ECRONICON OPEN ACCESS

EC PSYCHOLOGY AND PSYCHIATRY
Phenomenological Perspective

Suicide Attempt: A Phenomenological Hermeneutic Perspective

Ana Maria Lopez Calvo de Feijoo*

Adjunct Professor of the Institute of Psychology and the Graduate Program in Social Psychology at Rio de Janeiro State University, Brazil

***Corresponding Author:** Ana Maria Lopez Calvo de Feijoo, Adjunct Professor of the Institute of Psychology and the Graduate Program in Social Psychology at Rio de Janeiro State University, Brazil.

Received: July 21, 2017; **Published:** September 06, 2017

Abstract

The aim of this article is to show a phenomenological - hermeneutic understanding of the experience of those who think of suicide. We begin this study by assuming an unnatural attitude towards the phenomenon, that is, by avoiding the interpretations that are naturally established about suicide, such as illness, suffering, and despair, among others. These characteristics attributed to the one who thinks or carries out the act of putting an end to life are noticeable in our historical horizon. In this way, both health professionals and laypeople tend to take them as positive characteristics that identify a person as potentially suicidal. By assuming an unnatural attitude towards the phenomenon of suicide, it was possible to avoid the natural attitude and to understand that, given that it is a phenomenon and not a fact, the act of ending life can only be apprehended in the experience of one who thinks about ending his life.

Keywords: *Suicide; Phenomenology; Hermeneutics; Clinical Psychology*

Introduction

Thinking about suicide from the phenomenological-hermeneutic perspective requires us to move from the moralizing perspective that encompasses everything that is thought and said about the act of ending life. In order to be able to sustain a non-moralizing mode of suicide, we must phenomenologically destroy the current conceptions about ending life, so that we can approach who no longer wants to live without a normative morality that establishes what is good and bad, normal and pathological. Therefore, we need to approach the phenomenon without starting from the premises about suicide, such as: disease, pathology, suffering, despair, control.

The general studies on suicide carry a moral position committed to natural science, starting from the notion that life is a supreme good and for that reason must be protected at any price; and yet, since life is short, it must take place in an atmosphere of pleasure and happiness. With these maxims, many studies on the subject are developed in order to search for the causes of suicide, to establish stereotypes and, therefore, to be able to identify the suicidal one to put into practice the prevention of suicidal behavior. However, if on the one hand stereotypes help to identify the suicidal behavior, on the other hand there is the risk of being misled by prejudging it.

A stereotype is an unfounded concept about something and it carries a deprecating force. The stereotype problem is that it can lead to generalization, exclusion, xenophobia, intolerance etc. We stereotype people when we make generalizations based on appearance, behavior, clothes, skin color, nationality of individuals. Stereotypes also occur in relation to the people we interpret as having a suicidal potential, thus, when we create something as a suicidal profile, we assume a moralizing position about people, even if we categorically state that we have no prejudice about them.

Science immediately refers to a human act when speaking of suicide, and treats this action or intention as something to be combated or prevented, as the dengue mosquito is fought or transmissible diseases prevented. This can often lead to the isolation and avoidance of the one who thinks to put an end to life, because of the fear of being considered sick. These people often report that they feel misunderstood and lonely.

Currently the idea of committing suicide in 90% of cases is linked to pathologies such as depression or schizophrenia, so we end up stereotyping even who sees in the desire to die a full exercise of freedom. As we are totally immersed in the modern world where the technocracy prevails, we believe that suicide is something of a pathological order, but suicide was not always understood in this way, that is, with a moralizing manner. The position of science in relation to the act of ending life is not hegemonic. Many scholars deal with the phenomenon without moralizing it, as we can see in theology, philosophy and literature - all these knowledges do not share the natural scientific position.

The question that must be posed here is: how to proceed in order to avoid the judgements with regard to the act of ending life? We know that many philosophers and writers do not allow themselves to be determined by the morals in force. That is why we will resort to what some philosophers and writers think about the subject so that we can move from the hegemonically moral and therefore stereotyped thinking about suicide.

Suicide as an exercise of freedom

According to Minois [1], to give up life, in the Hebrew world between 1750 BC and 539 BC, in the Old Testament, appeared in a strict and neutral sense, denoting acts of courage in Saul, Samson, Eleazar, Razis, Aithophel, Ptolemy Makron. In archaic Christianity we can cite the Apostle Paul between 5 AD and 10 AD, who considers coming out of earthly life as a path to a better world. The Latin Cicero (106 BC-43 BC), Virgilio (70 BC-10 BC), Seneca (4 AD-65 AD) and Tacitus (55 AD-120 AD) referred to the act of deciding not to live as a precipitous departure, quiet exit, and calm march. They understood this act as more peaceful than dying wishing to live. Also, these philosophers do not show the signs of stigma that occur when the word suicide happens to be used in cases in which someone voluntarily decides to end life.

Hume (1755/1998) [2] already argued that philosophy acts as an antidote to scientific superstitions about suicide and affirmed: "A man, who retires from life, does not harm to society. He only ceases to do good" (131). And, with that said, is this man obliged to do a little good, continuing to live, even though it is a great evil to him? After all, why cannot a person dispose of their existence when life ceases to be just a weight to be a burden?

Camus (1942/2008) [3] says in the Myth of Sisyphus that suicide is the real problem to be seriously considered by philosophy. Philosophy aims to know about existence, tries to do this by looking for the categories that support it. However, in doing so, it eventually moves away from what ultimately constitutes the meaning of existence. Camus tells us that the act of wanting to end life brings us immediately back to life and death, that is, the two insurmountable limits of man's existence. The wish to put an end to life brings in its core the thinking of whether life deserves to be lived. This question relates to the commitment that one establishes with one's own life.

In Courant's (1982) [4] publication *Conversation avec Werner Schroeter* (Conversation with Werner Schroeter), Schroeder says that "Looking at death is a dangerous and anarchistic feeling against established society. Society plays with terror and fear." Foucault [4] concludes: "It is not only said that it is not good to commit suicide, but it is considered that if someone commits suicide it is because they were not well at all" (p.7). This dialogue draws attention to the way in which the moralizing and normative determinations of a certain historical horizon totally cover the possibility of thinking more attentively about the phenomenon.

We know that Foucault [5] attempted suicide on a number of occasions. In this interview, he makes clear the meaning he articulated in relation to ending life: "I am a partisan of a true cultural combat for re-instructing people that there is no conduct more beautiful, that merits more reflection with as much attention, than suicide" (pp. 7-8).

We can see examples of a quieter deal with suicide in literature, as happened, for example, with the story of Raphaël de Valentin, portrayed by Balzac (1831/2008) [6] in *La peau de Chagrin* (The magic skin). Raphaël, in desperation to have failed in love and also professionally, intended to end his life. He was about to commit the act, when he received a miraculous gift from the hands of an old man and began to fight to make his life last. Machado de Assis (1882/2008) [7] also shows us in *To be or not to be* (To be or not to be) young man, who, being certain that he would end his life, ends up giving up because he fell in love with a girl. Finally, the girl turns him down, he loses his job, and at that moment, he does not kill himself and does not even remember to do it.

The non-moralizing position on suicide can also be found in other fields of knowledge. Cattapan [8], psychoanalysis scholar, criticizes the proposal to create a network control for prevention purposes and he also defends the abandonment of a moralizing attitude based on a psychopathology of life and biopolitics, which aims the control of life and death. He claims that dealing with suicide is a matter of tolerance. "The suicidal one does not tolerate life and biopolitical society does not tolerate suicide" (p.183).

Kusmanic [9] draws attention to the little emphasis that studies on suicide give to the personal experience of who tries to commit suicide. Feijoo [10], in her research on suicide in a phenomenological-hermeneutic perspective based on the Husserlian proposal to approach the phenomenon, she says that before any analysis of the phenomenon, we must consider the phenomenological reduction so that we do not take for granted what appears in natural attitude, as we shall see below.

Suicide from the phenomenological hermeneutic perspective

Husserl (1889/1973) [11] refers to the natural attitude as that in which the world is taken as ontologically valid, in which life in its acts and interests is correlated with things in the world, and things are taken as empirically given. The unnatural attitude concerns a particular mode of seeing things, in which there is an exercise of thought in the sense of suspending the natural attitude, bringing the phenomenon back to its intentional field and understanding it in its field of display. It is a reduction from the empirical to the phenomenological.

If we do not take an unnatural attitude, we base our research on idealistic, naturalistic, or common-sense premises, and then we distance ourselves entirely from the phenomenological view. By appropriating an unnatural attitude towards the phenomenon of suicide, we can avoid the hegemonic conceptions of health and disease; authentic and not authentic; good and evil - which fit into morality - as well as the notion of suffering and despair - as that which must be avoided at any price and which is often interpreted as the foundation of the act of ending life. It is necessary to get distance from what is given by the world as absolute truth, that is, to suspend [11] or to destroy [12] the supposedly absolute and incontestable truths.

It was through the phenomenological reduction that we acted in our research[1] in the psychotherapeutic relationship with those who were undecided about committing suicide. So we were able to describe what was at stake when there was a thought of suicide. In this way we had the opportunity to let the experience present itself, that is, let it appears through its statement, opening a space for the meaning and motivation of the intention to end life to come out.

In order to see suicide from a phenomenological hermeneutic point of view, it is necessary to reconstruct the sense of morality, suffering, despair, causality and prevention, as presented in studies that maintain the moralizing character of the natural sciences at its core, and then destroy the established truths. We will concentrate on the destruction of the moral truths dictated by our time.

We understand *morality* in the sense of a set of norms that prescribe how behavior should be given so that people conduct life in a balanced, conscious, authentic, healthy, good way and so on. Therefore, the standard that is followed is the guideline that will say: what is right and what is wrong; what is good and what is bad; what is health and what is disease. Religious or legal truths or theories, whether of science or common sense, determine, over time, the normative criteria of moral precepts.

[1]*For a nucleus of clinical care for people at risk of suicide: a phenomenological analysis of the decision to end life*, which has been developed at the Rio de Janeiro State University since 2016, under the coordination of Prof. Ana Maria Lopez Calvo de Feijoo - with CNPQ support.

The moralization appears in the elaborations on the suicide according to the criterion of utility that serves a certain time. That said, let us go to the different determinations that position morality. Christian determinations come with notions of sin, guilt, error, lack of meaning; with legal determinations suicide becomes a crime and, therefore, is legislated by the State; with the scientists, the moralization comes from the criteria stipulated by the model that refers to the categorization of the suicidal behavior and its consequent pathologization in a causal model; in common sense the idea of suicide is linked to courage or cowardice, to madness or suffering.

In the world in which we find ourselves the current morality says that committing suicide is not good, just as it says that the person who committed suicide was mentally ill. Once we can see being well and being sick, having pain and having pleasure as inherent in existing, suffering will no longer be seen as the great mark of who commits suicide. It is only free of stereotypes, prejudices and superstitions that we can approach the experience of one who has already rehearsed the act of ending life, since we are no longer led to think that, based on such behavior, it is necessarily suffering.

If we want to think about the phenomenon of suicide in a phenomenological perspective we need to take what happens in the sphere of existence in terms of cooriginality. To talk about the cooriginality of consciousness and the world means that we will not establish a temporal interval in the order of events. The sense of things is articulated in intentional fields, and these fields are mobilized in transcendence, that is, in space temporarily constituted as a dynamic and non-linear flow. Therefore we have to abandon the valid idea of the causal relation between events and work with the idea of motive. In this logic of thinking wanting to cease to exist cannot be related to lack of meaning; once the meaning is given in intentional fields not existing makes sense, that is, the decision to no longer live refers who decided not to live to a horizon in which not living makes sense. For all this we will speak in terms of motives and not causes in the face of the decision to end life.

We propose, then, prevention in its character of favorable reception, that is, opening a space of comprehensive listening to who says that wants to end life. We believe that in this way we can make others totally comfortable to speak of their intentions, without stigmas, prejudices or stereotypes. By being with others without judging, evaluating or prohibiting, a space is opened so that they can consider carefully theirs questions (if any). By doing so, they may even reconsider their decision.

Situations of suicide: from science to experience

I will bring up five situations in which the stereotypes consecrated by scientific studies hinder us from reaching the very experience of who is undecided about the continuity of their existence:

"I want to die" - the fatigue of living as an experience that creates an interest for death – who said that was a 105-year-old woman that had been referred to the Clinical Care Center because she had said in the screening that she was tired of living and that all her relatives had died. As in Formosa's words appeared elements that pointed to the fact that she wanted to die and as she also referred to relatives who had already died, besides living alone with the help of some neighbors, she had the diagnosis of potential suicidal since she had obtained three positive points in the suicidal profile.

The issue that is discussed in this section concerns suicide among the elderly. Minayo and Cavalcanti [13] conducted a study on suicide in elderly people with the objective of analyzing the factors associated with the risk of suicide in this age group and reached the following conclusions: it is the age group with the highest suicide rate that is twice as many as in other age groups; it is in the elderly population that there is the greatest proportion between attempts and consummation of the act, that is, in two attempts, one is consumed, in Brazil, in the United States of America and in Western Europe. The authors say that in investigating the literature on the subject in the last decades, they found that in suicidal ideations people refer to "thoughts of death, desires to die, fatigue of living, lack of sense of life, sadness with current course of existence "(p.752).

If we follow this lady based on what the literature says about risk factors and therapeutic action, she would be placed in the role of those who must be controlled in order to prevent the act from being consumed.

Regarding therapeutic action, Beasutrais (cited by Minayo and Cavalcanti, 2010) [13] recommends that older people participate more in social activities aimed at the elderly: "a sense of social connectivity and participation in community life seems to be protective against suicide in elderly people. Therefore the development of a social support network for these people should be defined with priority " (p.774). Siqueira [14], in this same direction, recommends that the elderly integrates into affective and family relationships and that they learn new technologies, stimulating the cognitive process. Our task is to pay attention to what the elderly has to say to us, so we could let them free so that they can tell us, without fear and without stereotypes, what is happening in their existence.

The researchers of this subject try to find the risk factors in order to be able to act preventively. The risk factors found in the elderly are: verbal innuendo that appear in conversations with friends, family, and companions; purchase of a weapon; depression; voltage; agitation; isolation; death of the spouse, friends and children; terminal illness; uncontrollable pain; fear of losing dignity.

If we want to assume a phenomenological attitude towards the question of the desire to put an end to life that appears in 60 years old people, we must first avoid premises established by scientific morality that life is a supreme good and therefore no one can disregard it and if this disinterest shows up, that is a problem of a pathological order. By removing from our field of view the stereotypes and prejudices about wanting to end life, we can open ourselves to the experience of others in a calm way and thus facilitate the expression of who thinks of suicide in a totally free way so that one is not afraid of speaking and being diagnosed or even hospitalized against one's will. In the case of this 105-year-old lady, when we position ourselves in an attitude of careful attention, she can tell us how there is a moment when it comes time to say goodbye. In her meeting with the psychologist, Formosa insisted on referring to the weariness of her life and wondered why she had not had the luck of her husband, brothers and friends who had died in their 90s. She said that it was not sadness, despair or suffering - she insisted on saying that she was happy, and had been very happy in her marriage, with her children, and stressed that she was calm but tired, as she put it: "everything is repeated: births, baptisms, weddings, burials, I do not like to participate in these things anymore, I prefer to sit quietly in my corner, most of the time, with my memories".

Formosa, many times when talking about the way her life was, reminds us of Lispector's short story (2008) [15] entitled *Viagem a Petrópolis* (Journey to Petropolis). Lispector tells the final moments of Mocinha's life. After losing her husband and her two children, alone in the world, she wandered from house to house, as a favor, but always maintaining a smile and showing pleasure in walking the streets of Rio, as if she had come from Maranhão to tour the city of Rio de Janeiro. After being abandoned in Petropolis by the family that kept her in an isolated place of the house, Mocinha leaned against a tree trunk and died. Lispector deals with the theme, making it clear that Mocinha's time has come, given the way people who no longer produce are discarded.

"I want to have white skin and good hair" – who said it was a nine-year-old child who was referred to the clinic for psychological counseling at the request of the School and the Municipal Secretary of Education with urgency. Jujuba [16], according to the school, she disturbed the order in the classroom and refused to comply with orders. The psychotherapist makes an appointment with the her grandmother who attends the meeting and says she does not understand why a nine-year-old child tries to commit suicide five times. The grandmother advises the psychotherapist that she will have difficulties in attending the child. First of all, Jujuba never entered alone in the office and at other times when she was accompanied by psychologists, she had scratched them and she also vomited, screamed, fainted and bit her tongue until she bled. The grandmother adds that perhaps those were the reasons why the professionals gave up on Jujuba.

Salles and Lemos [17] believe that it is necessary to expand the discussion about child suicide and demystify the idea that children do not commit suicide. This issue deserves more research and debate so that more attention can be paid to the phenomenon. These authors affirm that according to Souza (2010, cited by Salles and Lemos, 2015) [17] children up to nine years died of suicide between 2000 and 2008. They also emphasize that the child who commits suicide is in psychic suffering and that it is important to investigate the family, school, and community factors involved.

Kuczynski [18] states that studies on child suicide were conducted by Casper between 1788 and 1779, concluding that the phenomenon does not concern a particular historical epoch and is not even localized to a particular region. According to Shaffer and Fisher (1981, quoted by Kuczynski 2014) [18]:

Children and adolescents who commit or attempt (unsuccessfully) suicide have some characteristics in common: a third of those who achieve their intent have a history of previous attempts, and those who execute these attempts belong to a group of higher risk of successful suicide *a posteriori* (p.248).

According to the scientific literature, the fact that Jujuba has already tried five times the suicide is enough to consider that the child has a suicidal profile. It is interesting to know why the girl did not materialize the act. The literature says that many children do not successfully commit suicide, because they do not know the effective methods or do not have the strength to it. So we have to know which ones were the techniques used by the child. Jujuba first took soap powder dissolved in water, then ingested bleach, set fire to his arms and hair, and finally made use of caustic soda. On all these occasions she was taken to the hospital so that she could recover from the damage caused by her actions.

During medical or psychological consultations, the child refused to report the how and why of what he had done. Faced with what was asked of her, Jujuba remained silent and did not heed the requests of the doctors. These two modes of behavior of the girl pointed to two more indicators of suicidal behavior: social isolation and loneliness.

The psychotherapist, Marta, parting from a phenomenological position, opted not to consider what had been told about Jujuba, both in the school report and in the interview with her grandmother. The psychologist did not want to think and see Jujuba by diagnostic categories or profiles, she preferred to know her in her own voice, through what she had to say. At the moment Marta goes to get Jujuba in the waiting room, the grandmother introduce them to each other and Marta asks the girl if she wants to be with a psychologist, Jujuba readily replies that she does not, but would like to play with Marta in the toy room. The girl takes Marta's hand and they climb into the living room, without the grandmother.

Upon reaching the room, Marta realizes that the girl had wounds on her arms that she tried to hide with the sleeves of her dress. Marta sensibly realized that the girl did not want to talk about it, otherwise she would not hide the wounds. The psychotherapist decided to play with the child, without making any mention of her wounds. And the situation of silence that had occurred with health professionals was repeated in the relationship of Jujuba with Marta and she understood that the girl preferred to keep their memories and so both remained in silence. On several occasions, Jujuba sat next to Marta and caressed her skin, played with her hair. The child once said that she liked Marta's hair, but she did not like her own. Marta caressed the skin and hair of Jujuba. One day Jujuba said to Marta: "You know, auntie, I never wanted to end my life. What I wanted was to make my skin white and my hair straight".

"I'm not afraid of death" – words of a 12-year-old girl who was referred to the Clinical Care Center because she was a girl at risk of suicide. The psychological accompaniment took place in preventive character, since Toninha refers to the fact of not being afraid in any sense of her own death. Toninha says that she fears her mother's death more than hers. She says that she is not sad, for she likes going out with her friends, playing and studying.

The scientific literature refers to the fearlessness of death as characteristic of a phase of development in which the idea of finitude is not fully defined [18]. At the same time, we find another study [19] that refers to the importance of knowing the risk factors for suicide in this age group so that preventive measures can be taken, thus preventing the act from happening. This study refers to the psychic vulnerability of the age group of 15 to 24 years according to WHO studies. However, Cantão and Botti [19] draw attention to a study conducted in Minas Gerais between 1997 and 2011, in which the significant frequency of suicides occurred between 10 and 19 years.

It seems that the concern with prevention led the professionals, who carried out the screening of this young woman, to refer her to the Clinical Care Unit. If we pay attention to the risk factors: abuse of psychoactive substances, problems in the family structure, history of previous attempts and intrafamily violence, we realize that the young does not fit into a suicidal potential. It seems that what was taken into consideration was the logic that an ounce of prevention is worth a pound of cure. The point is: does not unnecessary prevention bring harm to the person who receives a potential suicidal tag?

The 12-year-old girl that we name here as Toninha said she does not understand why she was referred to this type of treatment, saying she has no problem that needs to be treated. She reports having friends and a close and supporting family. She says she is worried about her family, they are already over-controlling, now they will be more anxious. It's not going to be cool to be watched all the time.

Literature can help us to see what happened. Grimm's tale about *The story of the youth who went forth to learn what fear was* [20] portrays the story of a boy who did not know fear and that worried his family. There were several ways that John's father, brothers and friends sought in order for the boy to find a way in life. But although "apparently" this did not add up, John wanted to learn to fear, that is, he wanted to change. Despite numerous attempts, it was in the very existence that the boy suddenly shuddered. Suddenly John is frightened, shakes, and then the spirit awakens from the state of latency in which it was and such a happening opens the atmosphere of anguish and he discovers himself as possibility (freedom).

The same impatience found in John's family can be identified in Toninha's family. It was necessary to wait until Mary could appropriate the sense of finitude of her existence.

"I want to die" – that was said by a 16-year-old teenager who says she wants to die because she sees a lot of evil in the world and asks herself: *why should I live and have to see so many bad things?* This girl lives in a favela and at all times knows of people who are tortured by drug dealers. She told me that this happened to a friend of hers with whom she grew up together. This is a situation in which the adolescent, who we will call Joaninha, really wants to end her life, even though she does not fit totally into the risk factors.

This situation is very well portrayed in the novel *Thirteen reasons why* by Jay Asher [21] and is well known, because it served as the basis for the Netflix series with the same name. The novel tells the story of Hannah Baker, a teenager who ends her life claiming that she could not bear to deal with the indifference to the pain of others as it was the normal way in the small American town where she lived. The work is very interesting in the sense that it shows the Hannah's path until the consummation of ending life without mentioning causes for suicide, nor blaming those in the life of the protagonist. An inattentive reading may even lead one to conclude that Hannah was trying to get revenge for having sent recordings to everyone involved. However, the author leaves evidence that this was not the case. We can also say that the family was inattentive, because at that moment they are going through financial difficulties, however, Hannah, at no time refers to the family as inattentive.

At the end of the book, in a conversation with the school counselor - Hannah's last attempt to be welcomed - he tells her,

" - It is an option, and that's all we're talking about. Look, something happened, Hannah. I believe you. But if you won't press charges and you won't confront him, you need to consider the possibility of moving beyond this.

(…)

- Is he in your class, Hannah?
- He's a senior.
- So he'll be gone next year.
- You want me to move beyond this.

(...)

- Thank you Mr. Porter" (Asher, 2009, p.236) [21].

Hannah notes in the conversation with Mr. Porter what she had first experienced - the indifference with which people dealt with situations that would certainly have consequences. This made Hannah conclude that in a world where the other does not matter it is not worth living.

"**I cannot live without my beloved**" - he is a young adult of 28 years who suffers from a love that has failed. He went to the emergency service to get someone to talk to about his pain. Tião relates that he discovered that his girlfriend is his father's lover. He says he loves her a lot, but he cannot stand the fact that there is this relationship between his girlfriend and his father, and he cannot accept their unfaithfulness and disloyalty. Because she loved the girl very much, Tião talked to her about it and was willing to forgive her, as long as she finally broke up with her father. He spoke much of the matter, however, not referring to suicide. The medical team concluded that it was a mere heartache. And the boy presented only one risk factor among the risk factors specific to his age group [22].

Consumption and/or abusive use of alcohol and other psychoactive substances; family or parental problems; severe mental disorders; terminal illnesses; impulsivity; not having relatives and/or social ties; disruption of meaningful interpersonal relationships; financial problems; family history of suicide; childhood abuse; previous attempts and suicidal ideation; social isolation; affective losses; severe mental disorders, mainly depressive disorders and terminal illnesses; as well as demographic and socioeconomic variables.

And because it was not included in the risk group, the young adult was not referred to the Clinical Care Center. As soon as the boy left the office, he jumped to his death from the 12th floor. Something happened to this boy that science cannot predict, but literature can show as a possible outcome. Goethe (1821/2006) [23] portrays Young Werther's suffering for an ill-fated love affair. For not being able to consummate his love for Eleonora and, taken by passion, he puts an end to his life.

Final considerations

With the considerations on what is in question in the situations of suicide attempts, we could follow that it is a subject on which we still have much to clarify. We have seen that both overestimating risk factors and underestimating them is problematic. In both cases there is the danger of bringing harm to those who are going to seek psychological counseling.

We have also seen that scientific studies have much to tell us, but they still show insufficiency in understanding the phenomenon as a whole. Moreover, these studies often lead to misunderstandings. Given that suicide is a complex and difficult question to understand, or perhaps it is of the order of the unmanageable as much as existence itself, we need to seek more interlocutions with those knowledges that deal with the unknowable in a totally different way: philosophy and literature. The first helps us in the exercise of thought, the second helps us to see the experience in itself without prejudices, stereotypes or moral judgments.

Another issue that arises is the possibility of articulating a way of thinking about suicide without the notions of risk and non-risk, which support the idea of causality and prevention and which still keep the dichotomies of naturalistic theses. Is it possible, then, to articulate a way of thinking about suicide without the notions of causality and prevention? Is it possible to hold a non-moralizing position in order to sustain a psychological work in which the way of being with the other guards the relationship in an attentive and non-custodial and / or controlling reception? And yet: how can we get out of the moralizing notions of not seeking a suicidal profile and not adopting preventive postures without being accused of being indifferent and of speaking in favor of suicide?

In order to find a non-moralizing place in the face of suicide, we have been in constant dialogue not only with literature but also with philosophy, which from ancient times to the present approaches suicide as the main question on which philosophers should work (Hume, 1988; Camus, 2008; Foucault, 1982) [2,3,5]. Moreover, both literature and philosophy treat the issue as something of the order of the emotions, thus taking predictability and control as something that cannot bring question to its ultimate consequences.

With this study we were able to follow how we take an unnatural attitude in the clinical care of people who think about ending their lives. In clinical appointments, we saw that people referred to different motivations to commit or avoid the act: from concerns about the repercussions that such an attitude would bring on those they loved to the fact that their lives were not worth living, since they were of no use, and to remembering past experiences as a source of frustration. Such expressions are closely related to the way in which our senses are articulated in our world: from the stigmas surrounding the suicidal relatives to the idea that man is a resource to be exploited and as such must be productive, and to the idea that life should not be frustrated - if it does, it must be solved. Finally, the experience made explicit by those who are undecided about ending their lives has shown itself in its existential sense as an exercise of human freedom. This was possible to come out to the extent that we have avoided the natural attitude that positions suicide through pathologization, stereotype, or recrimination. We see that thinking about living or dying are always present possibilities in existence.

In the clinical modality from a phenomenological-hermeneutic perspective, we defend this exercise as a path of thought. And, in this way, we could clarify the possibility of safeguarding a position without premises, non-moralizing, non-causal, supporting a clinical performance in which prevention occurs as attentive care and respect, not guardianship and/or control.

Bibliography

1. Minois G. "*História do Suicídio:* A sociedade ocidental perante a morte". Lisbon: Teorema Portugal (1995).
2. Hume D. "*Sobre el suicidio y otros ensayos"*. Madrid: Alianza Editorial. (Originally published in 1755) (1988).
3. Camus A. "*O mito de Sísifo"*. (Ari Roitman & Paulina Watch). Rio de Janeiro: Record (Originally published in 1942) (2008).
4. Courant G. "Entre o amor e os estados de paixão: conversa com Werner Schroeter [Interview held by Michel Foucault]". *Werner Schroeter.* (Wandersor Flor, translator) (1982).
5. Foucault M. "Entre o amor e os estados de paixão: converva com Werner Schroeter". (Wanders or Flor, translator). Paris: Goethe Institute (1982): 39-47.
6. Balzac H. "*A pele de onagro"*. (Paulo Neves, Translator). Rio de Janeiro: L&PM (1831/2008).
7. Assis M. "*Obra completa em quatro volumes".* Rio de Janeiro: Aguilar (Originally published in 1882) (2008).
8. Cattapan P. "Moralização do suicídio". *Iluminart Journal* 9 (2012): 183-194.
9. Kusmanic M. "*Suicide from an existential-phenomenological perspective"*. University of Primorska, Koper, Slovenia, Draft Paper (2010).
10. Feijoo AM. "*Por um núcleo de atendimento clínico a pessoas em risco de suicídio*". CNPQ project (2016).
11. Husserl E. *„Cartesianische meditationen und pariser vorträge"*. Den Haag: Martinus Nijhoff (Original publicado em 1889) (1973).
12. Heidegger M. "*Ser e tempo"*. (màrcia de Sá Cavalcanti, Trad.). Petrópolis: Vozes. (Originally published in 1927) (1998).
13. Minayo MC and Cavalcante F. "Suicídio entre pessoas idosas: revisão da literatura". *Saúde Pública Journal* 44.4 (2010): 750-757.
14. Siqueira T. "*A percepção psicoterapêutica do suicídio na terceira idade na abordagem fenomenológica existencial"*. *Unimotrisaúde em Sociogerontologia Newsletter* 1.3 (2012): 62-70.
15. Lispector C (2008). http://claricelispector.blogspot.in/2008/05/viagem-petrpolis.html.
16. Velasque M. "Jujuba". In Feijoo, A.M. & Feijoo, E. *Situações clínicas II*. Rio de janeiro: Ifen (2017).

17. Lemos M and Salles A. "Algumas reflexões em torno do suicídio de crianças". *UNESP Psychology Journal* 14.1 (2015): 38-42.

18. Kuczynski E. "Suicídio na infância e na adolescência". *Psicologia USP* 25.3 (2014): 246-252.

19. Cantão L and Botti N. "Suicídio na população de 10 a 19 anos em Minas Gerais (1997-2011)". *Revista de Enfermagem do Centro Mineiro* 4.3 (2014): 1262-1267.

20. Grimm J and Grimm W. "João sem Medo". In: Andersen, H. C. E Grimm, J. e W. (Grimm Brothers). *Contos Infantis*. Selected and translated by Jô Andrada (2004).

21. Ascher J. "*Os 13 porquês (Thirteen reasons why)".* (J.A. Lemos, Translator.) São Paulo: Ática (2009).

22. World Health Organization. "*Prevenção do suicídio: Um manual para profissionais de saúde em atenção primária*". Switzerland: Geneva (2000).

23. Goethe J. "*Os sofrimentos do jovem Werther"*. São Paulo: Hedra. (Originally published in 1821) (2012).

Volume 5 Issue 2 September 2017