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The (un)bearable now: phenomenological reflections on psychological urgency and the overcoming of the biomedical understanding

ARTICLE

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Abstract

The present article aims to discuss the phenomenon of psychological urgency in its existential dimension, considering it not as a mere clinical condition but as an embodied and situated expression of experience in crisis. It departs from the understanding that psychological urgency, traditionally conceived by biomedical models as a critical manifestation of psychic suffering that demands immediate intervention, is often reduced to a set of symptoms and protocols, disregarding its existential complexity. The method consists of a theoretical-phenomenological analysis, grounded in authors such as Merleau-Ponty, Tatossian, and Fuchs, among other contemporary thinkers, articulating concepts such as lived temporality, the lived body, intersubjectivity, and Lebenswelt (the lifeworld). The paper is structured around three axes of discussion: (1) the conditions of possibility of psychological urgency, addressing it as a temporary shift in one's mode of living and inhabiting the everyday world; (2) the displacement from a biomedical understanding to a phenomenological reading of the phenomenon, distinguishing between symptom and phenomenon as central categories in clinical practice; and (3) the ethical and clinical implications of an expanded mode of listening, one that privileges presence and co-responsiveness within the therapeutic encounter. The theoretical findings indicate that psychological urgency cannot be restricted to a pathological or symptom-based event but rather manifests a form of estrangement in the subjective experience of lived time, the body, and the relation to the Other, as well as to the shared world. It is concluded that phenomenological practice can welcome this sudden shift not as something to be contained but as an opening toward care and the reconstruction of meaning. Within this horizon, psychological urgency may be understood as an expression of existential vulnerability and as an opportunity for re-engagement with the world, calling for an ethics of presence and listening.

Keywords: Psychological Urgency; Phenomenology; Biomedical Understanding.

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O agora (in)suportável: reflexões fenomenológicas sobre urgência psicológica e a (necessária) superação da compreensão biomédica

ARTICLE

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Resumo

O presente artigo tem como objetivo discutir sobre o fenômeno da urgência psicológica em sua dimensão existencial, considerando-o não como mera condição clínica, mas como expressão encarnada e situada da experiência em crise. Parte-se da compreensão de que a urgência psicológica, tradicionalmente compreendida por modelos biomédicos como uma manifestação crítica de sofrimento psíquico que demanda intervenção imediata, é frequentemente reduzida a um conjunto de sintomas e protocolos, desconsiderando sua complexidade existencial. O método consiste em uma análise teórico-fenomenológica, baseada em autores como Merleau-Ponty, Tatossian e Fuchs, e outros autores contemporâneos, articulando conceitos como temporalidade vivida, corpo próprio, intersubjetividade e *Lebenswelt* (mundo da vida). O trabalho se estrutura em três eixos de discussão: (1) as condições de possibilidade da urgência psicológica, abordando-a como mudança momentânea no modo de viver e no habitar cotidiano; (2) o deslocamento da compreensão biomédica para uma leitura fenomenológica do fenômeno, distinguindo sintoma e fenômeno como categorias centrais na clínica; e (3) as implicações éticas e clínicas de uma escuta ampliada, que privilegie a presença e a co-responsividade no encontro terapêutico. Os resultados teóricos indicam que a urgência psicológica não se restringe a um evento patológico e sintomatológico, mas manifesta um estranhamento no modo de vivência subjetiva do tempo vivido, do corpo e da relação com o Outro, bem como do mundo compartilhado. Conclui-se que a clínica fenomenológica pode acolher essa mudança repentina, não como algo a ser contido, mas como abertura para o cuidado e para a reconstrução de sentido. A urgência psicológica, neste horizonte, pode ser compreendida como expressão da vulnerabilidade existencial e como oportunidade de reabertura ao mundo, exigindo uma ética da presença e da escuta.

Palavras-chave: Urgência Psicológica; Fenomenologia; Compreensão biomédica.

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Introduction[1]

Psychological or psychiatric urgency is often understood as an intense manifestation of psychic suffering that requires immediate intervention (Sorte et al., 2020; Goretti et al., 2023; Carvalho et al., 2025). In view of the absence of a clearly delimited consensus regarding the nomenclatures and definitions of psychological urgency, this article proposes to reflect on this phenomenon and its implications for modes of care. Although functional within the medical clinical context, this conception is often anchored in a restricted perspective, based on objective and operational criteria, strongly influenced by the traditional medical and psychiatric model (Goretti et al., 2023). It is generally presented as linked to physical manifestations or previously defined symptoms, such as fear, anxiety, and emotional destabilization. Within this logic, psychological urgency tends to be associated with concepts that approximate crises and emergencies, as well as severe diagnostic conditions or behaviors that indicate imminent risk, such as suicide, self-harm, or heteroaggressiveness (Carvalho et al., 2025), although the structures of temporality and spatiality are altered in all these conditions, the mode of this alteration varies according to the clinical condition.

Departing from these assumptions, we ask ourselves whether it would be possible to think psychological urgency beyond its clinical and medicalizing markers. Are we reducing a singular and complex lived experience to a merely

[1] **Translator's Note:** This translation was produced with the assistance of artificial intelligence, specifically ChatGPT, model GPT-5.5 Thinking, developed by OpenAI. The model belongs to the family of large language models and features advanced natural language understanding and generation capabilities, with particular proficiency in academic, technical, and humanistic registers across multiple languages.
The translation was carried out from Brazilian Portuguese into English, following a section-by-section methodology, with systematic review of terminological consistency, preservation of the author's stylistic choices, and faithful rendering of the conceptual vocabulary proper to clinical phenomenology and existential psychopathology. Every effort was made to neither omit nor add ideas to the original text, respecting as closely as possible its argumentative organization, linguistic style, and conceptual density.
All quotations incorporated into the body of the text were translated directly from the version of the article provided for this activity, without independent consultation of source texts or alternative editions of the cited works.
The AI-assisted translation was conducted on May 25, 2026, and supervised by Fábio Luiz Socreppa da Fonseca. The translated version may subsequently be submitted to the author for review, consideration, and approval on June 02, 2026.
Readers are advised to consider that, while every effort has been made to ensure accuracy and fidelity to the original text, AI-assisted translations may present limitations in capturing expressions that are highly context-dependent, stylistic nuances, or culturally situated meanings. Any queries regarding the translation may be directed to the supervisor.

symptomatological reading? How can phenomenology contribute to a more sensitive and expanded understanding and listening to this experience? These questions invite us to rethink modes of listening and intervention, broadening the understanding of psychological urgency beyond a technical or medicalized response, recognizing it also as a human appeal for recognition and meaning, regardless of the context or clinical situation.

The very notion of "urgency" in mental health is marked by conceptual inconsistencies, especially when compared to related terms such as psychiatric emergency or emotional crisis (Sen, 2020). The literature indicates that these terms are frequently used interchangeably, without clarity regarding the criteria that distinguish or approximate them (Holanda, 2023; Carvalho et al., 2025). In view of this polysemy and of the growing centrality that psychological urgency occupies in mental health services, we propose here a phenomenological reflection on the notion of psychological urgency, seeking to understand it beyond the markers grounded in biomedical practice and to think it from the notion of phenomenon, as an experience that occurs in the ordinary course of life, but that may mobilize the person in their habitual lived experience when faced with the unexpected.

Etymologically, the word "urgency" derives from the Latin *urgentia*, formed from the verb *urgēre*, which means "to press," "to push," or "to urge," indicating something that cannot be postponed, that needs to be "resolved" as quickly as possible. The suffix *-ia* indicates a condition, such that *urgentia* may be understood as the condition or state of something that requires immediate or insistent action (Harper & Douglas, 2024), strengthening the idea of a temporality directed specifically toward the present, toward that which "urges," that which belongs to the "right now." We observe that the etymology of the term reveals a direct connection with time, since psychological urgency is intrinsically linked to the idea of something that demands immediate attention, without postponement. We understand that this notion of temporal pressure reflects the perception that urgent situations exceed the ordinary, configuring the need for rapid and decisive action. Thus, the concept or idea of urgency synthesizes a condensed temporal movement, compressed or even suffocated or unbearable, as indicated in the title of this presentation, in which the present becomes a critical space for resolving or attending to what is considered priority and inevitable (O'Dwyer, 2010; Silva et al., 2025; Carvalho et al., 2025).

In the present study, we situate ourselves within the field of clinical phenomenology, especially in its clinical strand, understanding the experience of psychological urgency as an expression of the mode of being-in-the-world in crisis. We draw on authors such as Merleau-Ponty, Tatossian, and Fuchs, who make it possible to think the phenomenon of urgency in its bodily, temporal, and intersubjective dimension, emphasizing the inseparability between subject, body, and world. This theoretical-methodological choice delineates the horizon of a phenomenological clinic, in which listening is directed toward that which manifests itself in lived experience, and not toward diagnostic categorization.

From this framework, we propose to develop a reflection on the notion of psychological urgency, understanding it as a possible discontinuity in lived temporality within habituality, seeking above all to displace its understanding from a merely biomedical, symptomatological, and medicalizing perspective in order to approach it as an existential and situated expression of human experience, a phenomenon that may suffocate and be lived in the present, making everyday continuity unbearable and unsustainable.

The work is organized around three axes: (1) the conditions of possibility of psychological urgency, addressing it as a temporary shift in one's mode of living and inhabiting the everyday world; (2) the displacement from a biomedical understanding to a phenomenological reading of the phenomenon; and (3) the ethical and clinical implications of an expanded mode of listening, one that privileges presence and co-responsiveness within the therapeutic encounter.

Conditions of Possibility in Psychological Urgency

We may say, first, on the basis of the etymology of the word, that one of the fundamental dimensions we indicate as a path for understanding urgency is the phenomenological notion of lived time. The experience of time is not reduced to an objective chronological sequence, past, present, and future, as it is commonly approached by scientific rationality and by traditional clinical models (Merleau-Ponty, 1945/2006; Souza & Moreira, 2020). Rather, it is a subjective temporal lived experience, traversed by the concrete existence of the person in their world. In Merleau-Ponty (1945/2006), time is not something external to the subject, but something lived from the body, permeated by memory, expectation, and affectivity. It

is an embodied experience of time, and not an abstract counting of minutes and hours, as the author states:

> Time is not a line, but a network of intentionalities. [...] The past is not past, nor is the future future. They exist only when a subjectivity comes to break the plenitude of being in itself, to draw a perspective there, to introduce non-being into it. A past and a future spring forth when I extend myself toward them. (pp. 554–558)

In psychological urgency, this lived temporality seems to become estranged or to become unexpectedly disorganized: the past may weigh as an unbearable burden, the future may close itself off as a horizon, and the present may condense into a feeling of paralysis, anguish, or despair. Time, which normally flows in a more or less stable rhythm within the habituality of life (Merleau-Ponty, 1945/2006), may become dense, suspended, or fragmented in this experience. The person in a situation of psychological urgency may not only suffer, but suffer within a time that has lost its habitual contour and, perhaps precisely for this reason, does not easily find words to express what they feel. In this sense, we understand that phenomenological listening and understanding of this phenomenon, by recognizing this temporal dimension of experience, open a space for welcoming not only *what* is being lived, but also *how* this lived experience takes place within a time that escapes linear logic and that demands a careful presence, attuned to the rhythm of suffering.

When the mode of inhabiting this time changes radically or unexpectedly, the subject may lose the coordinates that allow them to orient themselves in existence. This discontinuity in the mode of living habituality may then interfere with the capacity to recognize affective bonds, to maintain existential commitments, and to sustain a coherent narrative of oneself over time. Identity, which is built and reaffirmed in the temporal articulation between what we were, what we are, and what we project ourselves to be, may lose its consistency (Macedo & Silveira, 2012).

Phenomenological listening and understanding of psychological urgency are therefore grounded in the recognition that human experience is, at the same time, temporal and embodied (Moreira et al., 2025), that is, traversed by the lived body and rooted in an existential temporality (Merleau-Ponty, 1945/2006). This starting point implies considering that suffering does not manifest itself only in isolated contents or symptoms, as we have previously indicated, and that, from this perspective, the clinician is called to listen not only to what is lived by the subject in a pragmatic and factual way, but, above all, to how this lived experience becomes

(dis)organized in the flow of time and habituality.

In contexts of intense suffering, temporal experience may detach itself from habitual linearity, from chronological succession, and from the predictability that structures everyday life, giving way to a lived experience marked by ruptures, suspensions, or accelerations. Fuchs (2001, 2020) deepens this understanding by describing phenomena of temporal desynchronization between the subject and the world, in which lived time loses its connection with shared, intersubjective time. In these cases, the subject may perceive themselves as out of step with others and with the world, revealing that temporality is not a neutral background, but a constitutive dimension of existence (Macedo & Silveira, 2012). From this split, Fuchs (2012b; 2020) argues that the very cohesion of the self may be affected, producing a fragmentation of the experience of oneself and of the world, and compromising the continuity of personal identity. Thus, we understand that to comprehend psychological urgency phenomenologically implies understanding the ways in which time may change its lived rhythm within habituality and how, through clinical listening, openings may emerge for the reconstitution of an existential rhythm shared in intersubjectivity.

When this temporal fabric changes its rhythm in some way within habituality, a weakening of symbolization may occur: suffering may become opaque, difficult to name or communicate, and the subject may not even be able to formulate a request for help, not because of a lack of will, but because the conditions that would make such a gesture possible may be shaken. The Other, in this scenario, may appear as a distant, incomprehensible, or inaccessible presence, which further deepens the lived experience of isolation (Bloc et al., 2016). Thus, psychological urgency would not be merely a moment of intense suffering, but a possible crisis in the very structure that sustains experience. Time, language, the relation with the Other and with oneself enter into suspension, demanding a mode of listening that goes beyond the logic of immediate resolution and opens itself to the complexity of the lived experience (Souza et al., 2020).

The destructuring of the mode of inhabiting habitual time in psychological urgency is not restricted to the temporal dimension of experience, but reverberates upon the way the subject inhabits space, lives their own body, and relates to Others. It is a disturbance of the mode of being-in-the-world, in which the fabric of existence

loses its cohesion. As Merleau-Ponty (1945/2006) observes, time, body, and space are not separate domains, but interconnected dimensions of presence in the world; when one of them breaks, the entire perceptual and affective field is transformed. Moreira et al. (2025) point out that “the human being is rooted in the world” (p. 371), and further note, recalling that we are “immersed in what lies beyond us, beginning with space and time” (p. 371).

Space, previously familiar, organized, and predictable, begins to appear threatening, displaced, oppressive, or, at certain moments, completely empty. Everyday environments become difficult to endure, and even the home may cease to offer a symbolic shelter. This sensation may emerge in the face of various unexpected and destabilizing situations of habitual experience, such as sudden losses, changes of employment, family conflicts, receiving difficult news, delicate diagnoses, hospitalizations, or important moments of decision. The world, in this state, is no longer the one in which the subject moves with spontaneity and fluidity, but may be transformed into a field charged with estrangement and insecurity. It is understood that space is that in which the subject implicates themselves, develops, and projects themselves (Chamond, 2011). In psychological urgency, it may be understood that this projection may be affected or even weakened.

The body, in turn, which is our point of anchorage in the world and the basis of our perceptual and affective experience (Merleau-Ponty, 1945/2006; Souza et al., 2020; Moreira & Bloc, 2021), in situations that may mobilize an experience demanding urgent care, may be lived as strange, heavy, dysfunctional, or even anesthetized. This loss of the body’s naturalness, that which we normally do not notice because it functions as the transparent medium of our action in the world, reveals how essential corporeality is to our constitution as subjects. When the body becomes an object of suffering or alienation, it ceases to be a medium and becomes an obstacle, amplifying the sense of disconnection from the surroundings. Gestures, once automatic or full of intention, become hesitant or directionless; language becomes impoverished or fragmented; contact with the other becomes distant, opaque, or even impossible (Feijoo & Lessa, 2019).

Intersubjective experience also undergoes alterations in situations of urgency. The subject may perceive themselves as disconnected from the network of shared meanings, as if exiled from a world to which they no longer belong. This may occur in

more acute situations such as anxiety or panic crises, which also demand immediate care (Cerqueira & Nardi, 2010; Costa et al., 2019). Words may seem insufficient to express what is being lived, and the feeling of not being understood, or of there being no one who understands, intensifies the sense of isolation. In many cases, the Other, who could be a possibility of support, appears as someone distant, inaccessible, or even threatening.

Based on these observations, we understand that psychological urgency may be comprehended as a crisis in the *Lebenswelt*, this pre-reflective "ground" where everyday experience gains cohesion and intelligibility (Tatossian & Moreira, 2012). When this field becomes destabilized, the subject may experience a fundamental imbalance in their way of being-in-the-world. It is not, therefore, an isolated crisis or an episodic event, but an abrupt experience of change in the mode of being-in-the-world that traverses fundamental dimensions of existence: time, space, body, and alterity.

This phenomenological reading helps us to reach an idea of displacing the notion of urgency from a purely clinical perspective, in a medical sense, or diagnostic perspective, toward an understanding that privileges lived experience situated in the world. It is a matter of considering the singularity of suffering and the way it is inscribed in the body and in the world. Thus, psychological urgency is not something the subject "has," but something they "live" at that instant: a being in crisis, unsheltered from their world, suspended in time, and in search of support.

The (Necessary) Displacement of the Biomedical Understanding of Psychological Urgency: From the Clinical to Existence

More than an objectifiable clinical state, we suggest here that psychological urgency may be understood as a possible change in the mode of inhabiting time, a disorganization in the fabric of the *Lebenswelt*, the lifeworld, which, according to Tatossian and Moreira (2012), presents itself as it is lived in an everyday, pre-reflective, and shared manner. Inspired by existential phenomenology, especially by the work of Maurice Merleau-Ponty (1945/2006), we seek here to displace the focus from psychological urgency as a symptomatic event in order to think it as the expression of a mode of being-in-the-world, or of living habituality.

In other words, we situate psychological urgency as that which emerges when

the structure of everyday experience is abruptly shaken, rupturing the sense of continuity and predictability of habitual life. In this context, the subject finds themselves seized by a state of estrangement in the face of a sudden situation of suffering, which may range from the unexpected loss of a loved one to significant changes, such as changing jobs, cities, or schools. Psychopathological aspects must also be considered, such as anxiety crises, manic episodes, suicidal ideations or behaviors, among others (Costa et al., 2019; Goretti et al., 2023; Carvalho et al., 2025). Urgency, as the expression of a mode of inhabiting the world, may manifest itself both in apparently ordinary situations and in experiences marked by greater complexity.

As we turn to this distinction, we propose a theoretical and clinical displacement: to move away from a purely symptomatological reading of psychological urgency, generally understood as a set of signs to be categorized and managed, in order to conceive it as a phenomenon that traverses existence in a singular, situational, and embodied way within the subject's everyday life. "The notions of symptom and phenomenon occupy a central place in the tradition of phenomenological psychopathology" (Bloc & Moreira, 2013, p. 28), constituting fundamental categories for the understanding of psychic suffering from the standpoint of lived experience.

Tatossian (2006), as analyzed by Bloc and Moreira (2013), proposes a fundamental distinction between symptom and phenomenon, which proves decisive for guiding clinical practice beyond the strict reading of visible, quantifiable, or operationalizable signs. This differentiation invites the clinician to shift the focus from the mere identification of dysfunctions toward a deeper immersion in lived experience in its complexity and totality. The symptom, in this context, functions as an indication that something has broken or become disorganized in the subject's habitual mode of being.

When clinical understanding remains restricted to the symptom, there is a risk of producing a fixation that imprisons the subject within rigid diagnostic categories, obscuring their singular experience and reducing their possibilities of meaning. Such a framework tends to reinforce forms of heteronomy, insofar as the subject comes to be understood predominantly through external determinations, to the detriment of their own capacity for signification and response. Only when we open ourselves to the

phenomenological dimension of experience does it become possible to glimpse the emergence of subjective freedom, not as an abstract ideal, but as a concrete possibility of recognizing oneself and responding to the appeal of the present, amid the tension between autonomy and heteronomy (Moreira & Bloc, 2013).

This distinction becomes especially crucial in the context of psychological urgency, in which the risk of a reductionist approach traversed by biomedical discourse is even greater. To think the phenomenon implies understanding it not only as the manifestation of a symptom, but as the expression of a global mode of being that emerges in the clinical situation, a mode of existing that reveals itself singularly in the experience of urgency and that calls the gaze of the one who listens beyond diagnostic logic.

If we limit ourselves to biomedical logic and focus exclusively on symptoms, we tend to act under the paradigm of containment, stabilization, or control (Gama & Martins, 2012; Bloc & Moreira, 2013). In contrast, when we welcome the phenomenon, we begin to listen to the subtle ways in which the subject becomes estranged from their own paths (Feijoo, 2023; Feijoo & Bloc, 2024), their temporality, and their body, allowing experiences of change in habituality, discontinuity, or displacement to be expressed.

This movement is coherent with the very phenomenological proposal of moving away from objectifying and symptomatological explanations, opening space for a mode of listening that privileges the meaning of lived experience (Cury & Fedda, 2020), in its temporal, affective, and intersubjective density, as discussed in the works of Tatossian and Moreira (2012) and Moreira and Bloc (2013). The distinction between symptom and phenomenon, in this context, is not merely terminological; it marks the insertion of phenomenology into the field of psychopathology as a path for the construction and delimitation of a clinical model that is sustained upon and within experience (Moreira & Bloc, 2013).

In the context of the present research, phenomenological psychopathology presents itself as a fundamental path for understanding psychological urgency not only as a symptomatic manifestation, but as an existential phenomenon that reveals singular modes of being and suffering in the world. This perspective makes it possible to shift the focus from the identification of clinical conditions to the understanding of the subject's lived experience in its totality, just as it manifests itself in the situation

of urgency. As Messas et al. (2018) emphasize, phenomenological psychopathology offers a comprehensive map of the subject's lived world, making it possible to understand how suffering is organized and expressed in each particular mode of existing. It is, therefore, a change of perspective that not only redefines the object of clinical practice, from an entity to be corrected to an experience to be understood, but also reformulates the place of the clinician, who moves from evaluating technician to witness of the other's lived world.

Thus, when we understand psychological urgency as a phenomenon, we move away from an approach centered exclusively on the containment of symptoms toward a more careful attention to the existential situation in which the subject is immersed. It is a state marked by ruptures in the lived experience of habituality and by significant transformations in the experience of time, body, space, and relations with the Other. The phenomenological perspective not only reconfigures the way we listen to suffering, but also broadens the possibilities of intervention, inviting the clinician to welcome the subject's lived experience in its complexity and singularity (Feijoo, 2023; Feijoo & Bloc, 2024).

Clinical practice, within this horizon, becomes an ethical, sensitive, and situated space, where suffering is not reduced to a pathological datum to be eliminated, but recognized as the expression of a crisis that carries meaning and demands understanding (Tatossian, 2006; Fuchs, 2018; Moreira & Bloc, 2021). In this context, to intervene is not to impose normalization, but to open breaches through which the subject may reconstitute, even if in different ways, their relation to the world and to themselves (Feijoo, 2023). It is this listening that transforms urgency into possibility: not the possibility of immediate solution, but of encounter and reconstruction of meaning. Thus, shifting the gaze from symptom to phenomenon is also shifting care: from the urgency to contain to the urgency to understand; from the logic of normalization to the ethics of presence.

Ethical and Clinical Implications for an Expanded and Phenomenological Listening in Psychological Urgency

A phenomenological understanding calls us to a more sensitive and implicated clinical listening, less guided by rigid protocols and more committed to the singularity of lived experience (Dutra, 2020; Feijoo, 2023; Feijoo & Bloc, 2024). Far from

reducing urgency to a critical event to be contained or neutralized, this perspective invites us to consider that the subject in crisis is traversing a profound estrangement, an affective and existential discontinuity that disorganizes their habitual references and their mode of being in the world. Recognizing this condition implies an ethical and clinical challenge: that of welcoming pain without immediately translating it into diagnostic categories or normative responses, but offering the subject something more fundamental: presence, listening, support, and recognition.

The phenomenological clinical perspective invites us to profoundly rethink the very concept of care in clinical practice (Bloc & Moreira, 2013; Messas et al., 2018; Stanghellini, 2018). Rather than limiting itself to risk management or to the stabilization of symptomatic manifestations, care comes to be understood as an ethical openness to suffering (Melo, 2019), a gesture that aims to create conditions so that lived experience, often disorganized or without language, may gain form, expression, and recognition (Moreira et al., 2025). To care, within this horizon, is to sustain a space in which subjective fragmentation may find some possibility of cohesion, in which the subject may reconstruct their bond with the world (Melo, 2019; Feijoo, 2023).

Ethics in clinical care, according to Martins (1989), must be understood as a dimension of the disposition of the human world, that is, as the availability to welcome the other, instituting within the encounter a movement that enables intersubjective experience to gain meaning. In this same direction, Melo (2019) emphasizes that the encounter of care must be marked by implication, understood as an ethical and affective commitment to the other. Drawing inspiration from Merleau-Ponty's phenomenology of ambiguity, the author understands care as a clinical gesture, "as a mode of being with the subject in the world, of being available for dialogue" (p. 223).

Clinical care as gesture (Melo, 2019) thus becomes a practice of restitution: restitution of the continuity of lived time, of the thickness and density of experience, of the dignity of the subject in a situation of suffering. It is a care that takes place in the dialogical and relational encounter (Stanghellini, 2018), not oriented by the immediate search for a solution, but by the attentive listening to an existence that cries out for meaning, not a logical, explanatory, or interpretative meaning, but an existential meaning, understood as the possibility of reorientation, of reinscription in

the flow of life (Dutra, 2020; Feijoo, 2023).

All signification is intimately linked to lived time and lived space (Moreira & Bloc, 2012). This statement reinforces the idea that suffering is not something to be corrected from the outside in, but an expression situated within a given temporal and spatial configuration of existence. Therefore, to care is also to accompany the subject in their existential reconstruction and to make possible, within the clinical encounter, an expanded gaze, without giving a single contour to this experience (Melo, 2019), in the rescue of a habitable spatiality, and in the resumption, even if fragile and provisional, of their capacity to signify their own living.

Merleau-Ponty (1945/2006) presents an understanding of experience grounded in the coexistence of multiple contours, perceptual, bodily, and situational, in which the phenomenon always reveals itself in an unfinished way and at different levels of meaning. In the field of health care, as stated by Melo (2019), accentuating a single contour of an experience, here we refer specifically to psychological urgency, means "to reduce and deprive the phenomenon of an identity, since accentuating only one would mean abandoning its depth" (p. 217). In the clinical setting, Moreira et al. (2025) state that this work "requires, incites recognition as an attestation of singularity, going far beyond identities and diagnoses. Recognition shows itself as an attitude, as a movement so that the patient themselves may recognize themselves in a situated way within their world" (p. 371). In this sense, we may observe that phenomenological clinical attitudes in care provided in diverse contexts, or here, in the situation of psychological urgency, make possible a gaze that sees phenomena beyond the visible.

It is within this horizon that phenomenology reveals itself as a powerful conceptual and practical tool for rethinking the clinic of psychological urgency. Rather than approaching suffering only on its behavioral surface, it allows access to it in its existential density, as the expression of a mode of being in crisis, which is not reduced to a failure, but carries within itself a possibility of reconfiguration (Feijoo, 2023), understood in its multiple contours. Thus, phenomenological clinical practice does not seek to suppress suffering, but to sustain its crossing, placing its wager on the transformative power of listening and on the reopening of the lived world through the encounter with the other (Moreira & Bloc, 2021).

This discussion enters into dialogue with the phenomenological perspective of

intersubjectivity, according to which the presence of the Other is not merely an external datum or an additional element to individual experience, but a constitutive condition of existence itself in the world (Merleau-Ponty, 1945/2006; 1964). The Other is, at the same time, limit and possibility: they reveal aspects of reality that are not accessible in pure interiority, and it is precisely through this relation that the world becomes shared, habitable, and significant (Merleau-Ponty, 1964; Barata, 2008).

When extreme suffering invades existence and compromises the capacity to symbolize, narrate, and communicate, there is also a possible fracture in this fundamental dimension: the bond with the Other becomes weakened, and the experience of the world loses its quality of being shared. The subject may come to inhabit a disconnected, solitary world, in which time, body, and space become strange or inaccessible.

Faced with this disarticulation, the ethical dimension of clinical intervention emerges. Intense suffering calls the other, the clinician, the caregiver, the companion, to an ethical response that goes beyond any technical knowledge or institutional normativity (Melo, 2019; Dutra, 2020; Feijoo & Bloc, 2024). In this sense, we understand that ethics does not originate in prior moral systems, but in the concrete encounter with the face of the Other, which interpellates, destabilizes, and demands a response. This ethical call precedes all objectification or categorization; it is prior to diagnosis, technique, and interpretation (Dutra, 2020). The face of the Other is, in itself, language and vulnerability, presence and demand (Souza & Moreira, 2019). Recognizing this radical alterity is the first step for care to take place as living presence, and not as the application of protocols.

Tatossian (2006) deepens this perspective by affirming that every phenomenological approach to suffering must be traversed by a fundamental ethical attitude. The clinician, within this horizon, is not someone who “applies” a model or interprets signs, but someone who opens themselves radically to the alterity of the other, welcoming the lived phenomenon in its own expressiveness, without reducing it to prior categories. This phenomenological ethics is not anchored in cultural imperatives, but springs from the inner disposition to listen and to be-with, a listening that recognizes crisis not as noise, but as the singular language of existence in collapse or in transition. The clinical attitude proposed here is, above all, a posture of presence, sustained by respect, affectation, and availability to not-knowing.

In this direction, Fuchs (2018; 2020) broadens the discussion by situating ethics within the very dynamics of intercorporeality and shared temporality. Care, for him, is not a technique to be applied to the other, but a mode of being-with, a sensitive presence that attunes itself to the rhythm of another's suffering. It is an embodied responsiveness, in which the clinician allows themselves to be affected, adjusting their listening, their gestures, and their temporality to the one who suffers (Souza & Moreira, 2019). This intertwining does not aim to "cure" immediately, but to open a space where the world, temporarily lost or suspended, may begin to reorganize itself. From this perspective, phenomenological clinical ethics is realized as co-responsiveness: a continuous act of attuning oneself to the other, of sustaining co-presence even when meaning seems absent (Dutra, 2020). This corroborates Melo's (2019) idea when she states that "to care implies presence, support, recognition, and interpellation of this triad: demand, need, and offer" (p. 224).

In contexts of psychological urgency, this ethical listening of care acquires evident potency. Rather than seeking to rapidly restore a supposed normality or to reintroduce the subject into an expected functioning, it is a matter of remaining with the other in their existential vulnerability, recognizing and welcoming the singular ways in which time, body, and world become (dis)organized in their experience. The ethical clinical gesture, therefore, is not limited to a punctual intervention, but is expressed in the disposition to sustain presence, even when there are no clear answers or defined paths (Feijoo & Lessa, 2019). It is within this relational, fragile, and uncertain space that something of the bond may be reattached, allowing the continuity of existence, even if fragmentary, to begin to recompose itself, not through protocols, but through the authentic availability of being-with, silently, until the world begins to announce itself again.

Final Considerations

We therefore conclude that psychological urgency should not be reduced to an acute clinical symptom, to a technical category managed by standardized protocols, nor to a medicalizing term emptied of its existential rootedness. To reduce urgency to the operational logic of diagnosis and rapid intervention is to disregard the complexity of the human experience that is expressed there. Psychological urgency may be understood, above all, as an expression of the fragility of being-in-the-world,

of the constitutive vulnerability of embodied existence, or even of a rupture with the mode of living habituality that sustains our everyday life. It is a sudden change that affects lived time, the lived body, existential space, and the relation with the Other, fundamental dimensions that, when disorganized, may produce intense suffering.

By understanding it as this abrupt change, we open space for thinking a clinical practice that goes beyond risk management, symptom control, or mere behavioral stabilization. Instead, we open space for a more humanized and phenomenological approach, situated and contextualized, which recognizes in suffering not only a sign of possible pathology, but, above all, an ethical and existential appeal, a request for meaning that manifests itself at the limit of language and of shareable experience (Cury & Fedda, 2020). It is in the presence of the other that suffering finds the possibility of resignification. The clinical gesture, therefore, is not an intervention upon the subject, but a cohabitation of the lived experience that makes it communicable once again. Urgent suffering, within this horizon, demands not only action, but also presence; not only techniques, but also listening; not only forms of knowledge, but also affective and ethical availability.

Phenomenology thus offers us a fertile ground for thinking psychological urgency as a relational, historical, embodied, and ethical phenomenon, an experience that does not occur in a vacuum, but within the heart of an intersubjective world, marked by sociocultural contexts, affective bonds, and singular life histories. This invites us to abandon the haste for explanations or classifications and to sustain, instead, a deep, patient, and respectful listening to lived experience. Within this horizon, clinical practice becomes less a space of correction and more a place of encounter and reconstruction, where time may gradually begin to flow again, where speech may reappear, and where the world, shattered by collapse, may gradually begin to make sense once more. It is a matter of restoring trust in the flow of life, even when it seems to have been interrupted, and of recognizing that urgency, far from being only a problem to be solved, may also be a liminal moment of transformation and openness to care.

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