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RESEARCH ARTICLE

# Research advances on intervention in depressive suffering: Direct Approach to the Unconscious Method in a Personal Integration Therapy

**Maria Clara Jost** [1], **Tommy Akira Goto** [2], **Almeida Eunides** [3]

[1] PhD in Psychology. Postdoctoral studies in Psychology and Phenomenological Philosophy by Federal University of Uberlândia – MG-Brazil (UFU). Affiliation with: Renate Jost de Moraes Educational and Research Institute/ Humanistic Integral Health Foundation.
[2] Professor-Doctor of psychology and philosophy. Affiliation with: Federal University of Uberlândia – MG-Brazil (UFU).
[3] PhD in Psychology. Postdoctoral studies in Psychology and Phenomenological Philosophy by Federal University of Uberlândia – MG-Brazil (UFU). Affiliation with: Renate Jost de Moraes Educational and Research Institute/ Humanistic Integral Health Foundation.

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## ABSTRACT

**Background**: Depression is a severe mood disorder with a significant increase after the pandemic. Research and clinical interventions for this disorder are often polarized between biological approaches and those rooted in a biopsychosocial-spiritual framework. This study adopts the latter perspective, aligned with the Direct Approach to the Unconscious Method in a Personal Integration Therapy ~~Method~~, created and developed by Jost de Moraes (1936-2013) since 1970, which presents itself as a practical-theoretical possibility of intervention and change in depressive suffering.

**Aims:** To verify the efficiency and effectiveness of the Direct Approach to the Unconscious Method (ADI) used in clinical psychology through Personal Integration Therapy (TIP) in individuals diagnosed with depression.

**Methods:** This mixed-methods study involved a sample of 341 participants. Data collection occurred in two stages: initial and final stage (10 psychotherapy sessions). The psychotherapeutic process used was the ADI/TIP Method and the Beck Depression Inventory-II was the instrument for collecting quantitative data. These data were analyzed using the Statistical Package for the Social Sciences, the nonparametric Friedman test and the Wilcoxon tests with Bonferroni correction. Fifteen participants were selected for qualitative analysis using the Generic Change Indicators Scale (GCI).

**Results**: All participants (100%) demonstrated improvements, with an average reduction of 80.5% in depression scores and achieved high indicators of change in the qualitative analysis. The discussion was based on the psychological-phenomenological theory.

**Conclusion**: It is expected that the results of this research can contribute to advances in clinical-psychological interventions in depression and it is suggested that research be increased that meets the demands of a science that contemplates the human being in its integrality.

## Introduction

This research aimed to verify the efficiency and effectiveness of the Direct Approach to the Unconscious Method (ADI) used in the psychological clinic by Personal Integration Therapy (TIP) - ADI/TIP Method - in subjects affected by depression, although it addresses the subject from a relatively unexplored perspective. The disease has raised serious concern in society – around 175 million people are affected worldwide –, intensified during and after the SARS-CoV-2 pandemic.[1,2,3,4] Depression is expected to be among the top three most impactful global diseases by 2030. Neuroscience and pharmacology studies have devoted efforts to understand the biophysical mechanisms of the disease,[5,6] but these developments have been insufficient to address its multifactorial, multicultural and phenomenological nature. Research into methods of intervention for the disease is divided between those from a biological and pharmacological perspective – which consider depression to be a strictly biochemical occurrence – and those that distinguish it from the perspective of a psychological suffering that encompasses all human dimensions.[7,2,3] It is also recommended by early[8,9,10] and recent[2,3] studies the combination of drug treatment and psychotherapy.

This research agrees with the latter indication, but emphasizes a "psychonoosomatic" approach[11,12] to psychological suffering, according to studies that point to the interconnection between depression, sociocultural factors, negative events and low self-esteem.[13,14,15] Baztán[16] and Alonso-Fernández[7] delve phenomenologically into this research, considering depression an anthropological phenomenon, configured in different symbolic universes, intertwined by biological, psychosocial and cultural factors. They describe it as a "vital sinking" in which the "vital impulse" is interrupted, marked by feelings of "detachment from life", "emptying of the self", interpersonal and spatial lack of communication and altered perception of time, suffering that is sustained by the patient's distorted cognitions about him/herself. In this context, the authors characterize it as originating from a psychic disorder that permeates the affective sphere and is nested in the somatic dimension.[14]

Despite these studies, there is a lack of research on clinical-psychological interventions that consider a broader approach to the phenomenon and the investigation of the psychological processes through which changes occur. With this objective, Krause *et al.*[17] and Krause *et al.*[19]created the Generic Change Indicators (GCIs), which indicates an ideal sequence of changes common to various psychotherapies with satisfactory results. The GCIs indicate 19 items related to the evolutions of change observed in intra and extra sessions. This allows the analysis of the processes of "therapeutic change",[17,19] defined as the transformation in the "subjective theory" that occurs as a consequence of changes in internal references and the meanings given to symptoms and their correlations.

The items are acceptance of: 1) The problem; 2) The need for help; 3) The help of a professional; 4) Expressing hope; 5) Questioning the usual ways of feeling and acting; 6) Expressing the need for change; 7) Awareness of participation in your problems; 8) Discovering new aspects of yourself; 9) Manifestation of new behaviors and/or emotions; 10) Feelings of competence; 11) New characteristics between aspects of the self, the environment and elements of his or her history; 12) Reconceptualization of problems; 13) Transformation of values and emotions; 14) Formation of new constructs; 15) New constructs grow roots in the subject's history; 16) Autonomous understanding; 17) Recognition of the assistance obtained; 18) Decrease in asymmetry between patient and psychotherapist; 19) Reconstruction and re-reading of one´s history.[17]

Thus, it is clear that intervening in depressive symptoms implies considering the psychic origin and the objective-subjective aspects underlying the disease. Therefore, this research presents the clinical-psychological advances and the practical-theoretical possibilities of intervention and change in depressive suffering, supporting the theoretical discussion on the phenomenological analyses of E. Husserl and E. Stein's Phenomenological Psychology.

The ADI/TIP Method was created and developed by psychologist Jost de Moraes (1936-2013) who began her clinical-psychological research in the 1970s. The author designated this psychotherapeutic process as a method, as it is a procedure with defined steps that allowed the development of a standard in clinical research and its teaching and replication. Likewise, she identified it as an intuitive and descriptive methodology – and not deductive or inductive – that allowed a direct approach to the psychic contents sedimented in the unconscious layer of consciousness (ADI). The word "direct" means without analysis, interpretation, hypnosis, induction or other indirect resources to approach the unconscious psychic contents, enabling the therapeutic diagnosis of primordial psychoaffective experiences and changes in essential layers of subjectivity.

Another distinction concerns the notion of the unconscious. The "unconscious," as described by Jost de Moraes, [11, 12] does not correspond to the Freudian concept. The intuitive descriptions of the participants lived-experiences come close to the circumscription, in the psychic sphere, of the phenomenological unconscious. Husserl[20], when investigating the characteristics of passive syntheses, addresses the theme of the unconscious, describing it as one of the dimensions of apprehension of consciousness, which is not reduced to the reflexive mode. Its content becomes evident when it stands out from the associative synthesis carried out in the flow of intentional consciousness.[21,22]

According to Husserl, there is no separation between the conscious and the unconscious in the sense of distinct spheres or "opposing forces", but a flow of intertwined experiences. For Osswald[21] the separation responds more to a gradual scheme of deepening the psychic contents linked to their affective force. In this regard the phenomenological unconscious is articulated to a first-degree consciousness, or to a primordial, intuitive, passive and pre-reflective "impression" that grasps the whole immediately, and reflective consciousness is a second-degree consciousness, considering that the elements apprehended intuitively can become a subject of

reflection, allowing "the consciousness of the first-degree consciousness that accompanies the lived-experience". [23(p31)] Similarly, the "noological unconscious", as Jost de Moraes calls it,[11,12] is demarcated as everything that circulates in human interiority, linked to events experienced in the external world (psychophysical level) and their respective meanings and senses that occur in the internal world, including the dimension of free positioning of the *I* (psychospiritual level).[24]

This psychotherapeutic process is positioned as an evidence-based practice in psychology (EBPP) defined as a scientifically sustainable psychotherapy[25, 14] according to research carried out in the post-doctorate in psychology (Federal University of Uberlândia -UFU-2018) and philosophy (UFU-2022).[26, 27, 14,15,28,24] Added to these studies are the results of different investigations carried out over 50 years and 195 thousand patients treated (1975 to 2024). Positive quantitative results are of around 85%, including qualitative results with positive improvement in the psychophysical, psychosocial and psychospiritual spheres, with people from different cultures.

A prospective mixed longitudinal study was conducted by UFU-MG, Brazil (as approved by the "Certificate of Appreciation for Ethical Presentation" CAAE: 80587317.2.0000.5152), divided into two parts. The present study presents a section of this broader investigation, focusing on investigating the results of this psychotherapeutic process in the depressive symptomatology. In fulfilling the objectives, the methodological procedures and characteristics of this psychotherapeutic process were described, which was one of the data collection instruments. The results were then analyzed within the framework of phenomenological theory.[14]

## The psychotherapeutic process of the ADI/TIP Method

The Direct Approach to the Unconscious Method used in the psychological clinic by Personal Integration Therapy - ADI/TIP Method - was jointly developed both as a psychological-clinical investigation of psychic contents of the human inner world and as a psychotherapeutic process based on an intuitive and descriptive methodology. The psychic contents addressed are revealed through the perception and description of events "as they present themselves", emerging as internal images akin to "an inner movie", borrowing here the same metaphor used by Stein[31] to describe this potential of Human Person.

Due to its characteristics, this psychotherapeutic methodology enables a prospective and non-regressive intervention, as it starts with the origin of the psychological suffering and continues, together with the patient, to reconfigure the foundational registers identified as incongruent with the Personal *I*. Likewise, it allows for a short-term intervention: composed of 10 to 15 sessions, preceded by a preparatory stage and including therapeutic reinforcement, and achieves a psychotherapeutic intervention with a "psychonoosomatic" scope, a term coined by the author to designate the centrality of the "noological" dimension, as per Franklian terminology.[11,12]

Jost de Moraes, [11, 12] gradually developed specific methodological procedures: "therapeutic questioning", "directional inversion" and the "objectivization of context and content", revealing ways to approach key affective-emotional elements of human inner world. In this context, "therapeutic questioning" follows the proposal of Socratic "maieutics" (470-399 BC) though with distinct adaptations. It is considered that the person can be enabled to encompass the layer of intuitive apprehension of consciousness, which allows the apprehension of lived events, their contents and their meanings, which can be "decoded" always in light of the tripartite structure of the Human Person.[32, 11, 12]

The methodological proposition of "directional inversion" refers to the reversing of the order of approach to psychic elements inscribed in the stream of intentional consciousness, enabling the person to comprehend, through reflective consciousness, psychic and existential content intuitively registered in the unconscious layer. Simultaneously, these tools are employed to identify the essence of meaning embedded in the lived-experience, allowing what is subjectively configured to become objective. The integration of these procedures enables the person to undergo a "Circular Process" composed of a "diagnostic phase", which begins with the visualization, description and objectivization of the event intuitively perceived by the patient. Then, through "therapeutic questioning", the meaning content of each event and its connection to self-judgments is distinguished. Jost de Moraes[11, 12] refers to these as Register-Phrases (FR), which may be congruent with the *I* (positively valued) or incongruent with the *I* (negatively valued). These configurations of meanings are associated with modalities of self-configuration, [32] as they are revealed in the person's attentive movement of "*turning into oneself*" and affirming: *I am*.[11 (p10)]

Judgments are also identified regarding others (hetero-concepts) involved in the highlighted situation, as well as regarding the experienced situations themselves referring to positions taken, even if in a pre-reflective context. Next, there is the "diagnostic-therapeutic phase", aiming to understand the unconscious motivations behind one's own actions and those of other participants in the suffered event; followed by the "therapeutic phase", which seeks to dismantle the web of meaning connections that are incongruent with the *I*, in relation to oneself, others and situations experienced, a moment that Jost de Moraes[11] refers to as "decoding"; and the "phases of 'positivation' and 'verification'", which allow the discovery of events with constructive meaning contents, thus enabling the "closure" of the investigated problem situation and the testing of the outcomes achieved.[28,24]

This methodological procedure enables the emerging of unconscious memory, which differs from other intentional acts such as recollection, imagination and fantasy, a theme described by Husserl[31] when analyzing the demarcations of passive registers of consciousness - the unconscious.[14,15,28] In this process, interpretations and the use of explanatory-causal conscious memories are

avoided, since the patient describes what is experientially perceived in a "presentified" manner.
Although the author engaged in a dialogue with various thinkers along this path, the theoretical formulations and their phenomenological foundation were developed only after the consolidation of Jost de Moraes's empirical-experiential research, as part of a reflective effort to understand the clinical phenomenon that had already been brought to light.[14, 15, 11, 12]

## Methods

PARTICIPANTS

The sample included 341 Brazilian participants, over the age of 18, from different regions of Brazil, with complaints of depressive symptoms, who obtained depression scores without a diagnosis of psychotic disorders or use of non-stabilized psychotropic drugs. The research was observational with sampling by spontaneous demand, that is, participants spontaneously sought treatment using the Direct Approach to the Unconscious Method in a Personal Integration Therapy (ADI/TIP Method) and only between January and May 2024.

However, based on the results obtained, a *post hoc* statistical power analysis was performed, which indicated a power of 100%, evidencing the robustness of the findings for the observed effect.

DATA-COLLECTION

Application of the Beck Depression Inventory (BDI-II-): self-report inventory with 21 items, structured and validated to assess the level of depressive intensity according to the scores: minimum (0 to 11), mild (12 to 19), moderate (20 to 35) and severe (36 to 63).[29]

Ten psychotherapeutic sessions lasting 50 minutes each with ADI/TIP Method, transcribed in full.[30] Sessions were conducted by thirty-five psychologists with at least two years of training in this psychotherapeutic procedure, under continuous supervision to ensure adherence to the protocol.

PROCEDURES

The participants willingly sought the Humanistic Integral Health Foundation, social clinic, and TIP clinic. They signed the Informed Consent Form (ICF) accepting to participate in this research. The Beck Depression Inventory II was applied to all participants at the beginning and at the end of the psychotherapeutic process. Fifteen participants from the total sample were selected for the collection of qualitative data, according to the richness of the psychic contents described throughout the sessions.

RESEARCH STEPS AND EVALUATIONS

The procedures started with a medical assessment of all participants, followed by the application of the Beck Depression Inventory II. Then the participants went through the psychotherapeutic procedure and, in the end, the Beck Depression Inventory II was applied again.

The results obtained in the Beck Depression Inventory II were tabulated and analyzed with the statistical software Statistical Package for Social Sciences (SPSS). The qualitative results obtained by the Generic Change Indicators Scale were interpreted according to the phenomenological theory.

## Results

DEMOGRAPHIC DATA ANALYSIS

Descriptive analysis of demographics (Table 1) revealed that the sample consisted of 341 participants, aged between 17 and 81 years ($M = 37.58$, $SD = 15.19$). Regarding gender, the mean of 1.48 ($SD = 0.50$) indicates an approximately balanced distribution between male (1) and female (2) participants. In terms of education level, participants' educational attainment ranged from elementary education (1) to doctorate (6), with a mean of 2.86 ($SD = 0.85$), indicating that most participants had completed undergraduate education.

**Table 1.** Descriptive analysis of demographic data

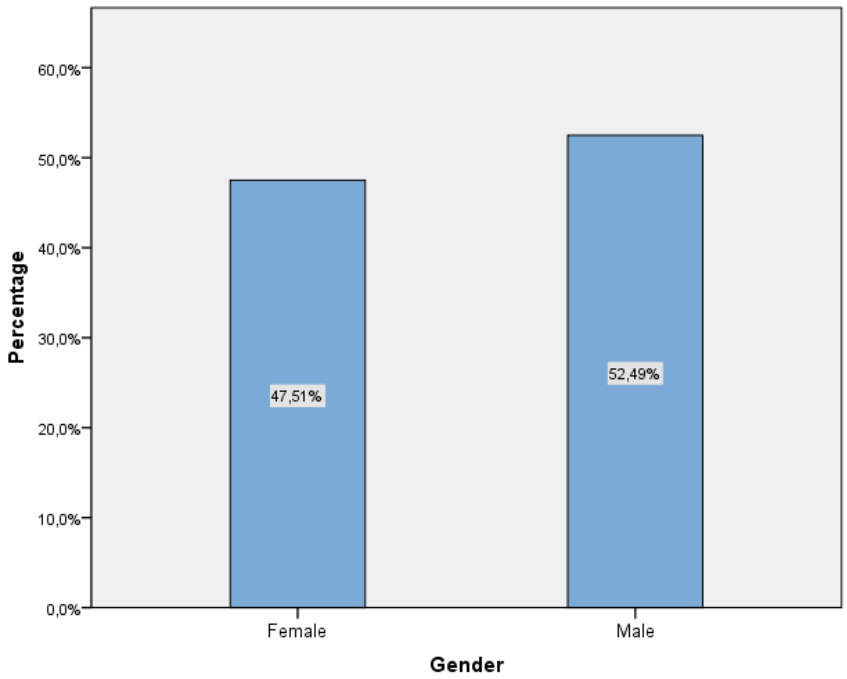
| Variable | N | Minimum | Maximum | Mean | SD |
|---|---|---|---|---|---|
| Age | 341 | 17 | 81 | 37.8 | 15.19 |
| Gender | 341 | 1 | 2 | 1.48 | .50 |
| Education | 341 | 1 | 6 | 2.86 | .85 |

The sample consisted of 179 male participants (52.5%) and 162 female participants (47.5%) (Table 2).

**Table 2.** Sample distribution by gender.

| Gender | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| Male | 179 | 52.5 | 52.5 | 52.5 |
| Female | 162 | 47.5 | 47.5 | 100.0 |

The bar chart (Figure 1) illustrates the percentage distribution of participants by gender. The sample consisted of 52.5% male and 47.5% female individuals, showing a relatively balanced distribution between the groups.

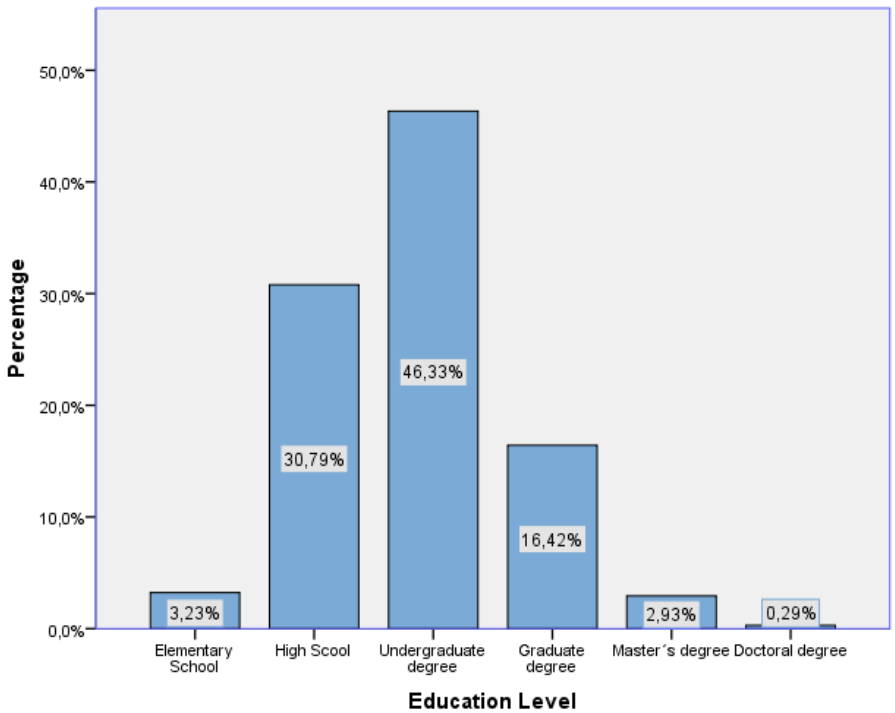



The sample included participants with varying levels of education, as shown in Table 3. The majority of participants (46.3%) held a university degree, followed by those with high school education (30.8%) and graduate degree (16.4%). A smaller percentage had elementary education (3.2%), a master's degree (2.9%), and a doctoral degree (0.3%).

**Table 3.** Sample distribution by education level.

| Education Level | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| Elementary School | 11 | 3.2 | 3.2 | 3.2 |
| High School | 105 | 30.8 | 30.8 | 34.0 |
| Undergraduate Degree | 158 | 46.3 | 46.3 | 80.4 |
| Graduate Degree | 56 | 16.4 | 16.4 | 96.8 |
| Master's Degree | 10 | 2.9 | 2.9 | 99.7 |
| Doctoral Degree | 1 | 0.3 | 0.3 | 100.0 |

The bar chart (Figure 2) illustrates the percentage distribution of participants based on their level of education. The largest segment of the sample holds an undergraduate degree (46.3%), followed by those with high school education (30.8%) and graduate degree (16.4%). Lower percentages are observed for elementary education (3.2%), master's degrees (2.9%), and doctoral degree (0.3%). These data indicate a strong prevalence of participants with higher education.



DESCRIPTIVE ANALYSES OF BDI SCORES

The BDI (Beck Depression Inventory) scores were analyzed at the initial and final stages. Descriptive statistics, presented in Table 4, indicated that the initial scores had a mean of 17.08 (SD = 8.97), ranging from 0 to 48. In contrast, the final scores had a mean of 3.89 (SD = 4.67), ranging from 0 to 32. These results show a significant reduction in BDI scores from the initial to the final stage, suggesting a substantial improvement in participants' depressive symptoms over the study period.

**Table 4.** Descriptive analysis of BDI scores at initial and final stages.

| | N | Mean | SD | Minimum | Maximum |
|---|---|---|---|---|---|
| BDI Initial | 341 | 17.08 | 8.97 | 0 | 48 |
| BDI Final | 341 | 3.89 | 4.67 | 0 | 32 |

COMPARISON ANALYSIS BETWEEN INITIAL AND FINAL STAGES: WILCOXON SIGNED-RANK TEST

A Wilcoxon Signed-Rank Test for paired samples was conducted to analyze differences between the BDI (Beck Depression Inventory) scores at the initial and final stages. The sample included 341 participants.

The results indicated a significant difference between the initial and final BDI scores ($Z = -15.74$, $p < .001$). Most participants showed a lower final BDI score compared to the initial score, with 329 participants demonstrating a decrease (negative ranks), while 7 participants showed an increase (positive ranks). Additionally, five participants showed no significant change between stages (ties) (Table 5).

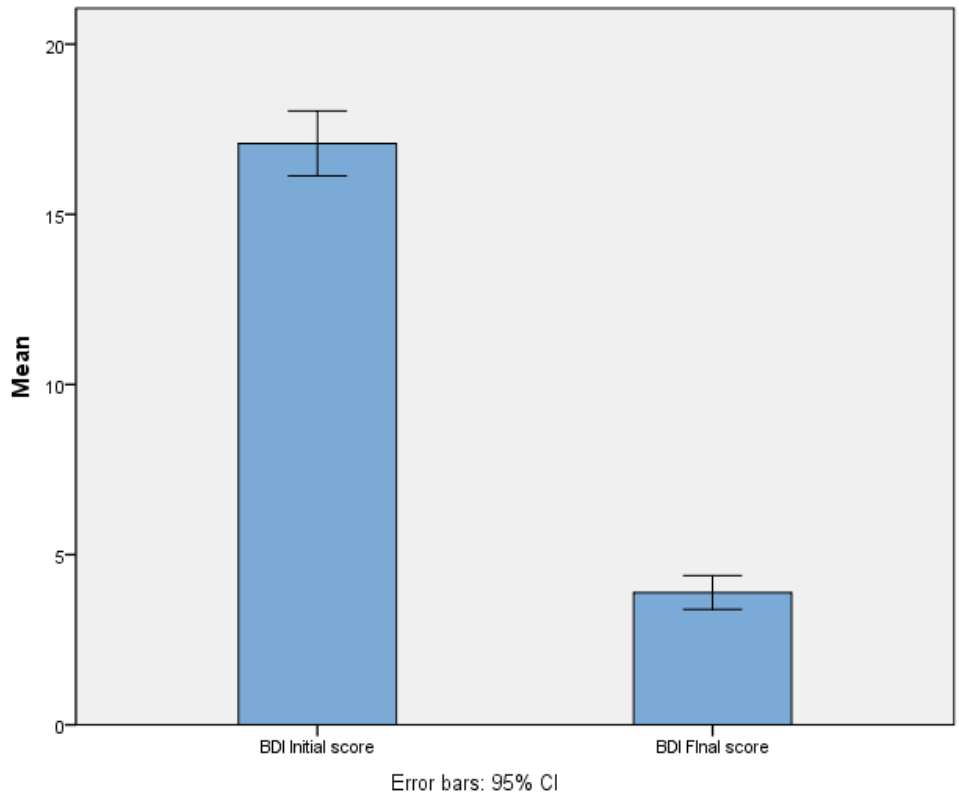
The effect size, measured by Cohen's d, was $d = -0.85$, indicating a large effect. This value suggests that the difference observed between the initial and final BDI scores is substantial and of high practical relevance.

**Table 5.** Rank distribution in Wilcoxon Signed-Rank Test (N = 341).

| Rank group | N | Mean Rank | Sum of Ranks |
|---|---|---|---|
| Negative Ranks (Final < Initial) | 329 | 171.28 | 56,350.5 |
| Positive Ranks (Final > Initial) | 7 | 37.93 | 265.5 |
| Ties (Final = Initial) | 5 | | |
| Total | 341 | | |

GRAPHICAL ANALYSIS

The bar chart (Figure 3) displays the mean scores of the Beck Depression Inventory (BDI) at both the initial and final stages of the study. The mean initial score was 17.08 (SD = 8.97), while the final score was significantly lower at 3.89 (SD = 4.67). Error bars in the chart indicate the confidence intervals for these means, highlighting the reduction in participants' depression scores throughout the study. The results demonstrate a significant improvement in participants' depressive symptoms, as evidenced by the marked decrease in BDI scores from the initial to the final stage.



STATISTICAL POWER ANALYSIS

Statistical Power Analysis was calculated using G*Power for the Wilcoxon Signed-Rank Test, with a sample of 341 participants. The critical t-value was -1.97, with 324.63 degrees of freedom. The non-centrality parameter (δ) was -15.37, indicating a substantial effect. The power (1 - type II error) was calculated at 100%, indicating that the test had a 100% probability of detecting an actual effect, if one exists. This suggests that the sample size was sufficient to detect significant differences between the study stages (T1 and T2).

## Qualitative analysis

INITIAL COMPLAINTS OF PARTICIPANTS (P) – DATA COLLECTED DURING THE FIRST PSYCHOTHERAPY SESSION

In the initial interviews, participants shared their experiences of depressive suffering and other related difficulties, such as: procrastination, sense of victimhood, negativity, feelings of failure, relationship challenges, emotional deprivation, low self-esteem, need for recognition and validation, in addition to feelings of sadness, emptiness and anguish. They described derogatory narratives about themselves as being "bad people", "incapable", "worthless"; additionally, they reported feelings of not being loved, being in the wrong place, being a burden, feeling intellectually inferior, among others. Feelings of internal confusion also emerged, including a perceived lack of personality or having lost the one they once had (P5, P10, P11, P15).

Participants reported difficulties in their primary (parental) relationships, with the maternal figure often described as "suffering and a victim of an alcoholic and/or unfaithful father" (P1, P11) or as a "cold, distant and unaffectionate" person (P3, P1); the paternal figure was described as: a "distant father" (P3), "cruel" (P1) and one who "abandons" (P4, P6); or alternatively as someone "weak, diminished and absent" (P1, P2, P3). In their secondary relationships, they reported having "few friends" (P3, P7, P14, P15), difficulties in expressing and receiving affection (P1, P3, P5, P10, P12), and intimate-affective relationships marked by challenges, distrust, injustices and disappointments.

***Therapeutic change assessment stage***

Data for this stage were collected throughout the psychotherapeutic process and at its conclusion, using the GCI.

***Final stage (immediately post-therapy)***

*Response to indicators of change – ind. 1 to ind. 5*

Participants presented the initial levels of GCI in the first psychotherapy sessions. They reported the experience of an "awareness" of unhealthy and negative self-configurations and behaviors that cause suffering for themselves and others. Some participants reported noticing changes such as the emergence of a "new will" and a reduction in the previously persistent feeling of guilt (P3, P4, P10, P15).

***Response to indicators of change – ind.6 to ind. 9***

Participants expressed the need for change, described the movement of becoming aware of its implications in the configuration of the disease and its inconsistencies in the understanding of themselves and their intersubjective relationships. Some participants began to draw connections between these early affective-emotional experiences and their illness, their attitudes of withdrawal, aggressiveness, isolation, and "loss of sense of one´s self."

After decoding the emotional registers associated with the identified problem situation, participants reported a deeper understanding of these situations, and the discovery of positive values, new behaviors, and emotions, both within and outside the therapy sessions, and an increased motivation for change: "I now understand the importance and the good I do, and this makes me want to be a better person" (P3).

***Response to indicators of change - ind. 10 to ind. 14***

Participants reported changes in intersubjective, family, extra-family, and marital relationships – including intimate affective relationships – and in the surrounding environment; they described feelings of self-confidence and changes in their negative self-concepts, expressed in register-phrases such as: "I am good", "I am a reason for joy", "I am a reason for togetherness!" (P1, P3, P4), comparing their current condition with that prior to psychotherapy: "now I feel free to open myself up to others and also to life" (P3).

***Response to indicators of change - ind. 15 to ind. 19***

Participants described the perception of new meanings, of a greater capacity to face difficulties and the feeling of a "new will to want", for example: I want to live, I want to grow, I want to love; affirmations that led to others such as I am capable, I can, I am free to be myself; they jointly described the feelings of being "someone integrated"; the sensation of "immense peace" and happiness. They also added the perception of new motivations, for example: "I am the defining condition of love in my family. I am a channel of grace. I have so much strength, such deep completeness, so much light!... Life is filled with meaning" (P8).

The average 80.5% reduction in BDI-II scores (from 17.08 to 3.89) supports the qualitative descriptions of increased lightness, hope and self-confidence (indicators 4, 10 and 13 of the GCI), suggesting that the subjective changes perceived by the participants are mirrored in measurable improvements in depressive symptoms.

## Discussion

Based on the analysis of patients' individual trajectories, consistent results were observed regarding the efficacy of the treatment. The data indicate that the treatment was highly effective, with all participants (100%) showing some degree of improvement. The magnitude of this improvement was substantial, with an average reduction of 80.5% in depression scores and a median reduction of 81.8%, suggesting a relatively symmetrical distribution of improvement among participants. Additionally, 92.6% of the patients achieved substantial improvement, with a reduction of at least 50% in scores, and 74.1% of them showed greater improvement, with reductions of 75% or more from baseline scores.

These results reinforce the need to understand the psychological processes behind both illness and

therapeutic changes; [17, 19] this task requires grasping the foundational characteristics that constitute the Human Person, [14,15,24,27] a response made possible by Phenomenological Psychology, whose epistemology underpins this research. Husserl proposed Phenomenology as a genuine and fundamental "first philosophy", offering a method rooted in experience and epistemological rigor, [33] aiming to explore the essences of lived-experiences; at the same time, he developed the project of a pure, *a priori* phenomenological psychology.

Phenomenological Psychology is a science of psychological-transcendental subjectivity necessary for the construction of empirical psychology, as it encompasses knowledge of the psyche before considering contingent aspects of empirical experience.[34] In his analyses, Husserl[35] highlighted lived-experiences (*Erlebnissse*) as distinctly human, and distinguished within them two complementary and interrelated layers: a) the first one refers to psychic-empirical experiences, whose contents of meaning (that which we encounter in experience) are grounded in the second layer; b) the second one, as the condition of possibility for the first, concerns psychic-transcendental lived-experiences.[14,15]

This study considers both the psychic-empirical experiences described by the participants and the changes observed after the psychotherapeutic process (92.6%), whose possibility is grounded in psychic-transcendental lived-experiences. A comprehensive understanding requires considering all human dimensions: the lived-body, the psyche and the spirit or "noological" dimension, as stated by Jost de Moraes,[11] clinically corroborating the phenomenological analyses of Husserl and Stein.

"Events"[36] described by the participants are not mere facts, as they express the person's subjective involvement in what occurred. All human experience unfolds within the space of the concrete, everyday *life-world*,[37] beginning with the perception of sensory data and immediate self-awareness, through the lived-body (*Leib*). According to Husserl,[34] the experience of the psychic is only possible through an organic body as the substrate of experience. An *I* that originally experiences the world has its own body (*Leib*) as a central element of its surrounding bodily world (*körperlichen*) and as the organ of perceptual representation, through which it experiences both things and intersubjectivity: this body is "my body (*Leib*)", since in it "my psychic life reigns", Husserl explains.[34(p103)]

Such human corporeality has a dual experience: the body as a purely physical thing (*Leibding*) and the lived-body (*Leib*) as an experience and dynamics animated by the *I*. The animation of the body appears here in a higher sense: that of "personal subjectivity," in which the spirit (layer of subjectivity) "reigns through its egoic acts (*I*-acts) over the body (*Leib*)" and "manifests itself as coexistent with the body (*Leib*)".[34(p126)] This Husserlian analysis is fundamental to understanding how, through intersubjective experience, both the psyche and the lived-body can be filled and transformed in their dynamics and states. Indeed, *psychic acts* and their residues are interwoven with the body, which is built "on an immediately embodied psyche" as the somatic foundation of the "sensible".

Thus, the experience of perception can target the external event in two ways: in its "perceived" or "noted" aspect; and in its "unnoticed" or "unattended" aspects; the latter, however, are equally registered[38,39] and synthesized by intuition, which unified all the intentional acts of perception.[40] This phenomenon is understood by considering the intuitive grasp of consciousness and its temporal conception.[41,11,14,15,28] These perceptions and apperceptions, in turn, provoke both objective and subjective effects in the person who experiences them, thereby entering the psychic dimension. When analyzing affective experiences within the transcendental sphere, Husserl[42(p339)] metaphorically mentions that feelings of joy or sadness appear experientially as being "toned" with brighter or darker tones, depending on the meaning of the event and its subjective "impression".

In the clinical context, phenomena have been observed that correspond to these Husserlian descriptions. Contents linked to the experience of love are "toned" with the colors of joy; while those linked to experiences of lovelessness and the rupture of trust appear "toned" with the colors of sadness.[14,15] These experiences provoke feelings of resentment, pain and anxiety that "resonate within", permeate the affective sphere, make the psyche sick and mobilize stances rooted in the central layer of human activity: the spiritual sphere. This dimension is coordinated by an "*I*"[34] that can make one's own body sick and, in the case of the participants, it appears associated with a contradictory "want" as they manifest the purpose of "not existing", of "nullifying themselves", of "becoming imperceptible", among others.

The sphere of the *I*, according to Husserl,[34] refers to a constitutive *I* from which all human activity originates: an *I* that is active and operative, responsible for all reflective and evaluative processes; an *I* of original institutions and subsequent institutions, as the identity of the *I* that fully retains its convictions. Thus, "the individuality of *oneself* is manifested in one's decisions, which are grounded on conviction".[34] Nevertheless, in the cases described, the *I* of freedom configures its own self in the direction of depressive illness, as described by the participants in the diagnostic phase of the Circular Process.

In other words, psychic-phenomenological lived-experiences are constituted by contents of meaning that emerge from psychic-empirical lived-experiences. These subjective, intersubjective and sociocultural contents of meaning are, in turn, intuitively and immediately valued (register-phrases) in a way that is either congruent (positive) or incongruent (negative) to the *I* in its own utter originality. According to Jost de Moraes, [11] the contents of meaning that are incongruent with the *I* are connected to nuclei of various forms of suffering whose meanings are "imprinted" on subjectivity and are more serious the earlier they appear in life, considering that the original experiences have their psychic origin already in the first *hyletic* impressions, that is, from the intrauterine stage.

This clinical observation is also consistent with the results of Stein's analyses, [43, 22] which distinguish, among the different lived-experiences, those that are original and those that emerge motivated by these first lived-

experiences. It also finds correspondence in Husserlian analyses,[44(p375)] which describe a primordiality forming in an original state, a "*pre-I*", that is affected, while still "in the maternal body", by the relational models of its first affective references. Corroborating these analyses, it is noteworthy that themes such as conflict between the parental couple and complaints of abandonment or emotional coldness, both between the parents and towards the child, appeared recurrently in the psychotherapeutic context,[11] rooted in patterns of depressive illness. This demonstrates that intersubjectivity lies at the foundation of the constitution and development of psychic life.[27]

In this context, it becomes possible to understand, from a psychological and phenomenological perspective, the symptoms of depression as related to: a) lived-experiences of the lived-body (*Leib*) overwhelmed by a depressive mood and deprived of vital impulse; b) affective lived-experiences marked by a lasting feeling of sadness; c) recollective lived-experiences centered on negative events; and d) lived-experiences of temporality dominated by the past. Indeed, participants described their perception of temporality as if they were trapped in the spatial and temporal confines of a life marked by a darkened affective tone, manifested both in depressive symptomatology[7] and in subjective and intersubjective lived-experiences, [15, 28] demonstrating that, when reaching the primal experiences, the origin of psychic suffering can be traced back to an *I* capable of shaping its own illness.

From the above, it can be inferred that the initial registers of existence, by negatively affecting the primordial *I*, may invert the original movement of "becoming oneself", as Stein[32] refers to this existential pursuit inherent to every Human Person. Stein[43,22] identifies a dual possibility in the *I*'s positioning, depending on the predominance of the laws guiding the configuration of oneself: a) a psychophysical *I*, governed by laws of qualitative psychic causality related to impulses and tendencies, elements inherent of passive life; and b) a spiritual *I*, governed by the laws of motivation of acts specific to active life. This indicates that the *I* and the oneself are not fully identical, since the oneself entails a retro-reference, and it is the *I*´s decision to shape this oneself".[32, 33,14,15,28]

Hence, in the diagnostic-therapeutic phase of this research, it was necessary not only to identify the original lived-experiences (*Erlebnisse*) that shape an ill-formed "mode of being", but also to grasp the affective-emotional impact on the participants' subjectivity. This understanding involves the perception of previously unnoticed horizons surrounding the parental couple, including, in turn, each individual's intra-family psychic inheritance. This phenomenon demonstrates that, from the intrauterine stage, intersubjectivity is the matrix of psychic life and plays an active role in the subject's constitution, so that both the body and the psyche are filled and toned by the psychic material transmitted to the child, especially through its parents. These clinical considerations are likewise grounded in the results of Husserl's[31] analysis and those of his commentators[45,46,26,27] on generative lived-experiences throughout all stages of human life.

Husserl[42] describes the original constitution of time through two axes of operations. The first one follows a longitudinal axis, which organizes the past (retentions), the present (proto-impressions) and the future (protentions) of acts and objects of consciousness into a unified succession: the living present (*Lebendige Gegenwart*), which is the source point of the temporal flow. The second one deepens in a vertical flow, forming a transversal axis that conforms units in time by associating the similarity of their contents, composing a "retentional deposit" or "layers of sedimentation", whose contents can "detach from the depth of memory" from an "affecting stimulus".[31(pp112-114)]

These two axes of temporal operations function together and establish a "bridge-connection" between the present and the past, associating them not through temporal proximity, but through the emotional closeness between retained contents (past) and present experience. This phenomenon is also observed in this psychotherapeutic methodology, as the patient/participant often describes unconscious content as an experience which, although referring to a past "event", is linked to the present through its strong emotional resonance, allowing the construction of meaningful "bridges" between events.

Therefore, the understanding of the unconscious in Husserl[31] becomes clearer, as it falls within the scope of passive syntheses, referring to the concepts of affection and horizon; in this way, it necessarily contains more than the consciousness, always limited by the structure of the attentional field.[21] In this sphere, if the conscious and the unconscious are distinguished only by levels of depth, as established, then the unconscious is "a background consciousness", which indicates a total "horizon" of modes of appearing and syntheses of non-actual validity, which act together in an intuitive, integrative, constitutive and pre-predicative way. Consciousness, thus, involves the entire horizon of lived experiences, both those "noticed" (perceived), which received the attention of the *I*, and those "unnoticed" in a conscious way but still apperceived, hence capable of standing out from the stream of consciousness and "awakening" the attention of the *I*.[31,14,28]

In this way, the awakening (*Weckung*) of unconscious memory is possible: "(...) because the constituted meaning is effectively implicit in the non-living form in the background consciousness (*Hintergrundbewusstsein*), which is then called unconsciousness (*Unbewusstsein*)".[31(p228)] It is thus considered that every detachment from the stream of consciousness implies an affecting content; and all affecting content implies a detachment,[31(p245)] thereby evidencing a circularity that marks the enigma of association corresponding to "(…) all the enigmas of the 'unconscious' and various ways of 'becoming conscious'.".[31(p214)]

From the above it is concluded that: first, the contents of the unconscious are not unreachable, since they can emerge into consciousness through an "affective stimulus";[31] second, the psychotherapeutic resources used in this process act as "affective stimulus", "awakening" unconscious contents considering that they remain and affect "the ways of experiencing" the present and the

future; and third, these unconscious psychic contents can be apprehended by reflective consciousness, thereby "making the unconscious conscious", as analytically conceived by Husserl.[31] Thus, these contents can also be addressed therapeutically (decoded), enabling improvements in bodily, psychic and "noological-existential" dimensions, as observed in the participants' results in this research.

Husserl,[31(p84,82,83-84)] in this sense, draws attention to the experience of an empirical *I*, which allows for the establishment of a *habitus* (§ 32), linked to the decisions of "*an I that decided in this or that way*" (§ 32), thus enabling the recognition that this "is my action", even if *I* transform myself; it is considered to be the same "I-person" who perseveres in one´s enduring will, "when *I* annul, when *I* deny my decisions and my acts". Certainly, "the *I,* amid these transformations, maintains a constant 'style', a 'personal character' (§32)", which provides the evident experience of the *I am* constantly given as myself.

This perspective broadens the clinical understanding of the "resistance to change" phenomenon, which, in patients' descriptions, appeared as unconscious reasons and motivations for "not changing". For example, many participants identified that the movement of "nullifying oneself", though self-destructive, was linked to an "unconscious motivation" "not to suffer", and/or "not to be a cause of conflict" between parents, or even referred to a difficulty in changing the *habitus* of a state of illness. However, even if the will to "want" is negative, given that the "personal *I*" marks the sphere of freedom – and, consequently, of the possibility of change, [36] – the will can also be modified by the decision of the *I,* thus enabling improvement not only in symptoms, but also in the "psychonoosomatic" domain.[11]

Stein[43,11] reinforces this position, highlighting that the same *I* that can "condition" oneself to become the opposite of what it ought to be can also reshape oneself in accordance to its original personal *I*.[11,12,32] This movement of change, in turn, marks a dynamic process[43] governed by motivational laws that reveal the conditions that activate transformation: the awareness, referring to "become aware" of a non-correspondence between the *I* and the oneself; taking a stand, marked by the will to shape oneself in line with one's personal I; and the act of decision-making, which defines free actions when the *I* fully manifests oneself as the "master of its living experience".

Similarly, Jost de Moraes,[11,12] affirms the possibility of therapeutic change of non-constructive affective-emotional registers (decoding), clinically identifying these internal movements of the *I* that align with the aims of this psychotherapeutic methodology focused on humanization and the integration of the whole being. These movements appear in highly specific ways within the psychotherapeutic setting. Indeed, participants experientially refer to themselves as: a "personal *I*", in line with Jost de Moraes's[11,12] formulation of the same phenomenon. According to patients' accounts, this *I* undertakes the task of self-formation, signaling its – albeit implicit – capacity to be, to want , and to act; in this way, they discover themselves capable of transforming "pathological modes of being" and of working to dismantle the web of negative configurations formed around the cores of psychic suffering.

It is also relevant to highlight Goto's[40] reflections on the process of "decoding" negative registers in the ADI/TIP Method. According to the author, "decoding in ADI is more than a simple "signify again"; it is the revelation of new meanings that, until then, had not been fully experienced". Goto[40] also clarifies that when the manifestation of a phenomenon is expanded, the phenomenon itself undergoes transformation. In the clinical context, it is concluded that if illness, such as depression, is the somatic result of how the *I* positions oneself in relation to its comprehension of certain circumstances, then, considering the clinical phenomenon of "decoding", when the affective-emotional perspective broadens, the apprehension and resulting positioning of the *I* towards its experience are also transformed. As a result, the *I* may begin to move toward a more coherent integration of oneself.

As Stein[22] emphasizes, and as confirmed in the clinical practice of this methodology, once the movement of change is initiated, a rupture in the web of intentional experiences becomes possible, allowing for the emergence of a "new class of complexes of acts", through a "new level of depth" that transcends the previous one.[22(p257)] In these conditions, even if the *I* remains "dormant", the appearance of "a personal value" that demands realization may prompt the *I* to "awaken" and act, opening oneself to the other and to the world.[32]

These Steinian insights are also reflected in the participants' descriptions at the end of the ADI/TIP Method psychotherapeutic process. In fact, destructive "wants" prior to "decoding" are replaced by constructive "wants", enabling the "awakening" of new positions, described experientially as: "it feels like I'm waking up", "I feel myself growing… appearing", "I feel within me a desire to live".

## Conclusions

The results presented indicate the possibility of intervention and transformation in depressive suffering, both in the psychophysical and psychospiritual dimensions. For such transformation to occur, it is essential to keep the I-person in perspective, both as world-constituting and self-constituting.[47] In fact, it is the same *I* that can fall ill in a response to painful emotional experiences, configuring a way of living or a depressive *habitus*; yet it is also an *I* that, when confronted with new perspectives arising from the apprehension of new meanings and motivations, may, even if not fully consciously, orient oneself "noologically" toward expanding and overcoming the conditioning forces of the psychic sphere.

Finally, serenity, confidence, and hope begin to emerge in place of anguish and fear – a process that Husserl[48] and Jost de Moraes[11,12] describe as a profound transformation in one's way of living, marked by the acquisition of a new and lasting capacity that enables the *I* to transform oneself. This suggests that the ADI/TIP Method may serve as a valuable support for one´s

mental health, contributing above all to advances and the broadening of possibilities in addressing depressive suffering. Further research is needed, however, with larger sample sizes and more comprehensive longitudinal designs.

## Conflicts of Interest Statement

The authors have no conflicts of interest to declare.

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