*Brief Report*

# Phenomenological considerations of the world of the obsessive patient

**Francesco Demaria [1,] *, Maria Pontillo [1], Domenica Bellantoni[1], Cristina Di Vincenzo[1] and Stefano Vicari[1,2]**

[1] Child and Adolescent Neuropsychiatry Unit, Department of Neuroscience, Bambino Gesù Children's 7Hospital, IRCCS, Rome, Italy
[2] Department of Life Sciences and Public Health, Catholic University of the Sacred Heart, 00168 Rome, Italy.
* Correspondence: francesco.demaria@opbg.net.

**Abstract:** Obsessive-compulsive disorder (OCD) remains, despite significant scientific progress, a pathological condition that is incomprehensible, due to its paradoxical psychological and behavioral symptoms. The present work aims at assessing current phenomenological understandings of this pathology. Among the cognitive models used today, post-rationalist cognitivism and cognitive neuropsychological psychotherapy, which both incorporate a phenomenological approach, seem most effective at grasping OCD patients' experiences of the world, which are typically characterized by hyper-reflexivity, at the expense of "natural evidence." For OCD patients, the emotional sense of the world becomes a set of sterile rules that determine a suffering life.

**Keywords:** obsessive patient, suffering, cognitive patterns, phenomenology

## 1. Introduction

Obsessive-compulsive disorder (OCD) is a neuropsychiatric disorder characterized by the presence of obsessive (i.e., intrusive, repetitive, unwanted) thoughts and compulsive behaviors or mental acts [1]. The disorder has a global prevalence of 0.25–3.0% [2]. However, obsessive-compulsive symptoms (OCS), more generally, are widespread. Among children and adolescents, OCS prevalence is reported in the range of 7–35% [3], and 30–50% of adults with OCD experience symptoms before the age of 18 years [4]. OCD is a chronic life condition [5,6].

Obsessions and compulsions associated with OCD can be time-consuming (often involving more than 1 hour per day) and may significantly interfere with every day life habits, compromising quality of life [7,8]. In the DSM-5, OCD is recognized within the specific diagnostic category of obsessive compulsive disorders, which includes related disorders; this deviates from its previous classification within anxiety disorders [9], reflecting scientific advances [10-14]. However, OCD remains a complex disorder with paradoxical psychological and behavioral symptoms [15,16]. Thus, it requires further research into not only its clinical and behavioral aspects, but also its experiential aspects [17,18].

## 2. Research objective

For a long time, clinicians have been curious about the main characteristics of patients suffering from OCD [17,18]. Studies have focused on the nature of their obsessions and the meaning of their anxiety, which they attempt to reduce via compulsions [19,20]; as well as the perception of disgust [21-23] and its pervasiveness in obsessive patients [7,8]. However, to date, research has not been able to grasp the true nature of OCD patients' suffering, with respect to their experiences of and representations of the world.

The present work aims at assessing the current phenomenological reading of this pathology, focusing on the relationship between the obsessive patient and their world and

 doi:10.20944/preprints202305.1714.v1

its representations, in order to better understand the particular suffering of the OCD patient. Phenomenology, according to its founder, Edmund Husserl [24], is an approach to philosophy that assigns primary importance to intuitive experience. Thus, it takes phenomena (as presented in phenomenological reflections that are indissolubly associated with the subject's perspective) as starting points and attempts to extract from them their essential experiential characteristics. More precisely, this approach is known as "transcendental phenomenology," and it has had a profound influence on modern cognitive frameworks..

**3. The world of the obsessive patient: Phenomenological considerations**

Since the earliest descriptions of OCD, researchers have debated how the phenomenology of the disorder should be understood [25].
Erwin Straus [26], one of the leading exponents of phenomenological psychiatry in the 20th century, noted that, in every day life, obsessive patients are blocked by obstacles and impediments that do not constitute problems for "healthy" individuals.
This simple statement leads to a fundamental question that may help us to broaden our understanding of OCD: Why are"healthy"individuals able to tolerate uncertainty, while such uncertainty seems towear out patients with OCD?
In attempting to answer this question, we will consider the traditional cognitive vision model [27], the post-rationalist cognitive model [28], and neuropsychological cognitive psychotherapy approach [29,30].
More specifically, we will attempt to determine which of these models—all of which are influenced by phenomenological thought—can most effectively grasp the world that is experienced by OCD patients.
According to the traditional cognitive model [31-33], individuals know the world through mental functions such as perception, attention, memory, and thought. Mental processes allow individuals to transform, reduce, store, and retrieve the information that reaches their sensory systems. Behavior is conceived of as a series of acts guided by cognitive processes to solve a problem, with continuous adjustment to ensure the best solution. The mind is therefore an apparatus with a fixed sequential organization, which regulates behavior according to its momentary objectives and reduces the discrepancy between subjective representations and facts in "reality.
For obsessive patients, the discrepancy between subjective experience and reality is so great that it leads to obsessions—that is, to incorrect assessments of the "truthfulness" of facts. OCS stem from patients' incorrect thoughts and evaluations of themselves and external reality, as compulsions and rituals are introduced to reduce the negative emotions that arise from these dysfunctional assessments [34]. Several studies [35-39] have provided support for these cognitive hypotheses and helped to outline two fundamental concepts that may, from this perspective, contribute to OCD: feelings of guilt and inflated responsibility.
For obsessive patients,the possibility that one may be guilty of something is experienced as not only demeaning and negative (as for healthy people) but, above all, as an unforgivable catastrophe that cannot be overcome [40-42]. This self-consideration goes hand in hand with OCD patients'exaggerated sense of responsibility [43,44], which Salkovskis and Forrester [45] defined as the belief that one has a fundamental role in determining outcomes and reducing negative consequences (i.e., through rituals or superstitious gestures).
According to cognitivism, uncertainty and doubt [46-49] are ill-tolerated by OCD patients, because an excessive sense of responsibility and guilt imprisons them in a vicious circle of thoughts (i.e., obsessions) and does not allow them to accept the situation as is. Their exaggerated and dysfunctional belief that they play a central role in determining consequences leads to an incorrect assessment of reality. Therefore, false, exaggerated, and wrong beliefs lie at the root of their condition.
Now, is it possible to understand a pathology as something that "happens" only in the

 doi:10.20944/preprints202305.1714.v1

mind? If one considers humans thinking machines, then this cognitive perspective is correct. However, this perspective, while contributinga meticulous and systematic analysis of the characteristics of obsessive thought, limits its observations to the functioning of the individual's mind, while overlooking the fundamental sense and meaning of the world in which OCD patients are trapped.

Straus's methodology of structural analysis [26] aims at tracing the constitutive essence and structure of psychic disorders. This involves comparing the characteristic elements of a given disorder with their correspondences in "normal" psychology. Straus claimed that, in psychiatric work, more attention should be paid to the standard modalities of phenomena, since it is only through comparison with "normality" that it is possible to achieve an adequate understanding of psychopathological manifestations. More specifically, he wrote [50] that "only after coming to understand the world in which the obsessive patient lives can one hope to know the genesis of the pathology."

Straus's phenomenology introduced a new vision of the individual, sensitive to the phenomenological approach—one in which the individual was no longer understood as an isolated subject, but as an inhabitant of the human world. This made different experiences understandable in the light of every day life. The object of Straus's phenomenology was individuals' experienced consciousness, be it "normal" or pathological.

According to Straus [26], pathology is an interruption of the "normal" subject–world relationship, since existence takes shape in relationship with the other. Therefore, for OCD patients, something is broken in their relationship with the world; what is lacking, precisely, is the sense of continuity and form that should characterize worldly objects (i.e., the physiognomy of the world). Existence, for OCD patients, is experienced as a shapeless whole (i.e., as aneidos, as opposed to the eidos, representing a harmonious articulation) of objects, moments, and sensations. Without a sense of outer organization, objects and the world lose their pleasantness. For this reason, Straus [26] described that disgust is the central and fundamental character of obsessive pathology.

Post-rationalist cognitivism developed the cognitive model further, in harmony with the phenomenological approach. This model does not consider psychological reality objective and objectively definable, but it instead regards it asthe product of the interaction between the observer and the environment [51]. In this framework, the mind is not a simple passive computer of information. Rather, it builds (based on cognitive schemes that organizepersonal meaning) reality actively through interaction with—and the interpretation and classification of—the surrounding environment [28].

Self-consciousness, worldviews, and existential temporality, in narrative form, follow verbal, unconscious rules (i.e., tacit knowledge) [52]. The continuous assimilation of experience over time progressively increases the inner complexity of the self, taking the individual to more integrated levels of self and world knowledge [53]. These are the epistemological criteria on which the post-rationalist psychotherapy of psychopathological disorders such as OCD are based [54].

Cognitive neuropsychological psychotherapy represents a natural evolution of cognitive psychotherapy. This approach combines recent developments in neuroscience, developmental psychology, and psychopathology into a unitary theoretical framework [55]. Through this rigorous and interdisciplinary perspective (referring to the phenomenological and hermeneutic traditions) [56], the individual represents an inseparable unity of mental processes, body, history, and planning. This allows for psychotherapeutic interventions that are scientifically reliable and formalizable, yet not reduced to technical protocol. The framework attempts to integrate the concepts of bio and psi to promote a science of the person that does not sacrifice anything of the human being who acts and suffers [30].

This model seems better able to grasp the meaning of the world of OCD patients, in

 doi:10.20944/preprints202305.1714.v1

alignment with Straus's thesis that obsessive patients, defending themselves from the world and its "ugliness," do nothing but isolate themselves and close themselves in their own reality, thus breaking the original relationships that characterize human beings. Through this lens, disgust is the meaning grasped at the world's opening [30]. Therefore, the only conceivable mode of an obsessive relationship with the world is defense from it and its formless shape.

The phenomenological perspective, alongside the post-cognitive rationalist framework and neuropsychological cognitive psychotherapy, contribute significant insights into obsessive pathology by reflecting on the meanings of the world, as experienced by OCD patients.

The cognitive neuropsychological approach builds on Blankenburg's [57] concept of natural evidence, related to the study of pauci symptomatic psychosis. Natural evidence represents the background of pre-reflexive obviousness that gives continuity to experience (thematic consciousness), a sense of self, and temporality. It is altered in psychopathological situations, creating a feeling of detachment and unfamiliarity [58]. For OCD patients, the emotional sense of the world is insufficient. Therefore, their relationship to the environment must be managed and regulated rigorously and systematically, in reference to an external and abstract set of rules (undergoing continuous improvement). This allows them to maintain an adequate sense of personal stability [30]. OCD patients therefore meet the other and the world through a mediation of the reference system. OCS emerge from an alteration (i.e., "insecurity") of personal identity due to a mismatch between the experience and the set of rules through which OCD patients perceive themselves [59,30]. Whenever an inconsistency occurs—that is, when experience can no longer be reconfigured through the set of rules—the subjective sensation is that of disintegration, since the sense of personal stability is shaken. Obsessions are the consequence of the interruption between experience and the reference system, and compulsions represent an attempt to reconnect these aspects through an immediate re-positioning [30].

## 4. Conclusions

The models of traditional cognitivism [27], post-rationalist cognitivism [28], and neuropsychological cognitive psychotherapy [29,30] contribute different understandings of OCD: all provide a descriptive picture of the pathology, but only the latter two, which integrate a phenomenological approach, focus on the particular relationship betweenOCD patients and their world, characterized by hyper-reflexivity at the expense of natural evidence [57,58]. For these patients, the emotional feelings that normally direct individuals pre-reflexively become a set of sterile rules that determine suffering in the world.

**Author Contributions:** Conceptualization, F.D. and M.P.; investigation, writing—original draft preparation, M.P., C.D.V. and D.B..; writing—review and editing, F.D., M.P. and S.V.; supervision, F.D. and S.V. All authors have read and agreed to the published version of the manuscript.

**Funding:** This work was supported also by the Italian Ministry of Health with Current Research 194 funds.

**Institutional Review Board Statement:** Not applicable

**Informed Consent Statement:** Not applicable

**Data Availability Statement:** Not applicable

**Conflicts of Interest:** The authors declare no conflict of interest.

## References

1. American Psychiatric Association(APA). Diagnostic and Statistical Manual of MentalDisorders, 5th ed. American Psychiatric Association, Washington, DC, **2013**.

2. Walitza, S.; Van Ameringen, M.; Geller, D. Early detection and intervention for obsessive-compulsive disorder in childhood and adolescence. *Lancet Child AdolescHealth*, **2020**; 4, 99-101. doi:10.1016/S2352-4642(19)30376-1
3. Fullana, M.A.; Mataix-Cols, D.; Caspi, A.; Harrington, H.; Grisham, J.R.; Moffitt, T.E.; Poulton, R. Obsessions and compulsions in the community: Prevalence, interference, help-seeking, developmental stability, and co-occurring psychiatric conditions. *Am. J. Psychiatry*, **2009**, 166, 329-36. doi:10.1176/appi.ajp.2008.08071006
4. Micali, N.; Heyman, I.; Perez, M.; Hilton, K.; Nakatani, E.; Turner, C.; Mataix-Cols, D. Long-term outcomes of obsessive-compulsive disorder: Follow-up of 142 children and adolescents. *Br J Psychiatry*, **2010**, 197, 128-34. doi:10.1192/bjp.bp.109.075317
5. Skoog, G.; Skoog, I. A 40-year follow-up of patients with obsessive-compulsive disorder. *ArchGenPsychiatry*, **1999**, 56, 121-27. doi:10.1001/archpsyc.56.2.121
6. van Oudheusden, L.J.B.; Eikelenboom, M.; van Megen, H.J.G.M.; Visser, H.A.D.; Schruers, K.; Hendriks, G.J.; van der Wee, N.; Hoogendoorn, A.W.; van Oppen, P.; van Balkom, A.J.L.M. Chronic obsessive-compulsive disorder: Prognostic factors. *Psychol Med*, **2018**, 48, 2213-22. doi:10.1017/S0033291717003701
7. Eisen, J.L.; Mancebo, M.A.; Pinto, A.; Coles, M.E.; Pagano, M.E.; Stout, R.; Rasmussen, S.A. Impact of obsessive-compulsive disorder on quality of life. *Compr Psychiatry*, **2006**, 47, 270-75. doi:10.1016/j.comppsych.2005.11.006
8. Stengler-Wenzke, K.; Kroll, M.; Matschinger, H.; Angermeyer, M.C. Quality of life of relatives of patients with obsessive-compulsive disorder. *ComprPsychiatry*, **2006**, 47, 523-27. doi:10.1016/j.comppsych.2006.02.002
9. American Psychiatric Association (APA). Diagnostic and Statistical Manual of MentalDisorders, 4th ed. American Psychiatric Association, Washington, DC, **2020**
10. Fouche, J.P.; Groenewold, N.A.; Sevenoaks, T.; Heany, S.; Lochner, C., Alonso, P.; et al. Shape analysis of subcortical structures in obsessive-compulsive disorder and the relationship with comorbid anxiety, depression, and medication use: A meta-analysis by the OCD Brain Imaging Consortium. *Brain Behav*, **2022**, 12, e2755. doi:10.1002/brb3.2755
11. Gonçalves, Ó.F.; Batistuzzo, M.C.; Sato, J.R. Real-time functional magnetic resonance imaging in obsessive-compulsive disorder. *Neuropsychiatr Dis Treat*, **2017**, 13, 1825-34. doi:10.2147/NDT.S121139
12. Kong, X.Z.; Boedhoe, P.S.W.; Abe, Y.; Alonso, P.; Ameis, S. H.; Arnold, P. D.; et al. Mapping cortical and subcortical asymmetry in obsessive-compulsive disorder: Findings from the ENIGMA Consortium. *Biol Psychiatry*, **2020**, 87, 1022-34. doi:10.1016/j.biopsych.2019.04.022
13. Thompson, P.M.; Jahanshad, N.; Ching, C.R.K.; Salminen, L. E.; Thomopoulos, S. I.; Bright, J.; at al. ENIGMA and global neuroscience: A decade of large-scale studies of the brain in health and disease across more than 40 countries. *Transl Psychiatry*, **2020**, 10, 100. doi:10.1038/s41398-020-0705-1
14. van den Heuvel, O.A.; Boedhoe, P.S.W.; Bertolin, S.; Bruin, W. B., Francks, C., Ivanov, I., et al. An overview of the first 5 years of the ENIGMA Obsessive-Compulsive Disorder Working Group: The power of worldwidecollaboration. *Hum Brain Mapp*, **2022**, 43, 23-36. doi:10.1002/hbm.24972
15. Moreno-Montoya, M.; Olmedo-Córdoba, M.; Martín-González, E. Negative valence system as a relevant domain in compulsivity: Review in a preclinical model of compulsivity. *Emerg Top Life Sci*, **2022**, 6, 491-500. doi:10.1042/ETLS20220005
16. Starcevic, V. The paradoxes of doubting in obsessive-compulsive disorder. *Aust N Z J Psychiatry*, **2016**, 50, 19-20. doi:10.1177/0004867415579468
17. Bouvard, M.; Fournet, N.; Denis, A.; Achachi, O.; Purdon, C. A study of the repeated actions diary in patients suffering from obsessive compulsive disorder. *Clin Psychol Psychother*, **2020**, 27, 228-38. doi:10.1002/cpp.2422
18. Vanin, JR. Obsessive-compulsive disorder: Suffering in silence. *J Am Coll Health*, 1990, 39, 47-8. doi:10.1080/07448481.1990.9936211

19. Coleman, S.L.; Pietrefesa, A.S.; Holaway, R.M.; Coles, M.E.; Heimberg, R.G. Content and correlates of checking related to symptoms of obsessive compulsive disorder and generalized anxiety disorder. *J Anxiety Disord,* **2011**, 25, 293-301. doi:10.1016/j.janxdis.2010.09.014
20. Szentágotai-Tătar, A.; Nechita, D.M.; Miu, A.C. Shame in anxiety and obsessive-compulsive disorders. *Curr Psychiatry Rep*, **2020**, 22, 16. doi:10.1007/s11920-020-1142-988
21. Davey, G.C. Disgust: The disease-avoidance emotion and its dysfunctions. *Philos Trans R Soc Lond B Biol Sci*, **2011,** 366, 3453-65. doi:10.1098/rstb.2011.0039
22. Davey, G.C.; Bond, N. Using controlled comparisons in disgust psychopathology research: The case of disgust, hypochondriasis and health anxiety. *J Behav Ther Exp Psychiatry*, **2006**, 37, 4-15. doi:10.1016/j.jbtep.2005.09.001
23. Sprengelmeyer, R.; Young, A.W.; Pundt, I.; Sprengelmeyer, A.; Calder, A.J.; Berrios, G.; Winkel, R.; Vollmöeller, W.; Kuhn, W.; Sartory, G.; Przuntek, H. Disgust implicated in obsessive-compulsive disorder. *Proc Biol Sci,* **1997**, 264, 1767-73. doi:10.1098/rspb.1997.0245
24. Husserl, E. LogischeUntersuchungen. Opera (1900–1901), 2 vols.
25. Visser, H.A.; van Megen, H.J.; van Oppen, P.; van Balkom, A.J. A new explanatory model for obsessive-compulsive disorder. *TijdschrPsychiatr,* **2009**, 51, 227-37.
26. Straus, E. On OBSESSION: A clinical and methodologicalstudy.Coolidge Foundation,New York, **1948**
27. Neisser, U. Cognitive psychology. Appleton-Century-Crofts, New York, NY, **1967**
28. Guidano, V.F. Psicoterapia cognitiva post-razionalista. Una ricognizione dalla teoria alla clinica. Franco Angeli, **2007**
29. Liccione, D. Psicoterapia Cognitiva Neuropsicologica. Bollati Boringhieri, Torino, Italy **2011**
30. Liccione, D. Psicoterapia cognitiva neuropsicologica. Bollati Boringhieri, Torino, Italy **2019**
31. Charniak, E.; McDermott, D. Introduction to artificial intelligence. Addison-Wesley, **1985**
32. Collins, A.; Brown, J.S.; Newman, S.E. Cognitive apprenticeship: Teaching the craft of reading, writing and mathematics (Technical Report No. 403). BBN Laboratories, Cambridge, MA. Centre for the Study of Reading, University of Illinois, **1987**
33. Schank, R.; Abelson, R.P.. Scripts, plans, goals and understanding: An inquiry into human knowledge structures. Erlbaum,New Jersey, **1977**
34. Mancini, F. La mente ossessiva. Raffaello Cortina Editore, Milano, Italy, **2016**
35. Mancini, F.; Gangemi, A. Fear of guilt from behaving irresponsibly in obsessive-compulsive disorder. *J BehavTherExpPsychiatry*, **2004**, 35, 109-20. doi:0.1016/j.jbtep.2004.04.003
36. Rachman, S. Obsessions, responsibility and guilt. *Behav Res Ther,* **1993**, 31, 149-54. doi:10.1016/0005-7967(93)90066-4
37. Rachman, S.; Thordarson, D.S.; Shafran, R.; Woody, S.R. Perceived responsibility: Structure and significance. *Behav Res Ther,* **1995**, 33, 779-84. doi:10.1016/0005-7967(95)00016-q
38. Salkovskis, P.; Shafran, R.; Rachman, S.; Freeston, M.H. Multiple pathways to inflated responsibility beliefs in obsessional-problems: Possibleorigins and implications for therapy and research. *Behav Res Ther*, **1999**, 37, 1055-72. doi:10.1016/s0005-7967(99)00063-7
39. Tenore, K.; Basile, B.; Cosentino, T.; De Sanctis, B.; Fadda, S.; Femia, G.; et al. Imagery rescripting on guilt-inducing memories in OCD: A single case series study. *Front Psychiatry*, **2020**, 11, 543806. doi:10.3389/fpsyt.2020.543806
40. Basile, B.; Mancini, F.; Macaluso, E.; Caltagirone, C.; Bozzali, M. Abnormal processing of deontological guilt in obsessive-compulsive disorder. *Brain StructFunct,* **2014**, 219, 1321-31. doi:10.1007/s00429-013-0570-2
41. D'Olimpio, F.; Mancini, F. Role of deontological guilt in obsessive-compulsive disorder–like checking and washing behaviors. *ClinicalPsychological Science*, **2014**, 2, 727-39. doi:10.1177/2167702614529549
42. Mancini, F.; Gangemi, A. Deontological guilt and obsessive compulsive disorder. *JbehavTherExpPsychiatry*, **2015**, 49, 157-63. doi:10.1016/j.jbtep.2015.05.003

43. Jansen, M.; de Bruijn, E.R.A. Mistakes that matter: An event-related potential study on obsessive-compulsive symptoms and social performance monitoring in different responsibility contexts. *Cogn Affect Behav Neurosci*, **2020**, 20, 684-97. doi:10.3758/s13415-020-00796-3
44. Tallis, F. Obsessions, responsibility and guilt: Two case reports suggesting a common and specific aetiology. *Behav Res Ther*, **1994**, 32, 143-45. doi:10.1016/0005-7967(94)90096-5
45. Salkovskis, P.M.; Forrester, E. Responsibility. In RO Frost & G Steketee (Eds.),Cognitive approaches to obsessions and compulsions: Theory, assessment, and treatment (pp. 45-61). Pergamon/Elsevier Science, **2002** doi.org/10.1016/B978-008043410-0/50005-2
46. Cervin, M.; McNeel, M.M.; Wilhelm, S.; McGuire, J.F.; Murphy, T.K.; Small, B.J.; et al. Cognitive beliefs across the symptom dimensions of pediatric obsessive-compulsive disorder: Type of symptom matters. *Behav Ther*, **2022**, 53, 240-54. doi:10.1016/j.beth.2021.08.001
47. Marton, T.; Samuels, J.; Nestadt, P.; Krasnow, J.; Wang, Y.; Shuler, M.; et al. Validating a dimension of doubt in decision-making: A proposed endophenotype for obsessive-compulsive disorder. *PLoS One*, **2019**, 14, e0218182. doi:10.1371/journal.pone.0218182
48. Nestadt, G.; Kamath, V.; Maher, B.S.; Krasnow, J.; Nestadt, P.; Wang, Y.; Bakker, A.; Samuels, J. Doubt and the decision-making process in obsessive-compulsive disorder. *Med Hypotheses*, **2016**, 96, 1-4. doi:10.1016/j.mehy.2016.09.010
49. Tolin, D.F.; Abramowitz, J.S.; Brigidi, B.D.; Foa, E.B. Intolerance of uncertainty in obsessive-compulsive disorder. *J Anxiety Disord*, **2003**, 17, 233-42. doi:10.1016/s0887-6185(02)00182-2
50. Straus, E. Sull'ossessione. Uno studio clinico e metodologico. Giovanni Fioriti Ed, **2006**
51. Guidano, V.F. Psicoterapia cognitiva post-razionalista. Una ricognizione della teoria alla clinica. Franco Angeli, Italy, **2016**
52. Guidano, V.F. La Complessità del Sé. Bollati Boringhieri, Torino, Italy, **1988**
53. Guidano, V.F. Il Sé nel suo Divenire. Bollati Boringhieri, Torino, Italy, **1992**
54. Merigliano, D. La psicoterapia postrazionalista. Casi clinici, metodi di intervento e aspetti applicativi. Franco Angeli Ed. Italy, **2019**
55. Liccione, D. Casi clinici in psicoterapia cognitiva neuropsicologica. Libreriauniversitaria.it, **2012**
56. Gadamer, H.G. Verità e metodo. Bompiani, Italy, **1983**
57. Blankenburg, W. La perdita dell'evidenza naturale. Un contributo alla psicopatologia delle schizofrenie pauci-sintomatiche. Raffaello Cortina Editore, Milano, Italy, **1998**
58. Costa, V.; Liccione, D.; Vanzago, L. Il mondo estraneo. Fenomenologia e clinica della perdita dell'evidenza naturale. Morcelliana, **2021**
59. Arciero, G.; Bondolfi, G. Sé, identità e stili di personalità. Bollati Boringhieri, Torino, Italy, **2012**