

Suicide in anti-psychiatry and in psychoanalysis

Cristia Rosineiri Gonçalves Lopes Correa

392

In psychiatry, the criteria by which the need for psychiatric attention is evaluated are often the object of disagreements, thus bringing to the fore debates regarding the validity of the concept of mental illness. Whereas anti-psychiatrists, such as Szasz (1961), argue against the prevention of suicide, Freud (1915) describes a case of melancholia that would justify psychiatric intervention in suicidal individuals. In this article, I examine these arguments and argue that Freud's account of melancholia puts Szasz's position into question.

Key words: Szasz, Freud, melancholia, suicide

Anti-Psychiatric Arguments against the Validity of the Concept of Mental Illness

The great debate about the validity of the concept of mental illness since 1960s has been sharply divided between two distinct and radically opposed to each other sides, namely the anti-psychiatric movement and the pro-psychiatric side. During many years, the field of psychiatry was constituted basically by those who are against and by those who are for the concept of mental illness as a valid concept.

The anti-psychiatric movement arguments against the validity of the concept of mental illness in the sense of regarding mental illness anything except illness as taken by the medical sense come from a variety of backgrounds – psychology, sociology and psychiatry itself. Such arguments were endorsed by critics such as Schneider (1950), Eysenck (1960), Laing (1967), Scheff (1966, 1970, 1986), Foucault (1965, 1975), Cooper (1971) and Thomas Szasz (1961, 1970, 1978, 1986, 1993) who have claimed others explanations to mental illness than those provided by orthodox psychiatry.

They have criticized the concept of mental illness as a valid concept in psychiatry on the grounds that the real origins of what psychiatry regard as mental illness are not medic ones. Rather, the underlying causes of mental illness for these critics involve either learnt behaviour (Eysenck, 1960) or a special strategy that a person invents in order to live in an untenable situation (Laing, 1967) or a response to the shock of being labelled and treated as insane (Scheff, 1966) or problems of living derived from man's struggle with the problem of how he should live (Szasz, 1961). Social critics such as Foucault (1965, 1975), Scheff (1966, 1970, 1986) and Cooper (1971) advocated that the role performed by psychiatric practice consisted in functioning as a politically repressive force and thus mental disorder would be according to these critics only ideological instruments.

Szazs' arguments against the validity of the concept of mental illness

Szazs (1961) was one of the first anti-psychiatrists to refuse the validity of the concept of mental illness arguing that the concepts of both mental and physical illness comprise deviation from well-established criteria. In relation to physical illness such criterion is clear, namely, the structural and functional integrity of the human body. Nevertheless, for Szazs, the same does not go for mental illness because what is regarded as mental illnesses by psychiatry encompasses deviation from psychosocial and ethical rather than physical standards.

The concept of illness, whether bodily or mental, implies deviation from some clearly defined norm. In the case of physical illness, the norm is the structural and functional integrity of the human body. Thus, although the desirability of physical health, as such, is an ethical value, what health is can be stated in anatomical and physiological terms. What is the norm, deviation from which is regarded as mental illness? This question cannot be easily answered. But whatever this norm may be, we can be certain of only one thing: namely that it must be stated in terms of psychosocial ethical and legal concepts. (p. 13)

394

As a corollary of defining the criteria by which we measure mental illness as psychosocial and ethical standards, Szazs argues that is logically absurd the proposal of solving problems derived from mental illness on the medical grounds since standards comprised by mental and physical illness are distinct. Then for Szazs just in case of physical illness medical interventions must take place. In other words, according to Szazs is completely incompatible to apply medical procedures to problems whose origins are other than medical.

"Since medical interventions are designed to remedy only medical problems, it is logically absurd to expect that they will help solve problems whose very existence have been defined and established on non-medical grounds" (p. 17).

Thus, Szazs concludes that mental illness does not exist, that it is a myth rather than real. According to Szazs, what people have to deal with in their lives in many times and that is diagnosed as mental illness, actually is "problems of living" derived from the man's struggle with the problem of how he should live.

However, Szazs ponders that when he asserts that mental illnesses do not exist, he does not deny the existence of the social and psychological occurrences to which this label is attached to. Instead of it, he just objects to the validity of the concept of mental illness with regard to medical diagnosis and interventions.

The expression "mental illness" is a metaphor that we have come to mistake for a fact. We call people physically ill when their body-functioning violates certain anatomical and physiological norms; similarly, we call people mentally ill

when their personal conduct violates certain ethical, political and social norms. (p. 23)

Hence, the core of Szasz's argument consists in claiming that in so far as mental illnesses comprise evaluations, the concept of mental illness is not reliable and then it is not a valid one. In addition, his conclusion from his argument is that mental illness is a metaphor.

The relevance of Szasz's argument is to reveal the presence of values in psychiatric diagnosis and consequently, how vulnerable psychiatry is to misuse and abuse both institutionally speaking (ex-URSS and Japan) and in our everyday lives when disagreement of patient's values with doctor's may take place. Therefore, Szasz's argument shed lights on cases in which disagreement of other than medical values lead to misuse and abuse in psychiatry. Taking for example what happened in the ex-URSS we can perceive the role performed by psychiatry to preserve the communist system namely to label as mentally ill people who were only political dissidents.

Nevertheless, even though Szasz's argument is relevant in the sense of accounting for cases in which psychiatric misuse and abuse may take place, Szasz's argument does not account for cases in which people deal with the real experience of suffering determined by their evaluation of certain significant experiences in their lives and as result develop grave depression for instance.

395

Szasz's Arguments against Suicide Prevention

Szasz (1986) has a specific argument against suicide prevention rejecting the features of irrationality, incompetence and insanity that according to him were added to the features of sin, sickness and crime intrinsic to suicide (p. 807). As result suicide remains subject to value judgement depending on the criteria, by which they are judged. For Szasz, the term *prevention* itself specially when coupled with *suicide* implies coercion (p. 808).

The core of Szasz argument against suicide prevention is that suicide is a physical possibility and a fundamental right. Therefore, there is no room for suicide prevention because, according to Szasz, the latter cannot take place without complete control and coercion over the suicidal person by psychiatrists.

But it is either impossible to do this, or would require reducing the so called patient to a social state beneath that of a slave. The slave is compelled only to labour against his or her will whereas the suicidal person would thus be compelled to live against his or her will. Such a life is not the life of a person or human being but only that of a human organism or "living human thing". (p. 808)

Szasz ponders that his argument does not cover cases in which individuals suffering of suicide ideas or impulses seek assistance for themselves. He is not claiming that such medical assistance should not be provided in such cases. However, for Szasz, except cases like that, any attempt of preventing suicide by psychiatry on the grounds that the individual is mentally ill without strong objective evidence that the individual's suicidal behaviour is caused by a demonstrable malfunctioning of his or her brain must be thought of as abusive because it involves control and coercive measures over the suicidal person. Suicide prevention constitutes disrespect to the individual's right to suicide grounded on free will and personal responsibility.

... although life is precious, disease, disability and dishonour may render a person life not worth living and thus may make suicide a blessing for himself or herself as well as for others and society. Nevertheless, we in the West, impose coercive measures on every would-be suicide (even the hopelessly sick and very aged) as if suicide were never desirable enough to justify it. (...)

... thus, treating suicide as a right does not mean that we must accept committing suicide as a morally legitimate option; it means only that we must abstain from empowering agents of the state to coercively prevent it. Mental health professionals could then treat suicide as they treat say, abortion – in other words, as an act they may approve or disapprove in general and may choose to counsel for or against in any particular case. (ibid., p. 811)

Then the result of the application of Szasz anti-suicide prevention argument is that in melancholia for instancel, the strong possibility of death explicitly resulting from depression constitutes an intrinsic right of one when he does not seek medical assistance for himself, nor his depression is caused by a demonstrable malfunctioning of his brain. Then, from Szasz's argument any attempt of preventing suicide in an melancholic individual it would be made with control and coercive measures over him.

Objections to Szasz's arguments against the validity of the concept of mental illness and against suicide prevention

Fulford on Mental Illness

Even though many suicidal individuals beg medical assistance for intervening and preventing them from killing themselves, very often severely depressive individuals have a strong wish to die and they commit suicide without explicit demand for help. Rather their decision seems unshakeable. Also, their depression

are not caused by demonstrable malfunctioning of their brain. To deny psychiatric intervention in such cases it would be negligence.

Moreover, the requests for assistance by suicidal individuals may not be explicit. Glover (1977) noted that demands for assisted suicide by one not completely incapacitated may be regarded to be a demand for help rather than evidence of a serious wish to die. On this ground, I argue that not only requests for assisted suicide but many depressive individual's verbalization of a wish to kill himself, should be regarded as a request for medical assistance. Again, it is not ethically justifiable to deny psychiatric interventions in such cases. Still, in psychiatry we can find arguments against Szasz's claim like the argument given by Fulford (1989) who claims that it is the failure of intentions the demarcation criterion to distinguish mental illness from other conditions. He claims that one who is mentally ill fails to act harmoniously with his intention and suffers from that. As a corollary of it, depressive individuals have a strong wish to die not grounded on free will and personal responsibility as advocated by Szasz. Rather, for Fulford, their wish to die are resulting from their mental illnesses – founded on the failure of their intentionality and actions – (Fulford 1989, 2001) which must be treated. In such circumstances, it is not ethically justifiable to deny psychiatric treatment for them.

In other words, according to Fulford, one's wish to kill himself must be respected only if it is taken on rational grounds, if it is the result of a rational and intentional decision to die. And on the other hand, requests psychiatric intervention if it is resulting from mental illness since mental illness involves a breakdown of rationality (Fulford 1989, 1995, 1999 and 2001).

Szasz's argument has the merit of warning that, in fact one's wish to die may express one's right to die and therefore must be respected in some circumstances. In fact, to think that all those who consider committing suicide are indeed mentally ill is questionable, and mental illness is often not clearly distinguishable from "normal distress" (Burgess and Hawton, 1998). However, suicide resulting from mental illness is a strong and concerning reality that request psychiatric intervention. Suicide rates are much higher among those with mental illness than the general population (*ibid.*). Fifteen percent of people with major depression eventually end their lives by suicide (Guze and Robins, 1970), as do 10% of those diagnosed with schizophrenia (Burgess and Hawton, 1998).

Heyd and Block (1991) argues that suicide is not only a functional problem to which therapeutic techniques are applied but also an existential one, in both the literal and the philosophical senses of the word. For them, the question is not how to achieve a better, more fruitful life, but whether to live at all. Then, they argue that it is next to impossible for clinician to regard suicide as rational in so far as

intentional self-harm represents such a grave affront to the psychiatrist's own value system (p.243).

Jochemsen (1994) argues that the request of the suicidal individual is not in practice the basis on which physicians decide to perform euthanasia, but rather they base such decisions on the condition of the patient (p. 212-213).

As melancholia illustrates, it is not ethically justifiable to deny psychiatric medical assistance for a suicidal individual, even that he has not explicitly requested psychiatric intervention and that his depression is not underpinned by strong objective evidence that his suicidal behaviour is caused by a demonstrable malfunctioning of his brain – the only acceptable criteria claimed by Szasz to justify psychiatric intervention.

By doing that, Szasz fails to account for the practical necessity of psychiatric intervention in melancholic individuals, when these individuals neither formulate explicit demands for help nor show mental illnesses as mental disorders supported by malfunctioning of the brain. Despite evaluation in melancholia places disagreement with what generally is expected from individuals in the same situation, namely, that generally people have the capacity of judging justly their responsibility and managing well their feelings, what really matters is that these individuals under these subjective experiences complain incessantly about their lack of self control, self management and thus about find himself under severe self-criticism and self-reproaches. They insist that they are suffering and that everything in their lives is being threatened by the lack of sense.

We can find another argument against Szasz's criticism in Freud's works. The account of melancholia provided by Freud, in psychoanalysis, has the merit of not only calling Szasz's criticism but also the argument given by Fulford, namely, the failure of intention in mental illness into question. We will be concerned with the account of melancholia supplied by Freud in the next section.

Freud on mourning and melancholia

As already said at the end of the previous section, another argument against Szasz's criticism can be found in Freud's works. Freud (1915) addresses depression by establishing similarities and distinctions between mourning and melancholia. For Freud both mourning and melancholia constitute the individual's reaction to the losses such as loss of a loved person or loss of some abstraction (i.e. liberty, an ideal and so on).

Freud asks for what people under the same situation, some develop mourning and others melancholia, the latter is defined by Freud as pathological mourning. According to Freud (1915) individuals who develop, melancholia

possess pathological disposition. With regard to the similarities between mourning and melancholia both the former and the latter display as symptoms profound painful dejection, cessation of interest in the outside world, loss of the capacity to love and inhibition of all activity (p. 252).

Nevertheless, what makes the difference between melancholia and mourning is that whereas the former encompasses a lowering of the self-regarding feelings that finds utterance in self-reproaches and culminates in a delusional expectation of punishment, the latter does not present the pathological element. Thus, in mourning, it is the world that has become poor and empty; in melancholia, it is the individual's ego that is worthless, incapable of any achievement and morally despicable; he approaches himself expecting to be cast out and punished. He abuses himself before every one and commiserates with his own relatives over their connection with anyone so unworthy. This picture of a delusion of (mainly moral) inferiority is completed by sleeplessness and refusal to take nourishment (p. 254).

The work of mourning consists in displacing the libido on to other objects after the reality-testing shows that the loved object no longer exists. Although this is not an easy task since it demands time and the individual may oppose to it, normally prevails the evidence provided by the reality. Then, after the work of mourning is completed the ego becomes free and uninhibited again.

Melancholia in turn does not refer only to the reaction to the loved object's death but to the reaction to the loss of a loved object in general. Whereas mourning does not show any unconscious element related to the loved object's death, melancholia comprises an unconscious nuance since in melancholia the individual knows whom he has lost but not what he has lost in him.

For Freud the key to understand what occurs in melancholia is the fact that the most violent of the melancholic's many and various self-accusations are hardly at all applicable to the patient himself, but to someone else. Someone whom the individual loves or has loved or should love. Thus, for Freud, the key of the clinical picture by which melancholia is constituted are the patient's self-reproaches that actually are reproaches against a loved object, which have been shifted away from the latter to the patient's own ego. The woman who loudly pities her husband for being tied to such an incapable wife as herself is really accusing her husband of being incapable in whatever sense she may mean this (p. 257).

Then, Freud sets up psychoanalytically the clinical picture of the melancholia. In melancholia, after the individual loses his loved object (by death, disappointment and so on) what follows is not a normal result of withdrawing the libido from this object and displacing it on to new objects as occurs in mourning.

Rather what follows is something different, namely, the libido withdrawn from the loved object instead of being displaced on to new objects was withdrawn into the ego and was used to establish an identification of the individual's ego with the abandoned object. The ambivalence existing in the love relationships also becomes effective and evident in melancholia. In melancholia, the ambivalence felt by the individual in relation to the lost object (love/hostility) makes room for one part of the individual's ego opposes to the other part of the ego; judge it critically as though it were the abandoned object. Such a critic agent that separates from the ego and performs this task is defined by Freud as superego in a later work (Freud, 1923). According to Freud (1923), in melancholia, the individual's ego submits itself to the critical judgments and punishments from the superego without objections because the individual's ego feels guilty of the loss of the loved object due to identification with the latter. The violent superego can treat severely the ego as the abandoned object from the identification of the former with the latter. What influences now the superego is a pure culture of the death drive which indeed, very often, succeeds in leading the ego to the death if mania does not take place.

400

Therefore for Freud (1915) the conflict due to individual's ambivalent feelings towards his loved object helps to explain what occurs in melancholia since the patient usually succeeds by the circuitous path of self-punishment in taking revenge on the original object. And in tormenting the loved person through his illness used with the purpose of avoiding the need to express his hostility to him openly.

According to Freud (1915), is this process of identification on the ambivalent grounds, opening the door to self-tormenting in melancholia that solves the riddle of the tendency to suicide in this condition. In melancholia, the ego can consent to its own destruction, can kill itself because the murderous impulses derived from the hostility related to the abandoned object return to the ego, and the ego can treat itself as the object (p. 261).

Thus for Freud are three preconditions of melancholia, namely, loss of the loved object ambivalence in relation to this object and regression of libido into the ego (p. 267)

Some Remarks

Thus, from this strong and effective argument given by Freud to account for suicide in melancholia, we can effectively call Szasz's criticism into question in so far as Freud shows in this essay that it is psychological basis, namely, the

loss of the loved object, ambivalence in relation to this object, and regression of libido into the ego that underlies melancholia. Also, we can effectively call the argument given by Fulford, namely, the failure of intention in mental illness, into question since Freud's argument implies the presence of an unconscious intention of own destruction by the ego in melancholia rather than the failure of intention. In other words whereas Fulford's argument is circumscribed to consciousness as Freud shows it is an unconscious intention which takes place and underlies suicide in mental disorders like melancholia.

Then, for Freud (1915), whereas mourning implies the ego to give up the lost object by declaring this object to be dead and offering to the ego inducement of continuing to live, in melancholia the ego tries to give up the abandoned object by isolated struggles of ambivalence with this object disparaging it, denigrating it and even killing it (suicide) (p. 267).

Melancholia comprises evaluations. The melancholic's experience of suffering is derived from his evaluation of his experiences and also melancholia shows disagreement of melancholic's evaluation with the "expected" from normal individuals' before the same experiences. However, the presence of evaluation does not mean that mental illness is not a reliable nor valid concept as claimed by anti-psychiatrists like Szasz because as we can forcefully see in the account of melancholia given by Freud, the presence of evaluation in melancholia is not what really matters in this picture. To understand melancholia from the presence of evaluation is to miss out the core of this picture shown vigorously by Freud. Still, to understand melancholia in terms of failure of intention as advocated by Fulford to deal with Szasz's criticism is to miss out the core of melancholia suggested by Freud as well. Rather, following Freud (1915) in this essay we can say that what really allows us to establish a psychiatric picture as melancholia is the following preconditions already emphasized- loss of the loved object, ambivalence to this object and regression of libido into the ego (p. 267).

In other words, the core of Freud's account of melancholia lies in the requirement of these preconditions, in the clinical implications placed by these preconditions. Therefore, the account of melancholia given by Freud becomes unjustifiable not provide psychiatric treatment for melancholic individuals on the grounds that mental illness does not exist in medical sense as claimed by Szasz. To do that it would be negligence as advocated by Fulford (1989).

In other words it is not ethical not treat individuals who complain to be suffering from mental illness on the grounds that matters which comprise evaluation are not valid and do not constitute medical concern. Thus, any attempt of denying psychiatric medical attention for those who are mentally ill may be regarded as "repellent" (Wing 1978).

References

- ALMOND, B. (Org.). *Introducing applied ethics*. London: Blackwell, 1995.
- BURGESS, S.; HAWTON, K. Suicide, euthanasia and the psychiatrist. *Philosophy, Psychiatry and Psychology*, Baltimore, Maryland, v. 5, n. 2, p. 113-126, 1998.
- COOPER, D. *Psychiatry and anti-psychiatry*. New York: Ballantine, 1971.
- EYSENCK, H.J. Classifications and the problem of diagnosis. In: EYSENCK, H.J. (Org.). *Handbook of Abnormal Psychology*. London: Pitman Medical, 1960.
- FOUCAULT, M. *Madness and civilization*. New York: Vintage, 1965.
- _____. *The birth of the clinic: An archaeology of medical perception*. New York: Vintage, 1975.
- FREUD, S. (1915). Mourning and melancholia. In: *S.E.* London: The Hogarth Press, 1961.
- _____. (1923). The ego and the id. In: *S.E.* London: The Hogarth Press, 1961.
- FULFORD, K.W.M. *Moral theory and medical practice*. Cambridge: Cambridge University Press, 1989.
- _____. Psychiatry, compulsory treatment and the value based model of mental illness. In: Almond. B. (ed.). *Introducing Applied Ethics*. Oxford: Blackwell, 1995.
- _____. Chapter 9. In: BLOCH, S.; CHODOFF, P.; GREEN, S. (Orgs.). *Psychiatric ethics*. Oxford: Oxford University Press, 1999.
- FULFORD, K.W.; DICKENSON, D. *In two minds: A casebook of psychiatric ethics*. Oxford: Oxford University Press, 2001.
- GLOVER, J. *Causing death and saving lives*. 2. ed. Harmondsworth: Penguin Books, 1977.
- GUZE, S.; ROBINS, E. Suicide and primary affective disorders, *British Journal of Psychiatry*, London, v. 117, p. 437-38, 1970.
- HEID, D.; BLOCH, S. The ethics of suicide. In: BLOCH, S.; CHODOFF, P. (Orgs.). *Psychiatric ethics*. 2nd edition. Oxford: Oxford University Press, 1991.
- JOCHENSEN, H. Euthanasia in Holland: an ethical critique of the new law. *Journal of Medical Ethics*, London, v. 20, n. 4, p. 212-217, 1994.
- LAING, R. D. *The politics of experience*. Harmandsworth: Penguin, 1967.
- ROTH, M. Schizophrenia and the theories of Thomas Szasz. *British Journal of Psychiatry*, London, v. 129, p. 317-326, 1976.
- SCHIEFF, F. J. *Being mentally ill: A sociological theory*. Chicago: Aldine, 1966.
- _____. Accountability in psychiatry diagnosis: A proposal. In: MILLON, F.; KLIERMAN,

G. (Orgs.). *Contemporary directions in psychopathology: towards the DSM-I*. New York: Guilford, 1986.

_____. Schizophrenia as ideology. *Schizophrenia Bulletin*, Oxford, v. 2, p. 15-19, 1970.

SCHNEIDER, K. Systematic psychiatry. *American Journal of Psychiatry*, Arlington, v. 107, p. 334-335, 1950.

SZASZ, T. S. *The myth of mental illness*. New York: Hoeber-Harper, 1961.

_____. Mental illness as a metaphor. *Nature*, New York, v. 242, p. 305-7, 1970.

_____. The concept of mental illness: explanation or justification? In: ENGELHARD, T., H.F.; SPICKER, S.E. (Orgs.). *Mental health: philosophical perspectives*. Boston: D. Rendel, 1978.

_____. The case against suicide prevention. *American Psychologist*, Washington, n. 41, p. 806-812, 1986.

_____. Crazy talk: Thought disorder or psychiatric arrogance? *British Journal of Medical Psychology*, London, n. 66, p. 61-67, 1993.

WING, J. K. *Reasoning about madness*. Oxford: Oxford University Press, 1978.

(Suicídio na antipsiquiatria e na psicanálise)

Na psiquiatria os critérios pelos quais a necessidade de atenção médica psiquiátrica é avaliada são passíveis de discordância permitindo que se mantenha o grande debate acerca da validade do conceito de doença mental. Enquanto anti-psiquiatras como por exemplo Szasz (1961) argumenta contra a prevenção de suicídio, Freud (1915) oferece uma leitura da melancolia que justifica intervenção psiquiátrica em indivíduos suicidas. Nesse artigo, eu examino esses argumentos e argumento que a leitura da melancolia sugerida por Freud questiona efetivamente a crítica feita por Szasz.

Palavras-chave: Szasz, Freud, melancolia, suicídio

(Suicidio en anti-psiquiatria y en psicoanálisis)

En psiquiatria los criterios por los cuales la necesidad de atención médica psiquiátrica es evaluada son pasibles de discordancia permitiendo que se mantenga el gran debate acerca de la validez del concepto de enfermedad mental. El tiempo que anti-psiquiatras, como por ejemplo Szasz (1961), argumentan contra la prevención del suicidio, Freud (1915) ofrece una lectura de la melancolía que justifica la intervención

psiquiátrica en individuos suicidas. En este artículo examino esos argumentos y argumento que la lectura de la melancolía sugerida por Freud cuestiona efectivamente la crítica hecha por Szasz.

Palabras claves: Szasz, Freud, melancolía, suicidio

(Le suicide dans l'anti-psychiatrie et dans la psychanalyse)

Dans la psychiatrie, les critères d'après lesquels la nécessité d'attention médicale psychiatrique est évaluée font objet de désaccord, tout en permettant que se maintienne le grand débat concernant la validité du concept de maladie mentale. Si des anti-psychiatres, comme par exemple Szasz (1961), font valoir contre la prévention du suicide, Freud (1915), par contre, offre une lecture de la mélancolie qui justifie de l'intervention psychiatrique envers les suicidaires. Dans cet article, j'examine ces raisonnements tout en argumentant que la lecture de la mélancolie suggérée par Freud interroge efficacement la critique proposée par Szasz.

Mots clés: Szasz, Freud, mélancolie, suicide

Versão inicial recebida em maio de 2007

Versão aprovada para publicação em junho de 2008

CRISTIA ROSINEIRI GONÇALVES LOPES CORREA

Psicanalista e Mestre em Filosofia e Ética da Saúde Mental pela University of Warwick (UK)

Av. Olegário Maciel, 1835/317 – Paineiras

36016-011 Juiz de Fora, MG, Brasil

Fone: (32) 3236-9016

e-mail: crlopes2001@yahoo.com.br