depression presents in three degrees: mild, moderate, and severe. Across all levels, it is characterized by diminished mood, reduced energy, and decreased activity. The ability to experience pleasure, interest levels, and concentration capacity tend to diminish. Symptoms may also include reduced appetite, difficulty sleeping, and lowered self-esteem and confidence.

The psychology team provided support to the patient's mother, who, distressed, reported that B. A. had mentioned a suicide attempt over the phone. The family member exhibited exhaustion and a sense of helplessness in response to B. A.'s suffering, recalling a challenging history with the patient throughout his life. She expressed concerns regarding the possibility of his discharge from the hospital and the challenges of adapting the home environment to accommodate him. According to Junior et al. (2008), building rapport can be challenging for the team; however, it is a critical factor in improving patient adherence to treatment, treatment efficacy, and the development of autonomy between the patient and the professional.

Upon arriving at the new ward, B. A. established a positive rapport with the multidisciplinary team, which was receptive to the proposal for a visit from his one-year-old child. The visit was organized by the psychology team, with the support of the physical therapy and nursing teams, who assisted with patient care and prepared him for the scheduled date. According to Junior et al. (2008), building rapport can be challenging for the team; however, it is a critical factor in enhancing patient adherence to and efficacy of the treatment, and the development of autonomy between the patient and the professional.

To facilitate the visit, certain behaviors were agreed upon in advance: accepting all therapeutic interventions, including medication; motivating himself to sit up in bed to improve autonomy – often compromised in SCI patients; and reducing phone interactions with individuals outside the hospital who induced anxiety and stress. Only through transference (a necessary condition for analysis) can the professional assume the role of one who supposedly understands (a role in which the analysand believes the analyst possesses deep knowledge of him) and thereby establish strategies to guide the treatment (Quinet, 2009).

Regarding the concept of transference, Freud (1914 [1915]/1996) theorizes that the subject unconsciously displaces libido from original past love objects to the figure of the analyst. In B. A.'s case, this libidinal displacement appears to have occurred toward certain members of the healthcare team. This mechanism is essential for establishing treatment, as, according to Lacan, transference is defined as a love directed toward knowledge (Quinet, 2009).

In psychoanalysis, transference typically occurs from the patient to the analyst; the reverse, from analyst to patient, is known as countertransference. In cases where the analyst's libido is directed toward the patient, the professional understands that they cannot reciprocate this transferential love, due to ethical and technical aspects of the treatment. Thus, the professional should leverage this mechanism to benefit the patient's recovery; reciprocating this transferential love would place the treatment at risk (Freud, (1914 [1915]/1996).

Due to his desire to see his daughter, B. A. considered following all the given guidelines, which improved his demeanor and interaction with the team. Landi and Chatelard (2015) explain that the ethics of psychoanalysis is grounded in desire, which is conditioned by lack; it seeks to awaken desire, allowing the subject to recognize their position of subjugation to the Other. Faced with the reality of lack, the desiring subject finds ways to cope with what is missing.

A few days before the visit, the patient once again displayed frustration, as he was unable to remain sitting up in bed and experienced momentary syncope. Feeling tearful and saddened, he believed that, under these conditions, he would not be able to see his daughter. The psychologist addressed these feelings, which involved mourning for his body and anticipatory grief (experiencing loss before it occurs) due to the fear of not seeing his daughter. In the process of mourning, it is necessary to recognize the importance that the individual places on the lost object. As a gradual process, mourning tends to drain the Ego's energies (Cemin & Einsfeld, 2022).

One of B. A.'s motivations to remain seated for extended periods was the prospect of having the visit take place with him seated in a wheelchair in an outdoor area of the hospital. *With the support of the multidisciplinary team and the patient's strong desire for the visit, B. A. showed the readiness necessary for it to take place* (emphasis added). The psychologist coordinated with the patient's wife for a morning visit, a time when there would be fewer people in the hospital's outdoor area, thus reducing the risk of contamination for the child.

In the days following the visit, the patient exhibited a cheerful mood, was more cooperative, and less reactive toward the teams. He expressed discomfort with the prolonged hospitalization and saw the rehabilitation hospital as a potential place to be "saved" from his SCI condition, once again displaying the bargaining stage. B. A. had begun to accept that his body had changed, yet he still hoped to reverse this situation. According to Kübler-Ross (1981), if a patient is given sufficient time and support to work through losses, they may no longer feel sadness or anger about their condition. The author also emphasizes the importance of distinguishing between acceptance and happiness.

Rehabilitation hospital vacancies are limited, and due to multiple infections, the patient's hospital transfer took longer than anticipated. While waiting for B. A.'s slot to become available, care training for family members, especially his mother and wife, was initiated. The family became a partner with the healthcare team in the rehabilitation and reintegration process, as the patient's new condition could lead to significant life changes, rendering him partially or fully dependent on others. In their role, healthcare professionals can assist individuals with SCI and their families in adapting to the new context imposed by the traumatic situation (Cruz et al., 2021).

Due to the trauma, the patient's wife decided to move to another city so that she could feel protected with her daughter. The family member experiences grief related to the reorganization of

life, both due to the family member who acquired a disability and the aspects of violence and social vulnerability. According to Bossardi et al. (2021), all changes and family planning efforts present challenges in seeking balanced functioning.

At a certain point, the patient was transferred to a rehabilitation hospital. Upon reviewing the patient's digital medical record, available within the rehabilitation hospital's system, it was noted that B. A. was discharged home, and his family members had received the necessary training.

Conclusion

The influence and experience of grief in the hospital treatment of a person who has suffered a spinal cord injury are of great relevance, as it is in the hospital environment that the patient first confronts the situation of loss and suffering. Grief can affect not only the patients but also their families and the healthcare professionals involved in their care.

Attention to and understanding of the grieving process and its stages can be crucial in providing more effective and compassionate care. Hospital psychology plays an important role in supporting patients, families, and healthcare teams during the grieving process, aiming to assist in coping with loss and promoting emotional health.

Therefore, the importance of addressing the grieving process in a way that is unique to each individual in the hospital context is essential for the well-being of individuals affected by trauma, as well as those involved in the care, treatment, and rehabilitation process, considering the return to their community.

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