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CLINICAL ASSESSMENT OF SUICIDAL BEHAVIOR: FROM BINSWANGER TO NOWADAY'S DASEINSANALYSIS¹

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ABSTRACT. We intend in this article to carry out a theoretical study and an experience report of the literature in which we will revisit the mode of clinical assessment of suicide in the work of Ludwig Binswanger. To do accomplish this task we'll investigate his famous case Ellen West, carried out even before he established his daseinsanalysis. With this, we intend to highlight the question of the psychiatrist in relation to a biological perspective in psychiatry, in which suicide is understood as a symptom associated with mental diseases, this trend is still present in psychiatry. Finally we will present our own clinical experience with suicidal behavior, in which it is taken as an existential possibility. Through a brief case report, we intend to show what we consider to be an unfolding of what begins with Binswanger: the daseinsanalysis. With the designation of nowadays daseinsanalysis, we intend to return to the work of Martin Heidegger and then continue to develop a serene approach to situations of risk of suicide in clinical psychology.

Keywords: Daseinsanalysis; clinical psychology; suicide.

A LIDA CLÍNICA COM O SUICÍDIO: DE BINSWANGER À DASEINSANÁLISE HOJE

RESUMO. Pretendemos no presente artigo realizar um estudo teórico e um relato de experiência, em que revisitaremos o modo de lida clínica com o suicídio na obra de Ludwig Binswanger, antes mesmo dele estabelecer a sua daseinsanálise, no seu famoso caso Ellen West. Com isso visamos dar relevo ao questionamento do psiquiatra com relação à psiquiatria de ênfase marcadamente biológica, em que o suicídio é compreendido como sintoma associado a quadros psicopatológicos, tendência essa que ainda se faz presente na psiquiatria atual. Por fim, apresentaremos nossa própria experiência clínica com suicídio, em que esse é tomado como possibilidade existencial. Através de um breve relato de experiência iremos mostrar o que consideramos um desdobramento daquilo que tem início com Binswanger, ou seja, a daseinsanálise. Com a denominação daseinsanálise hoje buscamos retornar à obra de Martin Heidegger para então continuar a desenvolver uma lida mais serena frente a situações de risco de suicídio na psicologia clínica daseinsanalítica.

Palavras-chave: Daseinsanálise; psicologia clínica; suicídio.

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EL MANEJO CLÍNICO CON EL SUICIDIO: DE BINSWANGER AL ANÁLISIS EXISTENCIAL HOY

RESUMEN. Pretendemos en el presente artículo realizar un estudio teórico y un relato de experiencia, en que revisaremos el modo de lectura clínica con el suicidio en la obra de Ludwig Binswanger, antes de que él estableciera su análisis existencial, en su famoso caso Ellen West. Con eso pretendemos dar relieve al cuestionamiento del psiquiatra con relación a la psiquiatría de énfasis biológico, en que el suicidio es comprendido como síntoma asociado a cuadros psicopatológicos, tendencia que aún se hace presente en la psiquiatría. Finalmente, presentaremos nuestra propia experiencia clínica con suicidio, en que éste es tomado como una posibilidad existencial. A través de un breve relato de caso, pretendemos mostrar lo que consideramos un desdoblamiento de lo que comienza con Binswanger, o sea, el análisis existencial. Con la denominación análisis existencial hoy, pretendemos retornar a la obra de Martin Heidegger para entonces continuar desarrollando una actuación más serena frente a situaciones de riesgo de suicidio en la psicología clínica.

Palabras clave: Análisis existencial; psicología clínica; suicidio.

Introduction

In 2019, half century has passed since the last meeting between Martin Heidegger (1889-1976) and Medard Boss (1903-1990). The philosopher's meetings with the psychiatrist were called *Zollikon Seminars* (Heidegger, 2009). We dare to say that this is perhaps the most important reference work for *daseinsanalysis*. On the occasion of the commemoration of fifty years, it is opportune to recall Heidegger's speech in his speech at the ceremony in honor of the composer Conradin Kreutzer (1780-1849), later published under the name *Release* (*Gelassenheit*). In his words, "A memorial celebration means that we think back, that we think" (Heidegger, 1959, p. 10). Then think about it. Quoting the philosopher again, the need for an alert is pointed out:

Let us not fool ourselves. All of us, even those who think professionally, as it were, are often enough thought-poor; we all are far too easily thought-less. Thoughtlessness is an uncanny visitor who comes and goes everywhere in today's world. For nowadays we take in everything in the quickest and cheapest way, only to forget it just as quickly, instantly. Thus one gathering follows on the heels of another. Commemorative celebrations grow poorer and poorer in thought. Commemoration and thoughtlessness are found side by side (Heidegger, 1959, p. 10).

This study is, therefore, an invitation to think, that is, a path of thought itself. It is a mere path and not a destination because the theme that is deposited in this text is one that reveals in a markedly radical way the insufficiency of any calculation or theory. We cite the conference *Serenidade* (Heidegger, 1959), because in it, Heidegger highlights the difference between what he calls calculative thinking and meditative thinking. Here, we try to invite the reader to think about the act of suicide. This event is capable of provoking an intimate restlessness and evoking deep questions, among them: how can someone want to end their own life? Certain questions do not have simple answers and those that do are often insufficiently posed. This theme arises, in our time, as if strangled by calculative 'thinking'. It is commonly believed that it is possible to completely control the event, and if this belief is not confirmed quickly, we conclude that it is a failure in the method, which requires correction to avoid further failures. It is urgent to meditate on the matter. And to

meditate, according to Heidegger (1959), consists of following the path that is shown in the walk itself.

We are also thinking about a clinic, more specifically, about the clinical dealing with situations where there is a risk of suicide. First of all, it is important to clarify what the act of clinical practice is. Clinic comes from the Greek *κλινικός* (*klinikos*), which in ancient Greece referred to the act of bending over a bed. In our case, it is not about bending of any clinic. Our proposal is to think about clinical daseinsanalysis and its relationship with suicide. It should be clarified that daseinsanalysis was initially founded by psychiatrist Ludwig Binswanger (1881-1966), who, dissatisfied with the biological perspective in psychiatry, wanted to conquer other horizons for understanding madness. For that, among other elaborations, he established a psychiatry based on the existential analytics envisioned by Martin Heidegger in his work *Ser e tempo* (1998).

Binswanger (1957) was also the first Daseinsanalyst to present a clinical case related to the theme of suicide, publishing it in the 1940s under the name *The case of Ellen West* (*Der fall Ellen West*). It is one of the most famous and controversial cases in modern psychiatry and, without a doubt, the most commented on, as it remains in the debates of psychology and psychiatry to this day. So many comments seem to stem precisely from its controversial nature, which generates accus Maltzberger, Clark, & Motto, 1996; Rogers, 1977 and even murder (Lester, 1971). On the other hand, there are those who defend it, such as Vincenzo Di Nicola (2013) when he states that blaming the psychiatrist for Ellen's suicide does not make any contribution to science.

Ellen West was a young Jewish aristocrat who was admitted to the Sanatorium Bellevue in Kreuzlingen, Switzerland, in the early 1920s. The clinic was run by Ludwig Binswanger, who treated the patient for a few months, keeping in constant contact with her husband. Both developed a friendship that spanned decades.

In order to understand Binswanger's project in relation to what he perceived in the biological perspective in psychiatry - which is why he wanted to look for other elements that would give him a broader view of psychic illnesses - we need to clarify what the psychiatry of his time was based on, which gained importance, preponderance and increased its influence in science today. Psychiatry in the time of the psychiatrist was struggling to achieve the status of a medical science. This area of study was totally overshadowed by neurology. That is why scholars on the subject were dedicated to describing behavioral disorders through symptoms with a biological origin. Psychiatry still maintains this project today, and for that it relies on exhaustive descriptions such as we can follow in the different descriptors present in manuals, such as the DSM 5. In this same reasoning, it became opportune to build a suicidal profile, in which suicide was historically associated with the category of mental illness. To verify such statements, review the bulletin entitled *Suicídio: informando para prevenir* (Associação Brasileira de Psiquiatria [ABP], 2014).

Binswanger: Ellen West's Suicide

In the exposition of the case portrayed by psychiatrist Ludwig Binswanger, Ellen West (1888-1921) was described as an intelligent, creative, but stubborn and inflexible woman. Ellen struggled with her weight and was terrified of aging. Anyway, Ellen did not want to get fat and did not want to age. As the psychiatrist stated, Ellen was seized by despair, understood as a disease of the will. If we dwell for a moment on Ellen's situation, we can see how she was disappointed with what she could not achieve, for example, being a

prominent professional, being slim and sensual, that is, always maintaining a youthful appearance.

As we follow the discussions and debates about Ellen West, we can see that attention and diagnoses turn to the way she related to food. She wanted to be thin and fearing that she would not reach her goal, she abstained from any food. According to Binswanger, based on her method called life history, she refused, even as a baby, to consume milk. The psychiatrist went so far as to say that Ellen already had a difficulty with regard to the environment (*Mitwelt*), Ellen suffered from what could be classified in psychiatry as anorexia nervosa. Her weight symbolized what was most repugnant to her, and which had to be fought at all costs. As a result, the young woman had developed bulimia and laxative compulsion. When she was hospitalized, aged about 32, she was no longer menstruating due to her low weight and had lost a baby to a miscarriage during early pregnancy. Ellen had already been treated by several psychiatrists, including great names of her time, such as Emil Kraepelin (1856-1926). Before her admission to Bellevue, she had also seen two psychoanalysts. The diagnoses raised in her treatments include: obsessional neurosis, hysteria, melancholia, mixed manic-depressive disorder, and, finally, schizophrenia (Binswanger, 1957).

During hospitalization, Ludwig Binswanger began to consider the final diagnosis of schizophrenia. Due to particularities of the case in question, he decided to convene a board composed of two more physicians for the final opinion. Alfred Hoche and Eugen Bleuler were called to compose the board and give their opinion on the case. In Binswanger's words:

They all agree that this is neither an obsessional neurosis nor a manic-depressive disorder and that there is no effective or safe treatment. We come, therefore, to the decision to give in to the patient's desire for release. (Binswanger, 1957, p. 46).

Ellen West left the clinic accompanied by her husband, due to the conclusion that there would be no effective treatment for her condition. In the days that followed, she seemed more alive than ever. She ate, read, recited poetry, walked and talked with her family as she had not done in years. She even devoted herself to writing letters to other patients at the clinic. At the end of the third day after a magnificent and ecstatic family dinner, Ellen retired to her bed and ingested a lethal dose of poison ending her life. Binswanger cited that on the day of her death, Ellen West's countenance "[...] was as she had never been in life: happy, serene, and at peace" (Binswanger, 1957, p. 47).

Binswanger in his psychiatric analysis went far beyond the biological issue as treated by psychiatrists of his time. And through his studies on philosophy, he did not fail to cite other issues present in Ellen's account. With regard to not wanting to die, he defended the psychiatrist that the young woman suffered from the disease of modern man, which is the disease of the will, in a total mismatch between what she wants and what she can. Binswanger's patient, in despair, did not know what was necessary and lost herself in the possible, wanted the eternal and feared the temporal. In this sense, the psychiatrist seemed to refer to Kierkegaard (1961) and his description of despair as a sickness unto death.

In the following pages of the work published by Binswanger, we find an articulation of Heidegger's existential analytics (1998) with some developments by the own psychiatrist, especially with regard to his description of being-in-the-world in three aspects (*Mitwelt*, *Eigenwelt* and *Umwelt*). But the author goes beyond Heidegger's existential analytics, bringing not only the idea of being-in-the-world (*In-der-Welt-Sein*) but also the notion of being-beyond-the-world (*Über-die-Welt-Sein*). With that, he approached something more than the somatic, that is, what transcended existence. Such a notion was later a point of

friction between Binswanger and Heidegger, but we will leave that discussion for a later time. What is important to be highlighted here is how the psychiatrist uses the idea of being-beyond-the-world to conclude that Ellen West's suicide was a certain fate and an act of authenticity:

From the point of view of 'Daseins-analysis', Ellen West's suicide was both an 'act of arbitrariness' and a 'necessary event'. Both statements are based on the fact that in the Ellen West case the being had become mature to face her death or, in other words, that death - this death - was the necessary achievement of the meaning of life of this existence (Binswanger, 1957, p. 88, authors emphasy).

In Binswanger's daseinsanalytic interpretation, Ellen West's suicide was seen as a consequence of existential facts described by him. In this sense, the life history method served to explain the existential dynamics of the patient. The events of the past led to the event of her death. If on the one hand, Binswanger argued that Ellen West's existence was stuck in the past, on the other, he justified the present on the basis of that past. Death in this situation would represent the being-beyond-the-world necessary and capable of breaking with prescriptions of the impersonal, that is, with inauthenticity. In this sense, the psychiatrist judged the search for death as an authentic movement. It should be clarified that authenticity in Heidegger refers to the exit from falling (*Verfallen*), in which we are inserted at the beginning and most of the time. Being authentic, in existential analytics, is configured as a break with the idle talk (*Gerede*) of the They (*das Man*). Thus, for Binswanger, the suicide present in this case represented an act of authenticity that was possible only in the face of the breach of prescriptions operated by being-beyond-the-world. However, it is worth reflecting on whether the reasons for Ellen West's death, such as staying young and thin, do not concern the very horizon of meaning in which we are inserted, since in our (Modern) historical moment, old age and obesity are seen as undesirable events. We can also include in this list the mourning for the loss of her child during pregnancy. From this perspective, Ellen's suicide could be seen as the most inauthentic of acts, since her criteria are the criteria of the impersonal.

By focusing on the exposition made by the psychiatrist, we realize that although he tried to be guided by the Heideggerian existential analytic, he ended up building, himself, another theory of an anthropological nature. Binswanger did not stop thinking about Ellen's situation through psychiatric determinations, so he adopted the diagnosis of schizophrenia. Based on Heidegger, he could never forget the epochal character in which this diagnosis was sustained. With this, the psychiatrist focused on the individual notion of the disease.

To clarify the problem mentioned above, that is, the anthropological and individualizing stance of Binswanger's conclusions, we must rescue Heidegger's position at the beginning of the *Zollikon Seminars*:

All the encapsulated, objectifying representations of a psyche, a subject, a person, a self, a consciousness, used until today in Psychology and Psychopathology, must disappear in the daseinsanalytic view in favor of a completely different understanding. [...] Human Da-sein as an area of being able to apprehend is never a simply present object. On the contrary, it is in no way and, under no circumstances, something that can be objectified (Heidegger, 2009, p. 33).

Gemino (2014, p. 101) argues that Binswanger's contributions "[...] left something to be desired with regard to the appropriation of concepts of phenomenology and of Heidegger's own thought". And he points to "[...] the need for a critical analysis of Daseinsanalysis". To undertake this comment, Gemino (2014) highlights the criticisms made by Heidegger (2009) present in the *Zollikon Seminars*. One of the criticisms highlighted by Gemino (2014) concerns the idea of transcendence in Binswanger. Heidegger said:

'Dasein transcends', that is, as being outside the there as a clearing of being, it lets 'the world' happen. But he does not initially go out of the 'self' towards another. He is, as a being of 'there', the place of everything that comes to meet. Dasein is not 'subject'. There is no longer any question of subjectivity. Transcendence is not 'the structure of subjectivity', but its 'elimination'! (Heidegger, 2009, p. 230, authors emphasis).

In this sense, Binswanger's being-beyond-the-world seems to be based on a misunderstanding of the idea of transcendence present in Heidegger's work, especially in *Ser e tempo*. From the notion of already always being transcendence that *Dasein* is, we can see the lack of foundation of being-beyond-the-world. In this way, the break with prescriptions does not result from it, but from the tuning with what Heidegger calls a fundamental affective tonality. Still within the problem of transcendence, Heidegger (2009, p. 229, authors emphasis) concludes that "Binswanger does not see what sustains and determines properly, the *understanding* of being, the opening, the being inside the clearing of being and with that the pure problematic of being".

With such criticisms, the necessary care is evidenced in the face of the pitfalls that arise in the transposition of existential analytics to daseinsanalysis, from fundamental ontology to regional ontologies, or even to the ontic sciences. But we consider that, if not all, at least some of these traps have been disarmed. We can now direct thought, make it move. But there is still an important question: although Binswanger has emphasized transcendence, when establishing a diagnosis and a prognosis of the Ellen West case, would not the psychiatrist be objectifying, that is, turning into an entity, a concrete existence? Did Binswanger treat suicide as a mere symptom of schizophrenia? If so, would not he have given minimal importance to ending life as a project in the face of the fact that all of Ellen's other projects had failed? This is not a mere baseless accusation, because in addition to the points already discussed, we can also add the association made by the psychiatrist between a certain mood (*Stimmung*) with death and psychoses, in the essay called *Sonho e existência* (Binswanger, 1973).

In addition to analyzing some of Ellen West's dreams present in this essay, we consider it important to highlight the specific passage in which Binswanger developed the aforementioned association. In this passage, he analyzed the report of a patient, who dreamed of an ethereal world, a universal sea in which he floated in a completely amorphous state. In the dream, he watched the Earth and the stars and felt extraordinarily agile and strong, even though he did not have his own body. In his analysis, the psychiatrist concludes:

But if the patient qualifies this dream as a dream of death. That floating like amorphous and that total detachment from one's own corporeal figure are not a favorable diagnosis. [...] But if the patient qualifies this dream as a critical moment in life and feels the content of his mental disposition in such a fascinating way that he continually relives it in the dream, sleeping or awake, and that he prefers this sensation to all other vital content and repeatedly tries to get out of life, that does not belong to the sphere of dreams, but to that of psychoses. (Binswanger, 1973, p. 76, our translation).

Nevertheless, this would be another point of support for the diagnosis of schizophrenia in the Ellen West case. The dream and the analysis in question are not part of this clinical case, but they have a point in common: the repetition of a desire not to live their own body, not to live their existence with what they need. But is this desire always a sign of psychosis? Freud (1996) had pointed out neurosis as a prevalent condition in his time, since it would be associated with the psychosexual development considered normal, in which the resolution of the Oedipus complex occurs through repression. A time that, with the advent of analgesics and with the advancement of medications in general, starts to seek a distance from the body's own experience as a body. There is a big problem there: if the

withdrawal from the body is a symptom of psychoses, then we would be living a moment of proliferation of these diagnoses.

But we still need to move away from psychopathological discourse so that we can return to daseinsanalysis. The criticism and warning exposed by Heidegger (2009) in the *Seminários de Zollikon* in relation to subjectivist and encapsulated perspectives also referred to this anthropologization operated by Binswanger, which decisively distanced him from the philosopher's way of thinking. Heidegger's critique was directed at any attempt to elaborate theorizations about man current in his time. Such criticism remains valid today, because when one wants to establish any idea of a suicidal profile (outdated terminology and, therefore, in disuse) there is also a reduction of experience, an objectification. This reduction falls back on the need for a theorization. Would this theorization not be insufficient to account for what, in fact, happens? Given the above, how is it possible to act clinically in so-called suicide risk situations (ABP, 2014) and still maintain the proposal of daseinsanalysis?

Daseinsanalysis Today: Exposition of a Clinical Case

Daseinsanalysis today (Feijoo & Lessa, 2019) was the name assumed by some clinical psychology scholars who seek the bases for their professional performance in *Dasein* analytics. To clarify the way in which these scholars continue to advance their research regarding the articulation of philosophy and psychology, they have published a collection composed of chapters from each of them.

Based on these daseinsanalysis studies, a clinical situation is presented here that we hope to be able to clarify. Caio⁴, the fictitious name adopted in this exhibition, is a young man, a student at the University of the State of Rio de Janeiro (UERJ). He had been referred by the Help Center for People at Risk of Suicide⁵ (NACE) for an initial consultation in psychotherapy at the Applied Psychology Service (SPA). Upon entering the room, the psychotherapist noticed that his face showed great sadness, his movements were slow, his speech was slurred, almost inaudible. He sat up, and seemed to take cover behind his own backpack. The psychologist asked him what had brought him there, why he had been referred for treatment. He promptly replied: I have been contemplating suicide. Many psychologists or students could be shaken by such a direct and frank answer, but in this situation the professional decided not to back down from the above and asked: And what have you been thinking about suicide? He then says he believes the world would be better off without his presence.

The conversation with Caio unfolded over many topics. He said he didn't have a father, as his father had abandoned the family when he was a child. He said he also doesn't have a mother, as she had committed suicide a few years earlier. He pointed out that his mother had a diagnosis of borderline personality disorder, which is why living with her sometimes became difficult. He said that his older brother was depressed and that he had also attempted suicide, but survived. The younger brother was diagnosed with attention deficit hyperactivity disorder and was in psychiatric care. A series of diagnoses seemed to

⁴ The information presented in this clinical case is part of a research project submitted to Plataforma Brasil, previously submitted to an evaluation that resulted in an opinion approved by the ethics committee of the University of the State of Rio de Janeiro - CAAE 02867218.9.0000.5282. The person described in order to guarantee anonymity spontaneously agreed to participate in the research, by signing an informed consent.

⁵ For more information about NACE and the project developed at the UERJ Applied Psychology Service, see Feijoo and Lessa (2018).

surround Caio's life. He reported that he was still going through a difficult time: he left his job to dedicate himself to his studies, and even so he failed seven of the eight subjects he took this semester. With no parents, no money, no academic performance, he was desolate. What we can say is that Caio was what suicidology calls a survivor, since his mother had committed suicide, his brother had tried and he was mourning the death of his mother.

Given what was presented, Caio could be classified at acute risk of suicide, according to the classification adopted by Botega (2015). This scholar, in the case of Caio, would indicate compulsory hospitalization. But that was not the decision of the psychologist who accompanied Caio. The professional took a different approach, since suicidal behavior encompasses ideation, thinking, planning and the act. Caio did not fit into this behavior. The professional arranged the time for the next appointment and waited for him. He knew that nothing could guarantee the boy's return. And yet nothing could stop him, should he decide to commit suicide. However, the professional still decided to wait for the next meeting. It is difficult to explain the reason for this decision, with only the observation that he decided to risk confidently in the return of the boy for the next visit. We know that in a situation like this, objective criteria seem to be insufficient for the decision to be taken. There were indications that there was no imminent risk of suicide for different reasons: he had no plan, method or even suicidal ideation. Caio told a painful story that pointed more to risk than protection from suicide. But without a doubt, he showed that he wanted help, he went to the psychologist, told his story, and trusted the professional. Due to all these elements, 'compulsory hospitalization' would be totally contraindicated.

At the scheduled date and time, Caio returned. The psychologist felt relief and resumed the conversation. That day, Caio seemed less melancholy. His speech was more organized, but he still showed signs that could fit him into the diagnosis of depression, such as: melancholy mood, fatigue, psychomotor retardation, thoughts of death, feeling of worthlessness and excessive guilt. Nevertheless, the objectivity of the diagnostic criteria did not seem to fully encompass his experience. They talked about topics that seemed important at the time. Caio revealed the guilt he carried for an argument he had with his mother, a few hours before her suicide. He wondered: had this discussion triggered the mother's suicide? There is no parameter that establishes an answer to this question, and it corrodes Caio from within. He also talked about how difficult it was to live with his grandparents, where he currently lives. He felt misunderstood. Although he did not mention suicidal thoughts on this second encounter, his existence appeared to have undergone no objective change since the last visit. Once again it was necessary to trust his return. It was a bit of a risk, again. However, in the midst of this situation, it was possible to understand that risk is always at stake in the clinic.

As summarized by Feijoo (2014), in the midst of the clinical risk, it is up to the psychotherapist to remain calm, in acceptance, and to establish an unnatural attitude. The unnatural attitude, typical of those who work clinically with *daseinsanalysis*, refers to the ability to retreat when the situation requires this movement. In the situation at hand, stepping back means waiting patiently and serenely, keeping an eye on the situation but knowing that you are unable to fully control it. It is also necessary to accept that the causal relationship does not fully explain a phenomenon as complex as human behavior, a fact that seems to be accentuated in suicide situations. In this way, it is necessary to see what is shown through its own emergence. Therein lies the phenomenological look. It is necessary to lose the vision biases that prevent seeing what is clearly shown.

In the concrete situation, there was a need to abandon theories about suicide and the so-called suicidal profile. It was necessary for what was at stake to appear in the

psychotherapeutic relationship, so that the patient in the situation in question could take ownership of his own situation. In this sense, technique and theory would be excessive and intrusive to the relationship established between Caio and his psychotherapist; not fitting at that moment, which would configure the need for retreat. This retreat, however, would characterize an opening of the way, as in the activity of plowing the land so that the seeds can germinate. It is a passive activity, an action that is also carried out as waiting, but necessary to provide the right conditions for germination. The growth of a plant depends on certain conditions, many of which are beyond the control of the planter, such as weather and rainfall. This is also how the psychotherapeutic relationship is established.

A week passed, and the psychologist continued to wait. Shortly before appointment time, the clinician decided to go to the bathroom. On the way out he met Caio. The psychotherapist greeted him, but he seemed to ignore the greeting and told him what was bothering him at that moment: "There is a girl on the twelfth floor!" Initially the message was not understood, which resulted in a question: "Is there a girl on the twelfth floor?" Caio replied with the same sentence. Then, suddenly, the message was understood. At that moment it was necessary to abandon any and all prescriptions. The psychologist asked him to wait with a colleague who was close to the place, and went out to check what was happening.

As he climbed the university's tenth-floor ramp, he confirmed his suspicion. That's what he feared: when he looks up, he sees a teenager sitting on the 12th floor railing of UERJ. She looked ready to launch. He then tried to approach, but was stopped by security on the eleventh floor, right below where the girl was sitting. From this spot, he could see her feet dangling and, at that moment, the psychologist was startled by his own coldness. He expected to have a tachycardia in the face of the situation, but he continued to remain calm. He tried to find a new route to the location. He went around the floors and finally managed to get to where the girl was.

It was necessary to keep a distance. Her advisor was lying on the ramp, talking to the girl. There was already a team of firefighters at the scene. Some distressed teachers watched from afar and waited for the outcome of the situation. A few minutes later, the psychologist slowly walked away. The firefighter who was on the floor ran, the other made a frontal approach by rappelling. There was a scream, the teachers looked away. It was not known whether the approach was successful. He kept looking. He sees the young woman being brought to the floor. Everyone was relieved. After a brief conversation with the advisor and with other colleagues who were at the place, we all concluded that the presence of more psychologists would be unnecessary, it was enough for only one to accompany her.

It's time to return to the Applied Psychology Service (SPA) with another concern in mind: How is Caio doing? Common sense anticipates that the young man should be completely upset. The psychologist came into the room, took a deep breath, and asked, "How are you?" The response was not what was expected. Caio said:

I'm fine [...] Do you know what it is? Three weeks ago, I was the one who wanted to throw myself off that ledge. But I was so nervous [...] I was out of breath; my heart was racing. I couldn't even stand to stay on the floor where I study. So, I went downstairs and started crying. Some friends found me and helped me. They sent me to NACE, and NACE sent me here. In those three weeks I thought about a lot of things [...] I was able to talk to my family about my mother's suicide. I thought that killing myself would do me good, but I realized that my mother's death was not so good for those who remained. Everyone misses her [...]

The two continued the session talking about various subjects, but this answer was what remained in the psychologist's memory. The young man who considered ending his own life and who fitted into virtually all predisposing factors and suicide precipitants pointed

out by Bertolote, Mello-Santos and Botega (2010) - history of mental illness in the family, history of suicide in first-degree relatives, fragile family bonds, depression, being unemployed and a drop in income – and who therefore presented a degree of acute risk, decided not to kill himself.

It is clear that this decision has a temporal character, and it is possible that at another time he will consider suicide again. But wouldn't it be so in any situation? Two months later, the two (analyst and analysand) were talking about Caio's indecision regarding the end of his relationship. Caio was dating a girl who supported him, but he was attracted to another person, whom he did not know personally, with whom he only had contact through the internet. Whoever attended to him at that moment could never have imagined that suicide had been an issue in his life.

By following this report, we can see some approximations to the analysis of the case of Ellen West as forwarded by Binswanger. Binswanger and this psychologist do not allow themselves to be guided by theories, manuals or even the epochal determination that life must be preserved at all costs. Both also did not allow themselves to be taken by despair. Faced with situations in which voluntary death is mentioned, serenity is needed. All this attitude of the clinician requires a suspension of the common-sense way of acting and feeling. And yet, the two chose to leave the one referred to by ending his own life in freedom, even at the risk of the fate that that decision may bring. The outcome, however, was different: Ellen ended her life, while our patient rearranged it in order to launch himself into other projects. It is noteworthy that these two clinicians were guided by the teachings of daseinsanalysis.

Considerações finais:

What this concrete situation exemplifies is the insufficiency of any theorizing about suicide. Even if the most accurate manuals are elaborated, they will never be able to encompass the multiplicity present in existence. Although Binswanger founded Daseinsanalysis, it is necessary to point out and rethink some of its procedures. Much criticism has been made at the Ellen West case. The case was revisited by names such as Michel Foucault, Carl Rogers (1977), Ronald Laing (1986), Salvador Minuchin (1984), among others. The main question raised by most reviews is, "Who killed Ellen West?" (Lester, 1971; Maltzberger, Akavia, 2008; Di Nicola, 2013) highlighting the role of Binswanger and Ellen West's husband in the case.

Akavia (2008) reignited the debate by carrying out a documentary review of the case. According to the author, both Binswanger and her husband would play a key role in Ellen West's death. Binswanger when making the diagnosis of schizophrenia, stating that it was an untreated disease at that time. Her husband also played a leading role in the outcome of Ellen's life by allowing access to the lethal dose of poison that killed her. Di Nicola (2013, p. 2, our translation) points out:

What is the mission of psychiatry? Is it to understand (Binswanger's goal with existential analysis), to classify (Kraepelin's and Bleuler's contribution) or to heal (Freud's contribution through psychoanalysis)? Are these different goals compatible or mutually exclusive? Critics of the case of Ellen West assert that she was misunderstood and mistreated. What lessons does she demand that we learn, at last? Can we let her find a voice to express her suffering, as Minuchin tries to do in his family drama about her?

Vincenzo Di Nicola's position on the issue problematizes Akavia's statement, stating that blaming Binswanger or Ellen's husband does not produce great scientific contributions.

Regarding the idea of healing, it is worth checking the numerous objections to this idea within psychology and psychiatry (Santos & Sá, 2013; Dimenstein, 2000; Galli, 2009). More specifically in relation to the idea of healing as suicide prevention, it is worth going back to the previous discussion. Would preventing suicide merely treat disorders that have suicide as a symptom? Or is suicide an existential issue? The notion that it is possible to trace a suicide risk profile does not seem to encompass the mystery that shrouds the theme.

Radically exercising daseinsanalysis consists of following the premise of Heidegger (2009, p. 33): “The human being-there as a region of apprehension of power is never a merely present object. On the contrary, it is in no way and under no circumstances something that should be objectified”. Therefore, it becomes necessary to abandon any pretense of an objectification of a phenomenon such as suicide. Abandoning any objectification of being-there also means renouncing any psychopathological categorization as an ultimate criterion. And this leads to the impossibility of tracing a suicidal profile.

Respecting the mystery of existence means admitting that, potentially, we are all suicidal, because this is a possibility that has always presented itself and still presents itself in our surrounding world, in our hermeneutic horizon. Therefore, the act of taking one’s own life can prove to be a possible event for anyone at any time in their life. Any attempt to predict something so surprising turns out to be mere theorizing, a mere attempt at control, and therefore insufficient.

Finally, we conclude that it is not possible to reach a conclusive answer about suicide. It remains a mystery. It is therefore necessary, in each service, to look again at the issue as if it were the first time. That’s how it must be. There is no absolute truth to be described. What can be concluded is that suicide is, in fact, a matter of the order of existence. And existence is pure mystery. There are no answers to report, but there are many questions to ask. So follows our path and our invitation to think. If possible, in addition to reading this text. Questioning concepts that remain unquestioned, asking questions that are not usually asked. And in this way, we can continue to think about daseinsanalysis so that we do not stop at what was once said by this or that scholar on the subject. And by renouncing the figure of a hero, we are free to consider what the tradition of daseinsanalysis has said, however, allowing this clinical treatment to advance in its openness character present in any space of relationship of being-there.

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