

# FEATS DO NOT DIE – PSYCHOANALYSIS AND END-OF-LIFE CARE

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**ABSTRACT:** The present paper discusses the main problems raised by the psychologist's intervention on a palliative care unit, from a psychoanalytic perspective. Parting from fragments of clinical cases and literature passages, it debates issues like the finitude of the subject, grief and the transference relationship. It concludes that a place where the patient can be listened, may crystallize something from the subject's speech and even write his own history, in what can be called a process of subjective construction, at this terminal point of the existence.

**Keywords:** Palliative care, desire, death, finitude, psychoanalysis.

**RESUMO:** Pretende-se discutir a problemática posta em jogo na intervenção do psicólogo em uma unidade de cuidados paliativos, em um trabalho orientado pela psicanálise. A partir de fragmentos de casos clínicos e lançando mão de passagens da literatura, tratam-se questões como a finitude fundadora do sujeito, o luto e a relação transferencial. Conclui-se que a escuta pode precipitar uma cristalização na palavra do sujeito e a escrita mesma de sua história, em um processo de construção subjetiva, nesse ponto limite da existência. **Palavras-chave:** Cuidados paliativos, desejo, finitude, morte, psicanálise.

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### 1. ONE DOES NOT SPEAK OF ONE'S OWN DEATH

Man has to “face the awareness that his existence is finite. This means to be born under a death sentence. If I was an animal (...) life could then be tolerable” says Danish director Lars Von Trier (*apud* BOSCOV, 2011, p.20-21) concerning life's unbearable aspect when speaking of *Melancholia*<sup>1</sup>. “I did the movie to say that, yes, depression is the end of the world”. “The film is not so much about the end of the world as it is about a mental state” (VON TRIER, 2011). *Melancholia* is “a pungent parable of the end of the world that every human being will have to go through when living his own death”. (BOSCOV, 2011, p.17).

One does not openly face the end of life. It is with fear that we think of our own death. According to Freud (1915b, p.290), death is unconceivable and unimaginable. “At bottom no one believes in his own death, or, to put the same thing in another way, that in the unconscious every one of us is convinced of his own immortality”. In other words, death doesn't exist for the unconscious and “it behaves as if it were immortal” (1915b, p.297). Although man might have tasted the pain of losing a beloved being, “he cannot experience himself as being dead” (1915b, p.295). That is because, as traumatic as those may be, he can only have records of his experiences, never of his own death. As Tolstoy (2006, p.49) illustrates in *The death of Ivan Ilitch*: “Ivan Ilitch saw he was dying and despair would no longer leave him. He knew, deep in his heart, that he was dying, but not only couldn't he get accustomed to the thought, he simply, in any way, couldn't grasp it”. Hence, given its impossibility, one does not speak of one's own death.

Paradoxically, finitude is the foundation of man. In other words, man has always been finite. According to Heidegger, man exists in a finite way; he is neither anterior to finitude nor there is a way it will not affect him. His death is certain and, concomitantly, undetermined as when it will occur: it can happen at any given moment. That is, “it's a constant risk, since it is neither possible to control nor to calculate the possibility of its existence even if what daily prevails is the movement to avoid the encounter with it” (LEITE, 2011). We witness, then, little daily situations of flight from death and death denial, that is, finitude: “Eventually, in the end, we also die, but, as of now, we are not touched by death” (HEIDEGGER, 2006, p.329). As of now, that is, with Clarice Lispector, (1984, p.636), “in terms of our daily and permanent resigned accommodation to irreality”.

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<sup>1</sup> In the film, a planet called *Melancholia* is about to collide with Earth which would result in its utter destruction. In this context, the character Justine, who is about to get married, receives help from her sister Claire who, with her husband John, prepare a sumptuous reception to celebrate the wedding. However, in front it all, Justine is, simply, apathetic.

This way, that from which we have news is from the collective repercussion of death, in the death of others. This, Tolstoy (2006, p.15) shows: “Three days of frightful suffering and then, death! Why, that might suddenly happen to me too now, anytime, he thought, and for a moment, felt terrified”. In losing one’s object of love, there is an ambivalent feeling: the pain of loss, and, concomitantly, a feeling of joy, by identification. That is what we see in: “the fact itself of the death of a near acquaintance aroused, as usual, in all who heard of it the complacent feeling that another died, not them. *There it is, he died; I didn’t* — each one of them thought and felt” (TOLSTOY, 2006, p.9).

Joy by identification with the object — in *he died, I didn’t*. But, in addition, at that moment, comes up the affective ambivalence inherent to loving relationships themselves if we understand, with Freud (1915a, p.183) that, in the unconscious, there is no negation and that opposites will coincide. That is to say, the coincidence of love and hate is intrinsic to loving relationships — what Lacan (1972-1973, p.122) will call *hatelove*. This is what we witness in the wife of W., a patient in end-of-life care. She tells us of how they met and how they fell in love. She tells us of the marriage, the children, the betrayal and the separation. She refers to W. as her true love, the man of her life, but, at the same time, says: “You know, I sometimes feel good seeing him like that, after what I’ve been through”. It is possible to read there the fusion of love and hate that are, in a certain way, inseparable.

We also encounter this ambivalent feeling when facing the death of the loved object in Machado de Assis (1987, p.16-17), with Fortunato, when face to face with the passing of his wife, in *The secret cause*:

He didn’t leave her anymore; he stared at the blurred and cold eye in that slow and painful decomposition of life; drank, one at a time, the afflictions of the beautiful creature, now thin and transparent, devoured by the fever and mined by death. A very rough selfishness, hungry for sensations, he did not forgive her a single minute of agony, neither paid them with a single drop of tear, public nor intimate. It’s only when she expired that he became dazed. When he recovered his senses, he saw that he was alone once more...

An ambivalence also found in Tolstoy’s Prascovia (2006, p.36-37): “Having come to the conclusion that her husband had a dreadful temper and made her life miserable, she began to feel sorry for herself. And the more she pitied herself, the more she hated her husband. She began to wish he would die, yet she did not want him to die”. His hate also: “Ivan Ilitch looks at her, scans her all over and, at heart, sets against the whiteness and plumpness and cleanness of her arms and neck, against the gloss of her hair and the sparkle of her eyes

full of life. He hates her with his whole soul. And, touched by her, he is forced to suffer an influx of hate" (2006, p.61).

## **2. IN THE GAP BETWEEN THE RECEIVING OF DEATH AND THE LOSING OF ONESELF IN IT**

When working in a palliative care unit where the experience of death is so pungent, it is important to acknowledge that there are limits from the point of view of the cure — since we're dealing with patients beyond any possibility of remission — but this doesn't necessarily imply a restriction of care. What is at stake is the possibility of moving the problematics from the field of failure to the field of personal experience in which death is seen not as scientific matter but as an existential one. In other words, dealing with the matter of the prognostic of the disease — his own or a family member's — in the field of impossibility, places the subject in another position than doing it in the field of impotence. Dealing with the matter from an impotent position may lead the subject to a feeling of guilt and to the "what if I had done things differently?" so often heard in the services. If the subject decides to accept that he is facing something impossible, the inexorable of death, other doors might open.

It is here, then, that we raise a question: as we often observe, how may a subject, when marked by death, hold such an active position in life that he is capable of deciding himself to move towards things that were impossible before.

Let's recall the case of A., admitted in the palliative care unit of the Cancer Hospital. A., albeit living with his wife for twelve years, married her a week before being hospitalized. Weddings are not uncommon in such circumstances. Somehow, the subject only decides to marry when in his death bed.

That brings us to Shakespeare (2002) and to prince Hamlet's tragedy. Only after being inoculated with a lethal poison, can Hamlet act and kill his uncle Claudius, thus avenging the death of the king, his father. He only acts when mortally wounded, in the short interval of time that he has between received death and losing himself in it (LACAN, 1989, p.60). It's the cut (in this case, literal, with Laertes' poisoned sword) of death that brings urgency. What is curious is that we watch, throughout the entire play and up to this point, to Hamlet's series of postponements of the fulfillment of his revenge. He procrastinates and hesitates. He asks himself "to be or not be — that is the question" (SHAKESPEARE, 2002, p.63), and questions himself whether he should live with his suffering or die to end it: "'tis a consummation devoutly to be wished! To die, to sleep" (2002, p.63). It's the neurotic willingness to *sleep*, in order to not confront the risks of desiring, that is, that which moves him. He conjectures:

*“Thus conscience does make cowards of us all,  
And thus the native hue of resolution  
Is sicklied o’er with the pale cast of thought,  
And enterprises of great pith and moment  
With this regard their currents turn awry,  
And lose the name of action” (2002, p.64),*

disorienting himself in paleness of thought in order to extinguish the strength of the action.

Paradoxically, in order to protect himself from the dangers of life, Hamlet is always grappling with death. In his trajectory, risk is avoided and, for that, he fears death by dying a little as he chooses a mortifying life. In other words, in the intention of avoiding death, death makes itself present as he, Hamlet, mummifies himself as he awaits for it. Procrastination places him, from the beginning, in the present since, living in the wait for death, he is, for starters, already dead.

How is it possible then that only when hooked to death, can he act? He only reaches out to Ophelia once she is definitely marked by impossibility, that is, once she’s dead and in her coffin from where she cannot call on him for nothing anymore. In the play, he avoids confronting the woman that seems to awake his desire. It’s only when he isn’t risking anything anymore that Hamlet throws himself in Ophelia’s grave. We allow ourselves a provocation here: is it in Ophelia’s grave or in his own, throughout the entire play, spending his life running away from what harasses him, his own desire?

We see, then, that, in a certain way, the mark of death brings with itself a thrust towards action. He who spends his life protecting himself, throws himself in the direction of desire in this ultimate moment as witnesses the prince:

I am dead [...]  
Had I but time (as this fell sergeant, Death,  
Is strict in his arrest), O, I could tell you—  
But let it be.

### 3. OF MOURNING

Back to the question of death’s lack of representation, what Elizabeth Kübler-Ross (2008) establishes regarding the phases the subject goes through in his acceptance, is phenomenologically observable. Defense mechanisms exist and, with them, important moments in the process of subjective elaboration. Not being exclusive to patients receiving bad news concerning a prognostic, family

members and closed ones can also be subject to them. These phases are not set, can alternate themselves and have a variable duration.

"No, not me, it can be true". "No it can't be with me". These are sayings of patients in the denial phase. "A patient's first reaction can be a temporary state of shock from which he recovers gradually" (KÜBLER-ROSS, 2008, p.47). This is the neurotic dimension of the subject's denial when face to face with his mortal condition, with the transience of his own existence, as previously seen. "It cannot be that I ought to die. It would be too terrible" (TOLSTOY, 2006, p.49), says Ivan Ilitch.

According to Freud (1925, p.253), "the denial is a way of receiving news of that which is repressed", that is, the repressed is canceled although not accepted. This means that, through the mark of denial, "thought frees itself from repression's constraints (1925, p.254). In an analysis, one discards the denial. For instance, when a patient, concerning a dream, says *it's not my mother*, it's as if he was saying: *it certainly is my mother, but I'm certainly not inclined to consider that. "This is something I would rather repress"*, that is, the "acknowledgment of the unconscious on the part of the ego is expressed in a negative way" (1925, p.257).

The second phase postulated by Kübler-Ross (2008, p.55) is the phase of anger: "No, it's not true, this cannot be happening to me!" "Why me?" When it is no longer possible to sustain the denial, comes the feelings of anger, revolt, envy and resentment: "They will go through the same thing I am and yet, they are merry! The beasts!" (TOLSTOY, 2006, p.47). Anger choked him. To which follows the bargain: "If God has decided to take me from this world and has not heard my plea full of anger, more condescending would it be if I plea calmly". And so, one first demands, then one asks for a favor. The next phase is depression. The author establishes the difference between a reactive depression, of a defensive nature, and a preparatory depression that establishes itself as a tool during the preparation of the imminent loss, on the way towards the next and final phase: acceptance. According to the author, the patient contemplates, then, his near end in a certain peaceful expectation after having felt anger, envy, depression and after having lamented the loss. We come to understand the moment as a certain resignation on the part of the subject when confronting the impossible.

On the other hand, Freud (1917, p.241) will define mourning as a "the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, an ideal, etc.". Hence, it doesn't only concern the loss of dear a person. Mourning implies the loss of interest in the outside world (viewed as poor and shallow), the loss of the ability of choosing a new object of love and the inhibition of all productivity.

The author speaks of an anticipated mourning, a defense against existence's transience and alerts us that "the value of beauty is independent of absolute duration" (FREUD, 1916, p.310). Or, in the words of Fernando Sabino (2011),

“the value of things is not in the time they last but in the intensity with which they happen”. If, on one hand, the anticipation of mourning can be a defense of the subject against the transience of existence, on the other, it can be seen as an important preparation to really announced losses, somethings we can approximate to Kübler-Ross preparatory depression previously seen.

Following Freud (1911, p.226), the pain comes from the fact that the libido clings to the object, not wanting to abandon it once lost. The mourning is there, in the “pertinacity of holding on to the sources of pleasures that one disposes of and in the difficulty in renouncing them”. He opposes normal mourning to pathological mourning, which he will call melancholia. As painful as it can be, mourning expires spontaneously and “our libido becomes once again free to, if we are young and capable of life, find substitutes for the lost objects in other ones that can be, if possible, as much or even more appreciated than the previous ones” (FREUD, 1917, p.252). We understand *young and capable of life* not so much as something concerning age but as subjective position, an active and desiring position.

#### 4. OF THE DIRECTION OF THE WORK

In palliative care, the concept of a *good death* is important. It implies dying with dignity, not accelerating (euthanasia) or slowing down (dysthanasia) the act of dying and thus, prolonging the suffering.

In an approach marked by psychoanalysis, the psychological treatment direction consists in an active support by building a space for the listening. What is possible to do with the patient is to bear witness with him to this limit point of existence, to accompany him in the psychic elaboration of his subjective questions. It’s about the building, about the crystallization of something, that is, of the very writing of the subject’s history. The patient’s work consists in the mobilization and in the strengthening of his subjective resources in the search for a personal knowledge that will help him deal with the imminence of death. Besides the intervention with the patient, the work covers the support of the family in this crucial moment, as we will see in the following cases.

##### 4.1 “I saved the life of four hundred people. Now I also want to be saved”

Sat in the infirmary of palliative care with his wife, V. says: “I saved the life of four hundred people. Now I also want to be saved”. V. works as a life-guard and was responsible for some truly heroic lifesavings. “They called me Pirarucu<sup>2</sup>. It’s the name of a fish. They called me by the name of a fish”.

<sup>2</sup> Fictional name.

“I threw myself on the floor, floundering like a fish out of the water” he says, speaking of the pain caused by the cancer. “When I found out, it was too late”. He tells, with a heavy heart, that for years he suffered from pains “but didn’t pay any attention” to it. “I thought it was something in the stomach”. What he did have was a cancer in the kidney that spread and his pains were, actually, the effects of the tumor growing and compressing his organs.

He is in a palliative care infirmary. In its origin, *to palliate* means to cover with a mantle [*the pallium*], to hide. In the field of medical care, it means to relieve from a pain but not to cure. What is there to say to V.? Is there something to say to him when he says “I want to be saved”? What we can tell him is that the lives he saved, his story, that can’t be taken away from him. This is what we have to say to him, and, at the same time, witness with him to the hardness of what he is going through, diminishing nothing, on the contrary.

Any tendency to disguise this in a supposed attempt to mitigate things would be false. As if one would, for example, say to a patient and his family: “we, that are here, must all die”. Saying things this way is not appropriate in the context for *we, that are here, must all die* doesn’t mean the same for each one of those present there. It would be a falsification of the hard moment that is being lived, turning the palliative into a cover-up. In a certain way, it’s almost as trying to deny the very truth of the sentence, a way of deceiving (oneself). Covering things up, in this case, not so much for the patient or his family but for the professional saying these things himself.

It is true that we all must die. Feats, however, don’t. V. reported a situation in which he had to make a decision that implied a certain transgression. He worked as a life-guard at the beach and someone was drowning in a river close by. People called for the Pirarucu: “Call the Pirarucu, Pirarucu will take care of this”. He couldn’t leave the beach, “what if something happened with someone at the beach?”, the responsibility was his. He made the arrangements he deemed necessary and dived into the river — he acted. That remains, that is the mark, that is what he is. Or better, if he is, he is there, not somewhere else, narcissistically, where one would like to be, where one would like to constitute himself.

In the sentence *we all must die* there is the truth of transience. How is then possible to work in a terminal patient’s infirmary where any healing treatment is no longer available? The work’s true dimension seems to be precisely in making room for that truth. Making room for the listening that builds the story of the patient, in this limit point or full stop of (his) existence. Maybe the work consists precisely in witnessing with the patient this limit point of the subject that is, actually, a limit point for all of us (be it denied or not). A listening that makes room for the crystallization of something, allowing, hence, the writing of one’s story.



#### **4.2 “My mother told my brother he was going to die from a cancer just like my father did”**

It’s also a place to be, at that moment, with the family. M. was hospitalized due to a sever worsening of his health state. With a lot of pain, he couldn’t eat anymore and his clinical condition got more serious every day. He was accompanied by his wife and brother and lived far, in another city. M., who really wanted to see his children, asked to go home, but it was not possible. We spoke to his wife to arrange for the children to come. M., who a few days before was lethargic, stayed awake during the afternoon that he and his wife spent with their true children. He held his daughter’s hands and said: “Take care”. He was waiting for his children to come. He died during the night.

“My mother told my brother he was going to die from a cancer just like my father did” said the thirteen-year-old daughter in one of the service’s room where also was his younger brother. When he is told that that was not true, that the fact that his father has had cancer didn’t mean he would also have it, the five-year-old boy who up until that moment seemed distant, promptly said: “But cigarettes cause cancer”, to which we came to the conclusion that yes, cigarettes do cause cancer.

#### **4.3 “I thought I held the world in my hands”**

E. arrives drowsy at the infirmary, presenting disorientation episodes that bother him. “I came next week... I don’t know what is happening to me, sometimes I say weird things...”. He tells the story of the disease and of the strong bond he had with the hospital team in which he was before being transferred to the palliative-care unit. Concerning the transfer, he says: “Ever since the doctor gave the news, I am very shaken”. “I thought I held the world in my hands”. He tells of his job as a bank clerk, of how he lost this job when the bank in which he worked was sold and how sad this made him. “I think there is connection between things”, he says, speaking of the discharge and of the beginning of the illness. His wife tells us of her husband’s episodes of mental confusion, a week before. “I think he’s running away, running away from the news”. The family shows that they are aware of the disease’s diagnostic and prognostic.

The following days, he complains of tiredness and how that stops him from talking. “And that [talking] is something I really enjoy”. He becomes restless, anxious and irritable: “I’m a feeling a discomfort and a nervous system”. He repeatedly sits on the bed and lie down again. The family stay with the patient at the hospital. He dies the next day. A clarity that reminds us of a passage from Clarice Lispector (1984, p.636) when she says:

I’m feeling a clarity so big that it cancels me as an actual and common person: it’s an empty clarity, how to explain? Just like a perfect mathematical calculation that we, however, don’t need. I am, in a matter of speaking, clearly seeing the void. And

I don't even understand that which I understand: for I am infinitely bigger than myself, and I don't reach myself. Besides, what to do with this clarity. I also know that this clarity of mine can become the human hell.

Tolstoy's character's clarity also (2006, p.46-47):

"It's not a question of appendix or kidney, but of life and... death. Yes, life was there and now it is going, going and I cannot stop it. Yes. Why deceive myself? Isn't it obvious to everyone but me that I'm dying, and that it's only a question of weeks, days...it may happen this moment. There was light and now there is darkness. I was here and now I'm going there! Where?" A chill came over him, his breathing ceased, and he felt only the throbbing of his heart. "When I am not, what will there be? There will be nothing. Then where shall I be when I am no more? Can this be dying? No, I don't want to!"

#### 4.4. "I avoid it as much as possible"

Hospitalized, S. speaks of her desire to die at home. She complains about A., her daughter, because she doesn't want to take her home. S. is aware of how serious her clinical condition is and of the prognostic. She says she misses home. A. and her two children who are four and fourteen live with S. Concerning the choice of the place of death, A. hesitates when confronted to her mother's choice: "What about the children? I avoid as much as possible to bring them here at the hospital..." "What if she dies at home? What about the children?"

A. avoids. She avoids because she *knows* what is best for her children, she knows what is *good* for them. What was possible to do, together, was to shake a little that certainty of hers. After all, is it that obvious that the children would be protected from their grandmother's death at home? Is it really certain that that this is the best option? It doesn't seem necessarily right that the subject should be spared of the tragic incidences of the real that affects his life. There is no way to know that sparing these children from the death of their grandmother is for the best. It's only *a posteriori* that they shall receive news concerning this event, in the temporality of the future past, in the *only afterwards*: it is only afterwards one can know the effects of this.

## 5. TESSITURA IN SPEECH

It is through punctuation that a scansion appears and, in turn, marks time: it cuts and make time. It constitutes itself as the "art of distinguishing, by way of accepted signals, sentences, partial meaning constituting those sentences and the different degrees of subordination suiting each one of those meanings" (LITTRÉ

apud SCIARA, p.76). Punctuation doesn't separate, it introduces new connections, that is, separating in a hierarchy, it connects constituent parts of the sentence, being, hence, responsible by the text's cohesion. It has, therefore, a connective function, connecting in order to make sense (SCIARA, 2009, p.77). That is to say, it is punctuation that, afterwards, gives a meaning to patient's text, as Lacan says (1985, p.297): "It is only when finished that the sentence exists and its meaning comes only afterwards". The work in a palliative-care infirmary is punctual. It is about establishing that what matters is the point when the work of subjective construction, in the writing itself of the subject's history, is interrupted.

If, on one hand, we try to run from the full stop, from the possibility of death, in denying our finitude, we see, in the pathology, the horror of it when taken to its ultimate consequences. In melancholia, there is no scansion and time becomes infinite in a succession of nows. The melancholic really believes he is immortal and goes through existence in great pain, in the anguish of immortality, by the curse to which he is condemned. Unbearable sentence from which not even through death can he escape.

Regarding everything we have seen concerning the finitude that founds us and the "inclination to not compute death in life's calculation", Freud (1915b, p.292) alerts us: "if you want to endure life, prepare to death" (1915b, p.301). According to him, "to endure life is still every living being's duty" (1915b, p.301) and recalls the Hanseatic League motto: "*Navigare necesse est, vivere non necesse!* — *To navigate is necessary, to live is not necessary*" (1915b, p.292).

To accompany a patient is to be with him in the aridness of what he goes through. To have a place for the addressing of all of this, for the collecting of his work. In other words, someone to share this construction with him can make all the difference. What is at stake is the building of a personal knowledge so that the subject is capable of going through this in a less crushing way. Personal knowledge insofar as it is not something given to him, but something built in a transference relationship, in the tessitura of speech.

We don't know, beforehand, to which paths the treatment will lead. Because of that, that which will emerge in the patient's speech as an effect of our presence will also surprise us. We are to put ourselves, in the transference, in a position where we don't know the patient's truth, but from where we can be with the patient, where, together, we can be surprised with what, emerging from that place, may come to be, taking his word and the truth that it carries very seriously. Sciara (2011) speaks of a certain disposition on the part of the practitioner in seeing himself included in the transference, in a way, against his wishes but with the duty of sustaining it. Unpredictable as it is, it is with surprise that we receive the place assigned to us in the transference. The unfoldings to which the

transference weaves together with the patient are unpredictable beforehand. It is only afterwards that a logical sequence can be read.

The analytical work would reside, then, in finding, with the patient, resources to sustain him, to *endure life* — and *finitude*. The presence (and the bet on a place of speech, the addressing, the investigation with the patient) can have the effect of a production of truth, with no need of an interpreter, when we bear to stay with what the patient says. This has consequences: we pay a price for the transference for the effect of the incidence of the real that emerges in the speech cuts on both sides, the patient's and the analyst's.

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