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ARTICLE

Corpo, Espaço e Encontro: contribuições fenomenológicas para o Acompanhamento Terapêutico de pessoas com esquizofrenia

Mayra Wainstok
Gabriel Becher

Abstract

This paper explores Therapeutic Accompaniment (TA) as a clinical device guided by Phenomenological Psychopathology, particularly as a therapeutic tool in the care of individuals with schizophrenia. Through a clinical case report written in both first- and third-person perspectives, the paper describes the clinical practice of TA in its clinical-relational dimension and analyzes its contributions to the reconstruction of the experience of being-in-the-world based on intercorporeality and spatiality. Within this framework, the paper proposes a discussion on the expansion of forms of care that consider the centrality of the subject's lived experience in relation to illness.

Keywords: Therapeutic accompaniment; Phenomenological psychopathology; Intercorporeality; Spatiality; Schizophrenia.

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Mayra Wainstok

Possui graduação em Medicina pela Faculdade Souza Marques. Tem experiência na área de medicina, com ênfase em Psiquiatria.

Contato:mayrawainstok@gmail.com

Gabriel Becher

Psiquiatra e psicoterapeuta pelo IPq, Bacharel em filosofia pela FFLCHeMembro-fundador da SBPFE.

Contato: becher.gabriel@gmail.com

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Resumo

Este trabalho investiga o Acompanhamento Terapêutico (AT) como dispositivo clínico orientado pela Psicopatologia Fenomenológica, notadamente como ferramenta terapêutica no cuidado de pessoas com esquizofrenia. Por meio de um relato clínico em primeira e terceira pessoa, o artigo descreve a prática clínica do AT em sua dimensão clínico-relacional e analisa suas contribuições para a reconstrução da experiência de estar-no-mundo a partir da intercorporeidade e da espacialidade. Nesse horizonte, é proposto um debate sobre a ampliação das formas de cuidado que considerem a centralidade da experiência do sujeito sobre a doença.

Palavras-chave: Acompanhamento terapêutico; Psicopatologia fenomenológica; Intercorporeidade; Espacialidade; Esquizofrenia.

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Contato:mayrawainstok@gmail.com

Gabriel Becher

Psiquiatra e psicoterapeuta pelo IPq, Bacharel em filosofia pela FFLCHeMembro-fundador da SBPFE.

Contato: becher.gabriel@gmail.com

Introduction

I made you meals, watched over your sleep
I was your friend, I took you along with me

Legião Urbana

When called for a home visit to a 17-year-old young man—whom I shall give the fictitious name of Caio—who refused to voluntarily attend a psychiatric consultation, I encountered a situation that made me question the way clinical practice is conducted with psychotic individuals, especially those with schizophrenia. From that encounter onward, Therapeutic Accompaniment (TA) presented itself to me as a unique therapeutic resource—more than that, as a mode of existing within mental health clinical practice. Interested in authors such as Araújo[1] (2025), who inquires about the possibility of the street being a clinic; Almeida[2] (2025), who considers space as an existential condition; and Englebert[3] (2021), who proposes the phenomenological concept of the territorial self, I sought to explore the Street as a possibility—not as an alternative space, but as a spatial alternative for my practice.

A dip in the sea, a play, a coffee—unlikely trajectories, yet sometimes the most viable ones for a therapeutic encounter. And it was precisely Caio who called upon me to investigate this type of clinical practice when, upon my arrival for the home visit, he informed me that he was leaving the house—thus signaling his refusal to be treated through conventional modalities—which required me to follow in his footsteps so that the encounter could take place.

TA is not simply an encounter outside the office, but a clinical-relational device realized in the subject's everyday life. It is, primarily, a way of accompanying the individual in their life: helping them to relate, to circulate, and above all, to live. More than a tool or the mere application of a technique, the practice of TA occurs in the encounter between the accompanied and the accompanier, that is, a clinical practice of *being-with* whose axis is presence. This presence can be understood, in phenomenological terms, through

[1] "In what situations can the street be understood as a clinic?" Araújo, F. (2007). *Um passeio esquizo pelo acompanhamento terapêutico*, p. 17.
[2] "The human, like the universe, is unfinished, always in a process of subjectivation, and space is its point of openness and becoming." Almeida, P. (2025). *Clínica e cartografia*, p. 33.
[3] "The proposal of the territorial self allows us to insist on the fact that the clinical relationship is characterized as much by an analysis of experience and a discourse about it as by a joint practice and shared lived experience that demand the sharing of a common space." Englebert, J. (2021). *Le «soi territorial»: propositions théoriques à partir d'une compréhension phénoménologique de la schizophrénie*, p. 1, our translation.

intercorporeality—the very condition of the clinical encounter is the intertwining of bodies within the same field of experience.

Co-creating possible worlds thus constitutes a fundamental step for subjects whose experience—marked by psychopathological phenomena—restricts their openness to the common world, allowing the primacy of the inner world to prevail.

In this sense, one might consider the movement of progressive withdrawal from the shared world stemming from the schizophrenic subject's lived experience; simultaneously, however, the social world responds to this condition through so-called "phenomena of social exclusion" (Tosquelles, 1975, as cited in Miguel, 2024). That is: if, on the one hand, the subject tends to withdraw from the world, on the other, this very world excludes them. Thus, creating existential territories and participating in practices that reinvent the experience of being in a world where the sense of sharing seems to have been severely impaired is the guiding wager of this study.

Method

This article is structured around a clinical case report approached within the TA modality, described from the perspectives of both first-person narrative—through direct quotations of dialogues between the professional and the patient—and third-person narrative, through descriptive accounts of the clinical encounter. Considering that TA constitutes a practice built within the everyday lives of the accompanied individuals, this research must ultimately rely on clinical description as its central methodological strategy. From this perspective, an investigation grounded in a care practice embedded in the subject's everyday life is nourished by the clinical account—not merely as an illustration of a theory, but primarily, in phenomenological terms in the manner of Merleau-Ponty, as its origin and evidence.

Although this study dialogues with various authors and is guided by distinct theoretical frameworks, the emphasis falls on the contributions of Phenomenological Psychopathology to the investigation of TA practice—allowing for the unveiling of the singular modes of care produced in the subject's everyday life.

Case report

Caio was alone at the time of my visit. The young man's escalating aggressiveness

had prompted his mother to leave the house—she was determined to return only when her son was medicated, despite his refusal. Since Caio spent his days confined to his room, there was a guarantee that he would not leave; thus, I arranged with his mother to see him that day. His mother assured me that my entry into the apartment would not be an issue, as the front door had neither a doorknob nor a lock—given the family's concern that Caio might intentionally lock himself in to the point of becoming inaccessible. I asked the mother to notify her son of my visit, and I arrived at the house at dusk. The building attendant used the intercom, with no expectation that Caio would answer—he was an important figure in keeping the mother informed about her son's movements. I went up. I entered the house and announced myself; receiving no response, I insisted. After a few minutes, the bedroom door opened, and Caio said: “I thought you had given up.”

He grabbed his jacket, put on his sneakers, and headed out the door. I asked if I could accompany him, and he mentioned he was taking the subway, which was a public space—his leaving the house made evident his intention to prevent the encounter. At that moment, I allowed myself to be affected by the unexpected turn of events, shaped both by the patient's conduct and by my own gesture, which destabilized my usual frameworks for conducting clinical practice. Faced with a scenario where the consultation would not take place in the format of a home visit, I decided to ride down the elevator with him and attempt an approach along the way. And so, a tentative dialogue began to emerge.

Caio commented that his destination was Botafogo[4], the place where he would meet his girlfriend, and asked if I knew the address—I did. Along the way, we conversed about three noteworthy themes: at length about the film *Akira*[5]; also about the difficulty of relating to his mother, whom he calls by her first name; and about the uncertain future of his relationship. Upon leaving the subway, the young man began to behave as if we were together: from the house to the subway, it was as if I were following him; exiting the subway, we began to walk almost side by side. I believe that the shared knowledge about the film *Akira* played a fundamental role in this shift in dynamic, since, upon noticing my interest in the film and my willingness to speak more about this subject than about restrictive medical matters, the young man began to engage with me from this common ground—shifting the

[4] A neighborhood in the city of Rio de Janeiro that houses the psychiatric clinic where Caio was recently admitted.

[5] Caio identified with the character Takashi, a likely orphaned child with psychic powers. In Katsuhiro Ôtomo's feature film (1988), Takashi lived in an internment institution, where he was forced to ingest drugs that suppressed his psychic powers and caused premature aging. Caio wore a jacket in his everyday life, like Takashi, even on hot days, as a form of identification with the lived experience of the character.

focus away from my role as a psychiatrist and toward a conversation between film enthusiasts.

We arrived at the destination, and Caio concluded for his own reasons: “she does not want to talk to me today.” With that, he became saddened. He explained to me that he had been communicating with his girlfriend through signals: the bedroom window light turned on meant she wanted to talk; the light turned off meant she wished for him to leave. The relationship began, according to his account, when he was admitted to a psychiatric clinic neighboring the building of his supposed girlfriend—never seen in person. We conversed about dating, and I became interested in knowing what it was like to relate to a girl he did not know personally. I emphasized that heartbreak is a dramatic experience: “I know it myself, I have been through breakups and suffered a lot.”

We were standing in the street, talking, until I ventured to invite Caio to sit down at a snack bar—the image of an açaí bowl on the sign had caught our attention. Another coincidence: we both loved açaí. The invitation was accepted, and the dialogue flowed. When I proposed that we ask for the bill, since it was late and I was feeling sleepy, Caio told me that this was a problem he did not face, as he had been sleeping very little for weeks. Intuiting the expectations of a psychiatrist, he looked at me and snapped that he did not need medication to sleep. He told me he had already seen nearly a dozen psychiatrists since he was 13 years old, and said he liked neither psychiatrists nor medications. On the other hand, he commented that I was “actually pretty cool for a psychiatrist.” He also said he was unable to understand why his mother insisted so much on doctors and medications.

Building on his statement, I consulted him regarding the possibility of using a medication only when he wanted to sleep more and better. He replied, “in that case, yes,” and stared at me as if surprised by the proposal. We went to the pharmacy together and bought a box of Olanzapine. [6]

We returned to his house, and upon arriving, he took the medication on his own initiative—to sleep and avoid thinking too much about the possible end of his relationship. I remained with Caio in his room until he fell asleep, anchoring myself in the previously

[6] Olanzapine is a psychotropic drug that combines antipsychotic and sedative effects. The pharmacological understanding, interpreted in a phenomenological key, will be explored in depth in a later section of this article.

established bond. Upon leaving, I encountered his mother seated in the living room[7], interested in knowing how the encounter had unfolded. I reported to her that Caio was sleeping and that he had agreed to take the medication. She smiled and asked me: "what miracle did you perform?"

Discussion

Based on the clinical account, I propose reflections, from a phenomenological perspective, on TA as a therapeutic tool for the psychiatrist. The purpose is to promote the opening of the interpersonal channel—notably in structural psychopathologies that foster radical social isolation, such as schizophrenia. Regarding these structural pathologies, Messas notes:

> Structural fragmentation affects the ability to *apprehend the other* (...). The other is an agent of a world of which the patient cannot partake and so cannot even understand (...). The other is twisted into a strange, alien and often hostile presence. (Messas, 2021, p. 153.)

Schizophrenic fragmentation, ultimately, promotes radical and definitive alterations in the way one relates to oneself, to the other, to time, and to space—that is, to the world. This transformation induces in the schizophrenic person a distinct mode of belonging: a belonging in which the personal world and the shared world coexist and overlap. Pankow (1969/1974) argues that the schizophrenic "has lost the possibility of entering the historical dimension, insofar as the very image of their body is disintegrated" (p. 9, our translation). It seems clear that a fragmented body will, in the same measure, face fragmentations in lived space—that is, at a territorial level—and, consequently, also in the construction of their biography. Deleuze and Guattari (1972, 1980) address the territorial dimension of the subject; Guattari (1992) deepens this debate as he depicts how processes of radical deterritorialization—that is, the loss of existential territory—are related to psychic illnesses. In this same direction, Englebert, in direct reference to the aforementioned authors, proposes the phenomenological concept of the territorial self, which highlights the importance of space in the organization of psychic life. To this end, he states: "we territorialize as we are, but also, it is in territorializing that we are" (Englebert, 2021, p. 9, our translation). Above all, it is through the body, in space and by means of space, that life takes place.

Such pathological alterations, especially those related to alterity and spatiality,

[7] Caio's mother felt secure in returning home after the building attendant informed her of our return to the apartment and upon learning of my presence in the house.

assume significant relevance in understanding the peculiar type of therapeutic approach proposed in this study—since a person who no longer experiences their thoughts, their body, and themselves as before will also ultimately refuse to relate closely with the other. Phenomena such as the loss of natural self-evidence (Blankenburg, 1971/2013) and hyperreflexivity (Sass, 2001) are associated with frustrated attempts to manage this modified "self"—which seems to be, in and of itself, considerably frightening. In this context, social isolation ends up being inviting—but not, for that matter, devoid of suffering. Therefore, the mediation of space can soften the impact of intimacy, potentially making interpersonal contact less threatening. In this sense, Sass (2019) also states:

> Be that as it may, it does seem that too direct a focus on the immediate one-on-one interaction with a therapist (...), can be counterproductive with many such persons; and that what is more helpful is the kind of sharing (...) that occurs when two people take some third thing as their shared object of attention.

Still, according to the author, "the most helpful forms of intimacy may sometimes be oblique rather than direct" (p.7).

The importance of therapeutic proximity—that is, the proximity in which the psychiatrist is invited to experience the patient's world directly—is also described by Dörr (1995) in the following terms:

> The schizophrenic has lost the freedom to experience the other in the proximity of trust, friendship, and love, creating a saving distance that may take the form of withdrawal or the most elaborate delusion (...). Consequently, as an essential moment of the treatment, it will entail guiding them to discover the hospitable character of proximity. (pp. 779–780, our translation).

It is worth recalling that the first name attributed to TA was Qualified Friend [*Amigo Qualificado*], upon its creation in the 1970s in Argentina[8]. This initial designation resonates with the writings of Lancetti (2006): "the position of a friend provides a continuous presence that makes it possible to break through the siege of the fundamental separation of a society where these people have no place to exist, or of a human group from which they live apart" (p. 114).

In an encounter with a TA, beyond the street and all the elements that compose it, the therapist's own life can function as a mediator with the world and foster a non-invasive approach—aligning with the aforementioned positions of authors such as Sass and Englebert. Furthermore, inhabiting space with one's body alongside the patient can be conceived as fostering stability—the therapist reinventing ways of inhabiting spaces with

[8] Mauer, S.; Resnizky. (1987). *Acompanhantes terapêuticos e pacientes psicóticos: manual introdutório a uma estratégia clínica,* p.39.

the patient, as someone who can truly, through intercorporeality, promote the courage of this body in the world, a body that finds in another body and in the sharing of everyday rituals the possibility of contours.

The individual with schizophrenia, akin to a thread, and beyond the fragmentation of the self, faces the risk of rupturing the very possibility of existing in the shared world: a thread alone breaks more easily than when intertwined with others. In a network, this fragility is not eliminated, but it can sustain what, alone, would tend to rupture. It seems to be regarding such a need for shared sustenance that Deligny states: “weaving a network often occurs as a reflex when existing is no longer possible” (Deligny, 1981, as cited in Miguel, 2024, p. 27).

Experiencing the world together with the patient requires being able to lend them our universe, given that, in more severe situations, it is not uncommon for the progressive withdrawal from the shared world to bring about a depletion of their possible repertoires. As in Caio's case, the choice of a food enjoyed by both could be more than mere nutrition—it was a unique opportunity to share a moment in attunement.

However, it is also paramount that we can take an interest in the patient's own universe; we must not forget, after all, that we are not dealing with schizophrenia, but with a person beyond their disorder. Although the emphasis here falls on psychopathological alterations, regardless of their severity, there is always a person, and, alongside them, histories, emotions, desires, and dreams. Wyrsch (1949/1952) emphasizes the clinical importance of not reducing the patient to their pathological condition—recentering the person within the schizophrenic experience. One cannot disagree with the Jaspersian thesis of schizophrenic illness as an incomprehensible evolution; but one must, indeed, frame it within a position that advocates for the transformation of the individual's mode of being-in-the-world—which, as such, must continue to be understood.

Expanding the reflection based on Wyrsch's ideas, it seems important to consider that a patient's sustained engagement in psychiatric care will not occur without much listening, creativity, patience, and, above all, an emphasis on the relationship—a relationship that inevitably takes place between persons. It is in this centrality that the practice of TA is constituted—in being able to conduct clinical practice within the blurring of boundaries. In other words: the therapist cannot merely be the one who occupies a role as an interlocutor of subjectivity, but someone who presents themselves as a person, which implies speaking about oneself, when appropriate, as well as sharing literary, musical, and

gastronomic tastes, etc. It is not merely a matter of being available for the patient, but rather of experiencing the world with them; it is about being able to reveal oneself, or rather, to inhabit a truly shared world.

In this sense, the clinical gesture of TA is presence, the sharing of a common field of experience through conversations situated in everyday life—not centered on the illness—displacing the locus of knowledge about the patient to the knowledge constructed in the clinical encounter. In complex cases, such as Caio's, marked by low adherence to conventional treatment, an exclusively third-person approach[9] or one restricted to the discursive dimension of experience can be incomplete, especially when the subject's urgent needs to weave their own existence are not addressed.

In this regard, Serpa Jr. (2007) states that "psychopathology is subjectivity in its entirety" (p. 12) and that subjectivity must be "its primary interest" (p. 13, our translation). In the same work, he emphasizes that the patient must not be "a mere provider of semiological data" (p. 16, our translation). The author also highlights the importance of "being surprised by the unusual nature of the lived experiences of madness" (p. 11, our translation), which reinforces the centrality of first-person experience and its irreducibility to objectifying descriptions.

In this context, it becomes fundamental to articulate first-, second-, and third-person perspectives for a broader understanding of psychopathological phenomena: this involves considering subjective experience (first person), the intersubjective dimension (second person), and observable and measurable data (third person). Together, this mode of operating in Psychopathology expands the complexity of understanding the psychic suffering of the individual receiving care.

Based on this understanding, and considering that all subjective experience is embodied, TA listens to and experiences with the person what they say about themselves and what they live through. Thus, the clinical relationship occurs beyond the transmission of information and begins to model an intersubjective field. Both the clinician and the patient, when relating to each other within the territory, can understand each other better: the clinician can see a person in active existence—not merely a sick person—while the patient can perceive in the clinician a subject, beyond the role they perform. Medicating a patient who can exist in the world with their psychiatrist can be a significantly less

[9] Serpa Jr. (2007), when discussing the contributions of Northoff and Heinzel (2003), presents first, second, and third-person perspectives as epistemological frameworks for understanding subjective experience.

challenging task, since it ceases to be an exclusively technical act; in a closer and less hierarchical relationship, the medication can represent one therapeutic element among others, and not the central element of this relationship and the treatment itself. In Caio's case, this seems to have been decisive for the acceptance of the prescribed medication.

Dialogue concerning lived psychotic phenomena and the sharing of these lived experiences—which ultimately prove to be exotic even for the individual experiencing them—can foster relief. Furthermore, the dialectical relationship between individual psychotic experiences and actual shared experiences allows the clinician to "practice life, instead of merely thinking about it" (Englebert, 2021, p. 8, our translation). In this sense, the author further explains that part of the therapeutics with psychotic individuals consists simply in being able to be together, without necessarily having to address a specific theme—so that clinician and patient can share "informal moments (...) in which the therapist might give the impression of not doing their job, when in fact they may be at the peak of it, in their subtlest ethical commitment" (Englebert, 2021, p. 8, our translation). Indeed, in these terms, one can conceive that the moment at the snack bar with Caio, sharing an açaí and exchanging stories, was a medical consultation.

A psychiatric treatment, considering care in its global dimension, typically includes a pharmacological prescription as a way to modify lived experience. Given the fundamental alterations of corporeality observed in schizophrenia, this prescription assumes paramount importance. Tamelini and Messas (2019) discuss the effect of antipsychotics through the expansion of the lived experience of corporeality; however, in isolation, such drugs do not exhaust the need of schizophrenic subjects to weave their own existence.

TA, grounded in intercorporeal experience, acts precisely at this sensitive juncture: while the psychotropic drug promotes an enhancement of corporeality through biological means, TA does so through the psychosocial dimension—in other words, they are tools that act upon existence in complementarity. Medication and TA do not aim to normalize the patient; on the contrary, both seek to sustain the individual's possibility of being-in-the-world. In this sense, doses of shared experiences are as indispensable to the treatment as the selection of appropriate medication.

Final considerations

TA, from a phenomenological perspective, configures itself as a clinical device capable of intervening directly in the lived experience of the individual with schizophrenia,

opening up possibilities for the reconstruction of their fragmented world. More than a technique, TA constitutes a mode of presence in which intercorporeality and spatiality allow for circulation between the personal world and the shared world. The effectiveness of care results from the articulation between pharmacological strategies and shared experiences, reaffirming the centrality of the subject's experience as an essential point for caring for a person—beyond their illness. Ultimately, added to this is a singular mode of clinical relationship: although asymmetrical, it is not structured as a unidirectional avenue of intervention, since it also impacts the ways clinical practice is conducted and demands from the therapist a continuous flexibilization of their interventional frameworks. Presence is never neutral for the one who experiences it.

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