Revista Argentina de Clínica Psicológica
2023, Vol. XXXII, N°1, 01-06
DOI: 10.53555/03276716.2023.7009

The Lebenswelt (Lifeworld) Of The Mother-Woman With Post-Partum Depression (PPD)

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ABSTRACT
This qualitative phenomenological research aims to discuss the Lebenswelt of women with PPD.
Continuous individual interviews were conducted with seven women, starting from the question: From your experience, tell me what it is like to have PPD. In the analysis, which was carried out based on the phenomenological method, five categories emerged that deal with the mother-baby relationship, body, time and space lived, guilt, society and feelings of love, fear, anguish and death. Results indicate that the experience is difficult and associated with physical, psychological and social suffering; that posture and bodily rhythm are marked by isolation, slowness and stagnation and that there is a feeling of "*dispotentialization*" and guilt, which constitute a barrier in the relationship with the other.

Keywords: Postpartum depression; Phenomenology; Phenomenological psychopathology; Maternity.

INTRODUCTION

In the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), postpartum depression (PPD) is classified as a depressive disorder beginning in the peripartum period, around the time of childbirth, to postpartum. According to the manual, 50% of PPD episodes start before the birth of the child. One in seven women experience PPD, which is a major public health problem, and when it is not treated affects the mother and children. PPD involves feelings of extreme sadness, indifference, fatigue, changes in energy, sleep and appetite, loss of pleasure in life, lack of interest and anxiety about the baby, feelings of being a bad mother, in addition to hormonal changes characteristic of the puerperium (APA, 2017).

When referring to diagnostic manuals we speak of the symptoms, which make up the pathology, but these do not encompass their meanings. In this article, we look through a worldly phenomenological lens and understand the symptom as a piece from the whole. When distinguishing symptom and phenomenon, Tatossian (1996/2012) writes "the phenomenon is much more than the symptom, because, indissolubly, it is comprised of the constituent and the constituted, the external manifestation and its meaning as a transcendental condition of possibility" (p.153). Thus, the symptomatological picture from the diagnostic manuals presented from the biomedical view shows, but does not understand, the experience lived as a phenomenon beyond the symptoms.

A phenomenological look goes beyond symptoms by seeking to understand the global way of being in the lifeworld (Lebenswelt) of each patient, who presents him/herself at the pre-reflective level (Tatossian, 1983/2012). In the depressive experience, the limit between sadness and depression is tenuous, with common sense not being able to differentiate these states. While depression is a mood disorder, sadness is of the order of feeling and is not, in itself, pathological (Tatossian, 1983/2012). This differentiation is essential in the postpartum period as the experience of maternal sadness or baby blues may occur. In this, the woman experiences a lack of confidence and decreased ability to take care of the baby, and in this period there is mutual recognition between the mother and the baby. Such an experience is not considered, properly speaking, depression (Carlesso & Souza, 2011).

This article aims to discuss the Lebenswelt (lifeworld) of women in postpartum depression (PPD). We understand that it is necessary to go beyond symptoms to reach the world of meanings attributed by women to their experience of being a mother. In this way, we seek to understand the meanings of the experience lived in its entirety, in the intertwining of the objective experience with the subjective experience, which makes up each Lebenswelt.

METHOD

In this research, we used the critical phenomenological method based on Merleau-Ponty (1945/2006), seeking to understand postpartum depression (PPD) in its multiple forms, from a worldly perspective that includes the cultural, the social, and the political as part of the etiology of psychopathology, being fundamental to the understanding of the phenomenon in its entirety (Moreira, 2004, 2009).

The research sites were the *Psicomater* clinic and the interviewees' home not linked to the clinic, both in the city of Fortaleza (Brazil). The first site is located at the Maternity School of Assis Chateaubriand (MEAC) and is

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intended for the care of psychiatric disorders in the perinatal period. The women interviewed at their homes were recommended by the contact network of the first author of this study, as well as by recommendations from the collaborators themselves. The research participants were chosen according to the following inclusion criteria: having a history of postpartum depression (PPD) and being at least 18 years old. All collaborators were informed about the ethical formalities of the study, signing the free and informed consent form (ICF). Ethical principles were followed in all stages of the research, in line with the Resolution of the National Health Council (NHC) No. 466/2012. Psychological support was provided in case of discomfort experienced as a result of participating in the research. The research project that originated this article was approved by the Ethics and Research Committee of the University of Fortaleza (Reference No. 2.723.791).

Seven women were interviewed, two of whom were being followed up at the *Psicomater* clinic, and were experiencing postpartum depression at the time of the research, and five women, not linked to *Psicomater,* and interviewed at home, indicated that they had already experienced postpartum depression. A total of 18 interviews were conducted, with an average of 3 interviews with each. The names of the interviewees were replaced by fictitious names in order to preserve their identities.

The phenomenological interview was used to access the world experienced by women in PPD, based on the guiding question: “From your experience, tell me what it is like to have postpartum depression”. The interviews were individual and continuous, with no previously established time. The interviews were recorded and later transcribed in full to be analyzed in their entirety, considering verbal and non-verbal gestures, such as crying, sighing, silence, and tones of voice, in order to understand the expression as widely as possible of the collaborating subject, thus enabling a greater approximation of the lived experience (Amatuzzi, 2009; Moreira, 2004).

The analysis of the interviews, which were carried out using the critical phenomenological method, (Moreira, 2004) was conducted using the following steps: 1) Division of the native text into movements, according to the tone of the interview: this is the initial step of the analysis, in which the literal transcription of the interviews was carried out by the researcher herself, considering in addition to the speech of the participants, the non-verbal aspects, such as silence, crying, gestures, tones of voice etc.; 2) Descriptive analysis of the emerging meaning of the movement: at this moment, the phenomenological reduction was carried out in order to understand the phenomenon from the participants' speech and not from their prior knowledge; 3) The movement of “leaving parentheses”: finally, the movement of leaving parentheses was carried out, in which the researcher stopped performing the phenomenological reduction and used previously contemplated theory to understand the content of the interviews, considering its multiple forms, such as political, ideological, biological, and cultural factors, amongst others. Table 1 shows the profile of the collaborators in this study.

TABLE 1 - PROFILE OF THE WOMEN INTERVIEWED

RESULTS AND DISCUSSION

Having identified the emerging themes from the content of the speeches, the following categories were constructed: 1) The mother-baby relationship and the signals from the body; 2) “A black and white world for me”: a time that does not pass, a space that suffocates; 3) “You won’t be able to live WITHOUT her ... I don't know how I will be able to live WITH her”: guilt vs. society; 4)
“A love full of fear, anguish and insecurity”; 5) The death of being a woman.

The mother-baby relationship and the signals from the body

The experience of PPD was considered by most of the interviewees as a phenomenon that is difficult to describe, it is associated with a high degree of physical, psychological and social suffering, and the initial manifestation occurred, mainly, in the alteration of the mother-baby relationship and in the signals from the body. Such signals were considered as the triggering moment, when faced with the responsibility that comes with the baby and its fragility, they experienced the feeling that they would not be able to cope, which generated feelings of anguish, guilt, feeling trapped and body pains.

In the interviews, a “disunited” character was perceived, in which women did not identify with their experience, feeling a division between themselves and their suffering, as something that came “from outside”, not belonging to them (Stanghellini, 2017). There was a feeling of confinement in the face of PPD, the symptoms making them prisoners of the disease. If we consider the human being and the range of meanings s/he attributes to her/his being-in-the-world, and not to the diagnostic label of PPD, this is an important way of understanding pathological experience (Moreira & Sloan, 2002).

"Not wanting to be around my daughter, not wanting to bathe her, change diapers ... There were times when I found myself standing looking at the ceiling, full of things to do and not wanting to get up to do anything” (Cecília)

We see, with Cecília, a break in her contact with the world, of which she feels at the center. There is a break

in the encounter with the other and this relationship with the baby, so socially valued, is weakened in the PPD. This phenomenon of centricity characterizes an anthropological existential marker of the melancholic type, the pathologies experienced as a vulnerable shelter in the face of a painful encounter with the other (Stanghellini, 2017). There is greater complexity in the current context of motherhood, in which the baby is seen as the center of the mother's life, with the mother being principally in demand for care and dedication in the formation of the child's personality (Zanello, 2018).
The relationship between mother and child, intersected by the PPD, was lived in an empty way. The vital impotence to act for the depressed individual has its source in the disturbances of the lived body, in the imbalance between the body that I am, or the subject-body, and the body that I have, or the object-body. The body that I am or subject-body means the body's own experience, a body in which I recognize myself. The body that I have or the object-body, on the other hand, acts as a point of connection with the world, allowing intersubjectivity in a body that can be seen as the other sees it (Tatossian, 1983/2012).
The feeling of helplessness was very characteristic of the experience of PPD in the absence of verbalization in the baby's first months. Daily acts were experienced as difficult when in contact with the world, which was no longer available or was felt to be insufficient. In the depressed individual's life, there is an identification only with the subject-body, the object-body turns off, which causes a disconnection from the other, with the world and with the baby, constructing a lonely life (Tatossian, 1983/2012). In the mother-baby relationship, there are also peculiarities in the first weeks that, when not cared for, may intensify or confuse the diagnosis of PPD: mother and child are little known, there is still no established communication pattern, and often the mother cannot distinguish the needs of the baby, who remains unsatisfied, and that can be manifested through frequent crying (Maldonado, 2000).
In this unstructured interaction, a deeply emotional relationship is built that can evoke feelings of anger due to the feeling of inability to meet the child's needs. In PPD, it is challenging to build the mother-baby bond in the face of the lack of investment in care and love and the feeling that this lack will never change, being felt only as burden and dependence. Stanghellini (2017) reports that one of the complaints of the melancholic individual, in an acute crisis, is the inability to love and be with the other. In PPD, at the same time that the baby's crying can be understood as a representation that s/he is there, it also highlights the impossibility of this encounter.
"You know that thing about you being unable to breathe, suffocating, tightness in your chest, wanting to cry. It is so painful ... can you go back and not get pregnant? My God, my life will never return to normal". (Maria)

The meanings attributed to life changes can lead to questions about their own lives, which no longer belong to them and which start to feel charged with loss of control and security, feelings of defeat and fragility and which are no longer sufficient. In depression, such movements refer to a poverty of gestures, a faded look, experiences of slowness of the body, fatigue and indefinable malaise. We can perceive the frequent attempt to verbalize as sadness the deep feeling of emptiness and indifference in the relations with the world of these mother-women, sadness being the emotional dimension most described in their experiences.

"A black and white world for me": a time that does not pass, a space that suffocates

Considering what is experienced as a phenomenon, in this category we turn to space and time. In the descriptions about PPD, time felt as though it had stopped and the space was experienced as suffocating.
This quote reveals a motherhood experienced in its complexity, responsibility and longevity, considering that once a mother, there is no longer the option of not being. Being is choosing oneself and that choice is put as an action into the world (Schneider, 2006), the being of motherhood is a choice that requires action without a determined time for completion. However, while undergoing the depressive experience, the woman is unable to move, she is paralyzed. In the reports of women with PPD there was a recurring projection of the future invaded by past experiences, combined with a feeling of helplessness. There is a disorder of the time lived during depression, with a paralysis of becoming and the future seen as closed, deterministic and without possibilities for changes (Stanghellini, 2017).
We understand that time lived is an opening to the future, an experience of power, but that during depression it is stagnant, just as the lived space loses depth and texture, individuals feel unable to appreciate the distance of things and movements or to concentrate on a certain point (Tatossian, 1979/2006). Even though she is surrounded by people and objects, her space constantly felt empty, which is rarely shared, since the social environment ends up restricting motherhood to a moment of fullness, in which the woman should be complete before her baby.
Time ceases to be lived as a means of development and changes, and starts to be felt as a repetitive confirmation of the comparison of the Self with its social roles (Bloc & Moreira, 2016). This feeling of being a viewer of one's own life is a characteristic feature of depression and is manifested in the experience of PPD. Lebenswelt (lifeworld) is marked by a generalized experience of not being able, recognizing and watching

this incapacity being expressed in perennial guilt (Tatossian, 1979/2006).

“The good days started to come more than the bad days, it was really a detachment ... and then my world started to turn pink. It started to get better ... before, it was like I was in a black and white world, in a tunnel without light, and little by little it became clearer, the light was entering ...” (Cecília)

Time and space were lived as definitive dimensions in the experience of PPD. However, with Cecília, we can see this transformation from a black and white world of depression to a world that has started to “turn pink” with its improvement process. In a dialectical way, the change in the perception of tones in the colors of her world began to occur in her new role as a mother.

"You won’t be able to live WITHOUT her, I don't know how I will be able to live WITH her": guilt vs. society

“They told me that I wouldn’t be able to live without her, and I asked myself: I don't know how I'm going to live with her, how I was going to work if I had to take care of her ... nobody could take care of her ... that burden was mine, I didn't see any pleasure in that”. (Cecília)

People in a depressive state submit to public opinion, common-sense stereotypes and social norms (Stanghellini, 2017), and in PPD there is an inability of women to significantly experience motherhood, free from ideologies imposed by society. The role of mother ends up being lived with the feeling of guilt, the obligation to care, to feel, to love, even with a support network.

“I felt guilty because I wanted to have him, it was planned, so how can I be depressed with a baby that I wanted to have, I can't. The guilt is that I can't find reasons to be so sad”. (Pietra)

PPD is experienced in a social context that relates being a good mother with the feeling of guilt, in which, at the same time, she demands and is demanded to always give more to her child, and is faced with the inability to act. Unlike what the literature points out (Bos et al., 2013; Frizzo et al, 2013; Mendonça et al., 2013; Zaconeta et al, 2013; Morales et al, 2014; Alexandre et al., 2016; Carvalho et al., 2016; Schaefer and Donelli, 2017) most collaborators did not present risk factors such as unplanned pregnancy, prematurity, single motherhood, marital and socioeconomic difficulties, amongst others, for postpartum depression. Many of the interviewees did not present these factors, and maintained healthy relationships with partners while having planned the arrival of the children.

“... there was a time when he (husband) left and I cried ... I started to think that he would think I was weak, a bad mother. Until today, I don't talk about postpartum depression much”. (Bruna)

In a depressive state, as in PPD, there is a selection of stimuli based on the reduction of contact with the world, which positions this individual as a deserter from the world (Tatossian,
1977/2016), allowing this woman not to fulfill her maternal duties. In PPD, there is a lack of the “protective value of depression” (Tatossian, 1977/2016, p.37), as social impositions still have an influence on the mother. The need to meet social demands can lead women to become ill, as in PPD, as well as intensify an existing situation. Being a mother, worker, wife and daughter can constitute conflicting values and goals, especially in the postpartum period. A possible clash of roles opens the way to guilt and exhaustion, the main symptoms of depression (Stanghellini, 2017).

"A love full of fear, anguish and insecurity"

Maternal love was often described by the interviewees through feelings of fear, anguish and insecurity, which were not initially recognized, combined with the whole social construct of being a mother, which does not include such feelings:

"I did not identify motherhood as a process ... that beginning of motherhood that begins and ends ... the postpartum period, the puerperium that will end, but that first care ... we give so much of ourselves". (Terezinha)

We understand that the relationship with the other means the intersubjective intertwining with the condition of being a subject, in the case of the woman who becomes a mother, she builds herself into this new role in the relationship with her baby. In the interviews, the responsibility for caring for the baby was expressed as innate to the woman. In PPD, there seems to be a constant feeling of debt with the role as a mother, as if it were never enough. Connected to this feeling of guilt, there is a stagnation in the past with the regret of pregnancy and the feeling of inability to care for the baby, the time lived stuck in the past that characterizes depressed experiences.

Looking at PPD as a phenomenon that has passed has a therapeutic effect, indicating the possibility of realizing one’s potential in the face of a crisis. It is in this sense that Tatossian (1977/2016) reports that depression is not purely a negative suffering, as it favors potentialities, with a possible fruitfulness from this experience (Bloc & Moreira, 2016). Expanding the concept of love was one of the lessons learned by these women with PPD, understanding that worrying, taking responsibility and being able to ask for help is also a way of loving.

The death of being a woman

Some women reported their lives prior to motherhood as dead, recognizing themselves in an experience of mourning. People who experience depression usually feel, at some point, that they have already died and that

their body has become a corpse (Fuchs, 2010). Thus, there may be a movement of denial of their very existence or the existence of the world, predominating a “feeling of emptiness, of petrification, of not living” (Tatossian, 1979/2006, p.117).

The notion of self or identity (Messas et al., 2018) presents itself as relevant in the discussion about PPD due to the implications of motherhood and the great changes in the personal experience of the mother-woman. This notion is reported from two different perspectives: The prereflective self, this being the most primitive form of oneself, “rooted in the lived body” (p. 466), a contact with oneself, a self-awareness of oneself; and the reflective self, referring to an experience that implies the possession of oneself, the appropriation of oneself.

From these two perspectives of self in PPD, it is considered that the most primitive form of herself is related to the identity of the woman before motherhood, and that it is lost in some way in this new context. We can speak of a kind of symbolic mourning that affects this self with the advent of motherhood, considering that the transformations are related to the way, for example, of being a woman who changes in resignations and the acquisition of new roles. The notion of reflective self, on the other hand, presents itself as a necessary adjustment for the woman to appropriate her new identity, her new role as a mother, considering all the impacts and meanings required in motherhood, which socially expects that every woman wishes to be a mother and is prepared for such a function (Messas et al., 2018).

“I get angry, I wanted to feel useful and not just be a recluse and be a mother (...) I felt that my life was over (...) when I had this baby, I won't do anything else and I still feel that way”. (Americana)

We perceive a kind of elaboration of mourning for the loss of life before motherhood. There is a lament before the pregnancy and the experience of interrupting a dream and not the beginning of a great project, a view commonly associated with being a mother. There seems to be a disorganization of the lived, a phase of mourning as described by Parkes (1998), in which each role or pattern of action is recognized as inappropriate or uncertain. We understand, with Tatossian
(1977/2016), that in depression occurs the loss of the woman's identity, before being a mother.

There is a need to build a new way of functioning in the face of change “towards a new way of organizing towards a new self” (p. 38).

FINAL CONSIDERATIONS

By diving into the lived world of women with PPD, it was possible to access their difficulties, one of the ways to recognize their experiences is to look at the relationship with their baby and the signals experienced from the body. It was perceived how the children were described as strength, love and hope, but also as sadness, indisposition and lack of courage to perform daily care. Such existential meanings are difficult to access, since culture still presents a romantic view of motherhood, defining it as natural, expected and guided by instincts. This interferes with the construction of the role of mother, which becomes permeated with guilt, for not achieving what is expected socially.

It is necessary for both the mother to allow herself and for the construction of her model of maternity to be allowed, to get in touch with all the singularities of her world. There is a kind of “social pact” where the challenges of motherhood are not talked about, allowing only positive feelings to be expressed. Through a certain emotional control, it is established what feelings a good mother should have. Thus, it is necessary to allow for the construction of different dialogues about motherhood, not just restricted to an ideal path to be followed, which can crystallize the woman's experience in motherhood, resulting in an illness such as PPD.

We conclude that the risk factors for PPD mentioned in the literature do not cover all experiences. Under the lens of phenomenological psychopathology, such an understanding is of fundamental importance for a clinical practice that, without losing sight of its biological significance, intends to go beyond a purely symptomatic and isolated understanding of the disease and to understand the woman and her experience of postpartum depression as eminently worldly, in the dimension of her Lebenswelt, her lived world.

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