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Should We Treat? A Reflection on the Limits of Psychotherapy

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Abstract

Background: We discuss our clinical practice in reference to philosophy and the historical background of major figures of psychoanalysis and mythology. We focus our reflection on the complex treatment of individuals with Asperger's syndrome. The inherent challenges posed by their condition significantly impact their quality of life and interpersonal relationships. **Purpose:** This paper develops the possibilities and constraints of psychotherapeutic interventions for individuals with Asperger's syndrome. We critically examine the nuanced concept of "normality" and explore the practical and ethical dimensions of directing therapeutic efforts toward the "normalization" of these patients. **Methods:** Our exploration begins by scrutinizing the healer concept within both somatic and psychological realms. Subsequently, we present observations on significant figures in psychoanalysis, namely Freud, Jung, and Lacan. Two clinical cases are then detailed to exemplify our perspectives. **Results:** The illustrated clinical cases underscore that attempts to "heal" individuals with Asperger's syndrome may prove ineffective or, in certain instances, even iatrogenic. Guiding these individuals on the path to "normality" might elevate stress levels and, paradoxically, diminish their overall quality of life. This can result in a profound and distressing regression. **Conclusions:** Our experience informs us that these patients cannot be "healed" in the conventional sense of normalized. Therapists must moderate their expectations, embracing and assisting in accepting the diversity inherent in these individuals. Our role is to support them in navigating the intricate compromises necessary to alleviate stress and enhance their overall quality of life.

Keywords

Autistic Spectrum Disorder (ASD), Asperger's Syndrome, Freud, Lacan, Jung, Psychoanalysis, Archetypes

1. Introduction

In the therapist profession, a precise diagnosis is important to treat a patient since we can rely on it when applying a remedy to a disease. This logic seems a simple truism, especially when young and relatively inexperienced. As the experience progresses, the therapist becomes weary of both diagnoses and even more related remedies.

We healers are proud to follow in the footsteps of Aesculapius. We often begin our career by pledging allegiance to him, his father and daughters by the Hippocratic Oath, which begins with: "I swear by Apollo the physician, and Aesculapius the surgeon, likewise Hygeia and Panacea, and call all the gods and goddesses to witness, that I will observe and keep this underwritten oath, to the utmost of my power and judgment" (Hippocrates, 1526).

However, while pledging our allegiance, we should also consider that Aesculapius, the physician human son of Apollo, was saved from the womb of a dead mother murdered by his father for adultery. This side of the story is a much darker heritage to consider and a heavy lineage to claim.

We must also remember that the great therapist shares his tragic origin with Dionysus, son of Zeus and the human Semele. Semele, a priestess of Zeus, caught the god's eye when she slaughtered a bull at his altar and cleansed herself in the river Asopus. Zeus, in eagle form, fell in love and secretly visited her, making her pregnant. Hera, discovering the affair, disguised herself as an old crone to befriend Semele. Doubting Zeus's identity, Semele asked for proof, demanding he reveal his divine form. Despite Zeus's warnings, she insisted, leading to her fiery demise. Zeus saved the fetal Dionysus by sewing him into his thigh, and later, Dionysus rescued Semele from Hades. She ascended to Mount Olympus as the goddess Thyone, presiding over the frenzy inspired by her son.

Perhaps we really need both the son of the Logos and the Lord of Chaos to heal our Dionysian confusion: humanity seems closer to unfortunate Semele, who is pregnant with a chaotic Dionysus.

In this story, Aesculapius represents the somatic side of medicine. The organization of the concepts is as clear and rational as possible. It is necessary to treat quickly since the timely provision of the remedy is essential to avoid the patient's suffering, sometimes unbearable, the invasion of the body by illness and, ultimately, death itself. The doctor must rely on certainties, at least temporary—today's certainties are tomorrow's errors—and protocols so as not to get lost in the face of the patient in danger. We will have doubts later. The patient must at least continue to breathe. Here, we thank Aesculapius and his Apollonian clarity: fortunately, the ambulance is coming!

Dionysus seems to represent instead the vast region of psychic care. In ancient Greece, alcoholic intoxication had a divine, even divinatory, aspect because it allowed approaching mystical ecstasy—albeit with significant and even devastating side effects. Chasing away the symptoms with a remedy that worsens them after a transient reprieve is a well-known aspect of psychiatric drug treatment

with addictive effects—e.g. benzodiazepines or opiates—but less frequent in psychotherapy. An orthodox Freudian analysis applied to a person on the autism spectrum often leads to overexposure to their insurmountable difficulties in understanding reality, so this approach is contraindicated. The problem is that the diagnosis of autism spectrum is not easy in the mild forms, and caregivers often direct the patients towards cognitive behavioral therapies, with the risk of trapping them even more into their obsessive and compulsive functioning. Nevertheless, something must be done.

Asperger's syndrome is a hyper-adapted chameleon.

2. The Wounded Healers

Often in psychiatric care, the clarity of choice, or simply clarity of mind, that rational light that should allow us to "see distinctly" may be dazzling and ultimately blinding, like the fire that consumes the woman carrying the sacred child—Dionysus—when she sees Zeus's full glory.

Dionysus' mother, Semele, as said before, wanted to see the face of Zeus and had caught fire. The fire also consumes Coronis, dead and still pregnant with Aesculapius, for it is from the funeral pyre that Apollo, after having too hastily defended his honor, in total repentance of his act, saves his son, snatching it from his dead mother's womb.

We find in Dionysus and Aesculapius the essence of the wounded healer, the shaman (Brouwer et al., 2023; Carminati & Gall Carminati, 2020), who passes through an ordeal of suffering, sometimes close to death, to return to a life as a caregiver. The initiatory journey through the Underworld is also present in heroic figures such as Odysseus, Aeneas, and even Dante, who recounts his own experience.

Several streams converge to create this image. The experience of sufferance creates an "inner sick" that "resonates" with the patient and allows the patient to find their "inner healer" who will conduct them from illness to health. The healer, having made the journey once, can guide the patient. Also, illness and quasi-death experiences connect the shaman with those who went through this path and died. This "conversation" with the souls of the deceased allows them to gain strength and wisdom to share with their patients. We could call this journey of catharsis a "creative disease".

Expanding this thought, without considering other psychoanalysts who may have similar traits, Freud, Jung, and Lacan share with Dionysus, Aesculapius, and the shamans the creative disease.

It is not in the authors' desires to exalt martyrdom or sanctify suffering; we are far too good living, very selfishly attached to the "arithmetic of pleasures"[1]

[1]The concept of the arithmetic of pleasures was introduced by the utilitarian philosopher and economist Jeremy Bentham, who introduced a "quantifiable" concept of the greatest happiness for the greatest number of people (Bentham & Cléro, 2005). This is considered an example of ethical hedonism, of which Epicurus was the inventor. Michel Onfray "retrodates" this concept to the philosophy of Epicurus in his lecture on the philosopher (Onfray & Onfray, 2019).

(Balaudé & Epicurus, 1994; Erler et al., 2023) to sacrifice our human serenity to the "stairway to heaven"[2]. Nevertheless, experiencing suffering is helpful, if not indispensable, in order to heal the suffering of others.

Looking at the Freudian, Jungian, and Lacanian "topologies of the soul", we see the structure that was theirs in transparency, which is surprisingly straightforward. Except that to be able to see it, it took us decades of personal analysis.

In short, Freud is a hysteric, his anxiety coming from conflicts between Nature and Culture, that is, between desire (lack according to Plato or action-motivating force according to Spinoza) and pleasure. Freud has an elaborate mental structure and a certain balance. We are definitely in the genital phase, as there is the paternal separating third, severe and imposing, but we have moved beyond the maternal dyad, and the father is trustworthy enough to be hated. The rebellion against the father is only possible when he appears as strong and dependable. Very often, the offspring of fathers whom the children felt weak or "incompetent" cannot rebel because they fear that "killing the father" would mean destroying the supporting familiar structure and, ultimately, facing death. A strong father can be "defied" without fear of actually "killing" him. Popular wisdom often says that "the worst parents are treated best by their children". In reality, their children "spare" them because they consider them inadequate. Nevertheless, this is not without effect on the children since it deprives them of the educational experience of the confrontation with the authority in a "safe" space.

Jung is a great depressive who suffers from a lack of acceptance of his limitations. He escapes the fear of death with the vision of an almost divine, redeeming Self. He has the intuition that the unconscious is not just "the crumbs that fall from the table of consciousness" but that there is a much larger unknown but highly structured region beyond the individual, encompassing the "magmatic" collective unconscious and what he calls "central fire". Jung's structure looks very vulnerable. The father is idealized almost as a pagan God, too idealized to be effective, just enough to play his role as the third element, separating the child from the maternal dyad. Jung's father was a "broken man" who had lost his faith and could neither make peace with this idea nor regain a new "sense" for his life. He deeply felt the contradiction between his duties as a rural pastor and his lost vocation. Jung had to save God without forsaking his father's lost faith. So, he moved God from the skies to the depth of the unconscious in the form of an archetype, the "numinous".

Lacan has the traits of Asperger's syndrome. The reality for him is incomprehensible, and language acts as a screen between reality and the imaginary, in

[2]Escaping his brother Esau, who has vowed revenge over Isaac's blessing, Jacob travels to Haran at his mother's request to find a wife among his family members. Upon his arrival in Louz, he experiences a remarkable dream where a ladder connects heaven and earth, with angels descending and ascending. It is there that God reveals Himself to Jacob, thus renewing the covenant established with his ancestors. Upon awakening, Jacob solidified this covenant and sanctified the place, now called Bethel. This account emphasizes the spiritual dimension of Jacob's quest and his commitment to God's covenant.

which the subject remains imprisoned. The mother-child dyad—the reality—is unattainable and unknowable for him because he is entirely inside it, and no distancing is possible. The father seems not to exist because the symbolic does not allow him to know reality, but only to escape into the imaginary. Lacan seems not to be able to find a "real" place for the subject (or for himself) and uses symbols to try—endlessly and hopelessly—to decipher the emotional world. We have a trace of this in Lacan's silence about his father in his writings and interviews. In his despair to traverse the screen of the language and face naked, wordless reality, Lacan makes language the founding principle of all knowable things, our conscious and unconscious mind. He is so afraid to confront what lies beyond—the mother? The father? Both undivided?—that he considers the contact with reality (the Real) the essence of traumatism.

However, Lacan was right in his intuition that words separate us from the concept they symbolize. When we learn the word "white", we can no longer see a white rose for what it is because we "must" disassemble it into "white" and "rose". So, a white rose has something in common with white snow or a white wall, which is absurd.

Only "ambiguous" words save us from an endless fragmentation of reality into mutually excluding categories. Ambiguity is why we can stop this process at a given level of granularity and talk to and understand each other, as it gives us "space to maneuver". If we had no "ambiguity" in our exchanges, we would not be able to communicate. Perfect clarity would lock us into a monistic universe and drive us to madness in the long run. We are in the middle of a Lacanian topic, well-illustrated by his image of the Borromean knot.

In Lacan's vision, the symbolic, i.e. the language, seems to separate us from reality rather than allow us to access it. It takes us away from the Real and into the Imaginary. This is a typically autistic vision. The Lacanian (real) word, blinding in its clarity, lacks the ambiguity and shadow necessary for understanding it.

All the above does not mean diminishing the incommensurable contributions of these thinkers to human knowledge, nor reducing them to a mere "psychological reaction". Nevertheless, we are often moved by very basic forces, as they themselves would easily recognize. Ultimately, what matters is what we make of the forces—triebs—coming from the depth of our unconscious. It has been said that the loftiest philosophical constructions are but very sophisticated justifications of a simple idea.

What prompted our reflections is that for Aesculapius and Dionysus, the fire is behind them, separating them from the mother. Being Lacanian, we could say that the fire-word-father separates them from the Real-dyad and allows them to act in the Imaginary-social as healers. The Logos—the symbolic—is the domain of the Father who edicts the law, necessarily expressed in words, and this law constructs the Imaginary where we live. It is less obvious to find the maternal—pre-verbal—environment in this vision unless we accept that the mother is "pushed" into the Real, therefore a non-knowable and potential source of trau-

ma if "discovered". We would be tempted to say "the Real we come from" since, at least ontogenetically, we must have had a pre-logos period—in our mother's womb, that is (Freléchoz et al., 2021).

Did Lacan understand that separating oneself from maternal reality is necessary to access paternal-social with the logos? If yes, and our intuition above has some ground, he did so banishing the Mother—or at least the pre-verbal, dyadic mother—outside the Imaginary.

Was this process impossible for Lacan, the autistic? Was his own logos too unambiguous to be comprehensible, and this pushed him to study it all his life? At the end of his life, aphasia robs Lacan of words: the fire has burned his tongue. Nevertheless, rarely has the Oedipus complex been worked on in its neurodevelopmental aspect so deeply as by Lacan.

3. Dionysus and Aesculapius

We can interpret the mythical characters of Dionysus and Aesculapius as the two poles of the healer archetype, the Apollinean, and the Chthonic[3]/Dionysian.

These are also the two poles of the mind-body dualism, from the point of view of care, and are both characterized by a tragic birth and a motherless upbringing after a divine conception.

The value of introducing the concept of "archetypes" to support our view is introducing "explanatory" categories. However, what is the relationship between these categories and the reality they are supposed to represent? Moreover, are not "diagnoses" "categories", too, "universals" that allow us to "speak" about the patient in "codified" terms? Dare we say that diagnoses are also "archetypes"? Furthermore, if so, do they represent realities, or are they just words, "flatus voci"?

That is the big question. Historically, this is the centuries-long philosophical debate between the "nominalists" and the "realists".

4. What Is There, There?

The nominalists' and realists' conceptions of reality represent two fundamental philosophical perspectives on the nature of existence and universals.

Nominalists, such as William of Ockham, argue that universals, like categories and general concepts, have no independent existence. They consider only individual entities real, while general terms are just linguistic conventions for grouping these individuals.

Realists, on the other hand, like Plato, believe in the actual existence of universals. For them, abstract concepts have a reality independent of our thinking, existing in a transcendent world or as perfect ideas.

This divergence influences metaphysics, epistemology, and philosophy of lan-

[3]The term "chthon" in Greek signifies the Earth, and chthonic gods are associated with the Underworld, the subterranean domain ruled by Hades and Persephone. In Greek mythology, notable chthonic deities encompass Demeter, Hecate, and Nyx. This concept stands in contrast to the Apollinean, which pertains to the heavens and Mount Olympus.

guage, fueling debates about the nature of reality and the validity of knowledge. Nominalists emphasize individual and particular reality, while realists insist on the objective existence of universal forms. These perspectives have profoundly shaped philosophical thought through the centuries, influencing fields such as the philosophy of science and the theory of knowledge. However, this is just an aspect of a more fundamental question explored by philosophy.

The fundamental debate in philosophy centers on the relationship between ontology and epistemology. Ontology seeks to understand what exists in the external world, while epistemology explores how knowledge is acquired. Ontologically, a major divide arises between monism and dualism, questioning whether what we perceive encompasses everything or whether the explanation lies in an "otherworld". Epistemologically, the critical question is whether a functional explanation of the world indicates a certain degree of existence for the elements used by that explanation.

Historically, this debate began with categories effectively ordering our world. Plato takes a decidedly realistic and dualistic stance, placing real categories in the "world of ideas" accessible only to philosophers. Aristotle attempts to temper Plato's extreme dualism, but both are realists. Aristotelian compromise gave rise to nominalism within scholasticism.

Psychoanalysis enters this debate by applying it specifically to the soul. Freud introduces a psychological dualism where psychological reality is explained in the unconscious. Freud's dualism is contingent and reversible, a "pathological" dualism of the soul that analysis can reduce back to unity.

However, with Freud's second topic and the "death drive", the unconscious gains permanent structure, reintroducing dualism. Freud refrains from declaring the ontology of the subconscious, either nominalistic or realistic.

Jung continues this by reintroducing Platonic universals with archetypes, embracing dualism and realism. It is, however, a materialistic dualism, even if we could interrogate ourselves on the extent and significance of the "numinous" archetype. Jung's dualism is materialist because he does not seem to admit an ontological God, but it is still a dualism because the explanation of this world, particularly of the synchronicities, is in another world—the collective unconscious—obscure and unknowable. Moreover, Jung's "numinous" archetype remains ambiguous, and at times, Jung seems to admit some form of ontological existence of a divine entity.

Epistemologically, Jung's universals—the archetypes—are unknowable entities, void of form, pure "vis formandi"[4]. They are but a relationship between signifier and signified. Analysis makes us aware of relations between entities belonging to the same archetype but never reveals the archetype itself. Lacan, a student of Freud, pushes this process to extremes. Language creates relations between signifier and signified, constituting the only knowable reality—the imaginary. The "Real" becomes an unknown and monstrous realm, with undeniable ontology but an impossible-to-define epistemology—a peculiar compromise.

[4]Desire to give form. Here, there is a Nietzschean echo of the "Wille zur Macht" (Will to Power).

By removing the real into an epistemologically quasi-unreachable region, the Question between nominalism and realism loses practical significance. The Real cannot be symbolized; therefore, "Universals" cannot, by definition, refer to anything real. They become symbols of language, infinitely multiplied. We live in the Imaginary, the space of relations. While the reality of our existence may not be in doubt, the Question becomes irrelevant, echoing Sartre's notion: "We are what we make of what remains of what others have made of us".

5. Back to Our Soul

Freud had to fight hard with significant economic hardship, earn a living, and almost renounce his life as a man with his wife to reduce the number of children to feed. Anna Freud comes from a "fortunate mistake" and comes into the world long after her siblings. Why didn't such an intelligent man, instead of mortifying himself, use contraceptives (they have been around forever!) (Anderson & Johnston, 2023; McLaren et al., 1996), taking his good pleasure? Probably because his psyche could not take things more lightly. Freud was mired in neurotic anguish centered around Oedipus and would not explore the power of the Mother-Child Dyad, so much more terrifying than the conflict with the Father (Galli Carminati & Carminati, 2020).

Jung is a sensitive young man, very well married to a wealthy heiress, brilliant and shrewd-minded. He sees the ancestral fear of archetypal depths and dives into it. Freud rejects it because he is probably aware of the vastness of the universal subconscious that escapes him and risks overwhelming his psychodynamic model. Freud always felt the lack of a "positivist" foundation for his theory after Fliess abandoned him and the (hopeless at the time, and even now) project to provide a somatic foundation for his theories. Jung's "mystical" vision would take him far from his "comfort zone". Jung pays dearly for the look he dares to give to the tapestry of archetypes structuring our world, and he falls ill with a deep depression. His wife despairs and asks for the help of "Jung's Jewess" Sabina Spielrein (Launer, 2022; de Mijolla, 2014), the former mistress of her husband and a fine psychoanalyst. Ms. Jung is also a psychoanalyst and understands what is at stake (Gaudissart, 2010; Neri et al., 2002).

Jung manages to overcome his depression. He draws and writes, in Gothic (!), the Red Book, pouring his sufferings into it. Like a shaman, he journeys to Hell and emerges, if not victorious, less desperate (Drob, 2023; Jung, 2011).

Sabine Spielrein suggested the concept of the death wish to Freud, and we can imagine that she knew something about it (Launer, 2011; Spielrein & Pflumio, 2022).

Lacan, the bilingual, reads Freud's works in the original language and manages to decipher what Freud himself did not understand to have said. Through reading, words, and finally, language, he explores the depth of the Other. Lacan knows how to do this, with his attention to details, caesuras, punctuations, and, above all, he knows only this, using a linguistic screen to try to understand the

Real. But it smashes into it like a fly against the glass, so he dreams of another Imaginary world (Lacan, 1966).

Are Jung's Red Book and Lacan's mathematizing language different screens between them and reality? We have discussed this in other writings (Galli Carminati et al., 2023b, 2023c, 2023d; Galli Carminati & Carminati, 2020), the difficulty for everyone to separate from the mother-child dyad, but especially for people with autism spectrum disorder. For them, the separating third—the Father—appears as a terrifying figure or is simply absent, which may be even scarier. For Freud, the father is the father of the horde to be killed, whom, therefore, the child can hope or dream to kill. The screen between the dyad (Lacan's reality) and the world we live in (Lacan's imaginary) is a symbolism that is less "difficult" to read.

Let us turn the sentence another way: Freud has less need of Jung, with his Gothic, and of Lacan, with his mathematizing language, of protection from the gaze of the Real/invader. Or is the Oedipus complex, so linked to patriarchy, in *re ipsa*, the screen that Freud tries to put between him and his mother? Curiously, Freud was born with a caul, a screen between him and reality and the maternal reality, too.

In any case, at the funeral of his mother, who died at a very old age, 34 years after his father, he sent his daughter and did not attend. Freud had health problems, and he, too, was weakened by age. He writes to Ferenczi:

"This great event affected me in a very special way. No sorrow, no regret, which is probably explained by the incidental circumstances: his great age, the pity her distress inspired towards the end, and, at the same time, a feeling of deliverance, of emancipation, the reason for which I think I understand. I did not have the right to die while she was still alive, and now I do. One way or another, the values of life will be noticeably altered in the deeper layers. I did not go to the funeral, and Anna represented me there, too" (Freud et al., 1979; Lehmann, 2003).

Lacan was right when he wrote that Freud himself did not know what he was saying, which was said with Lucifer's admiration for God (Lacan & Miller, 1998).

Freud uses the law, a form of code, a form of language, to separate himself from maternal reality. This choice indicates an advanced elaboration of the relationship with the mother and the possibility of creating borders, preventing the mother from "invading" the son. The concern for an embryo, if we can put it in these terms, is being internal to the invader being the invader of the invader, which poses an inextricable problem of borders.

Is language, which arrives or seems to arrive much later, used by Lacan as a border? Is this a possible path?

We return to Lacan's mathematical language to emphasize that mathematics is not obscure, quite the contrary, but it is probably perceived as such by Lacan, who was not a mathematician by trade. He collaborated with a mathematician, Alexandre Grothendieck (Carrive, 2012; Gauthier-Lafaye & Connes, 2022), but he did not have formal training in mathematics. Learning mathematics, like a

child learns language, trains the mind to use its formalisms automatically, making it accessible.

Lacan and Jung, in a less obvious way, use screens between themselves and reality and within themselves to protect from external and internal reality. These screens set the boundaries between reality (the dyad) and themselves.

The language screen avoids the dazzling clarity that reduced Semele to ashes. This screen is chosen as "hermetic" as possible, so that the enclosure of the "fire of truth" is hermetic.

Hermes links body and mind, Dionysus and Aesculapius. He is the messenger (the alchemical soul) who bridges the gap. The messenger God provides the etymology of the adjective "hermetic", i.e. difficult to understand. We circle back to the necessary ambiguity of communication. He also assists and supports the last glance of the soul that leaves life (Hermes psychopomp). In times not so long ago, the bridge was, like the entrances to the ports, where the "dazio"[5] or toll was paid, and San Dazio (Saint Dacian) was the protector of these places. It may seem trivial, but Dacian is described by Gregory the Great in Chapter 4 (Book 3) of his Dialogues (Grégoire et al., 2021) as an exorcist.

6. Screens and Borders

In alluding to the screen's function, we point out that its presence between the person and the mother (we mean mother as an imago, as the Lacanian Real) is not present from the outset. As primitive as it is, this defense system is still powerful. "Drowning in the mother" somatically leads to physical death (meconium inhalation syndrome). Psychically, it blocks development at a very primitive stage of non-individuation.

However, the screen is not what prevents us from seeing reality as it is, for we simply could not see it, or rather bear the sight of it if the screen were not there. On the contrary, the screen reveals reality to us because, without it, we would not be able to know it or interact with it. We need an intermediary, an *ancilla* who accompanies us in acquiring knowledge, like Dante, who needed Virgil and then Beatrice. The screen becomes the veil in the Muslim tradition, which is well explained in Ash-Shura Surah (42/51) of the Noble Qur'an: "It is not for any human that God should speak to him, except by inspiration, or from behind a veil, or by sending a messenger to reveal by His permission whatever He wills. He is All-High, All-Wise"[6]. Here, the veil becomes the frontier of our knowledge, an essential epistemological element that, if on the one hand, prevents us from going further on the other, allows us to encounter and exchange with reality. However, to be able to exchange, it is not enough to go to the border. We need "someone who knows", the prophet, the minister of religion, the psychoanalyst, the bootlegger—and finally, the smuggler.

Children transition from the protective yet limiting screen to the border, mark-

[5]Toll in Italian.

[6]Translation by Talal Itani (Telal, 2009).

ing a pivotal moment of empowerment, enrichment, and individuation. This developmental shift requires a conducive environment; a disadvantaged and abusive upbringing confines a child behind the screen, impeding their progression.

In instances of mental illness, resistance to treatment often stems from the reluctance to establish a boundary between oneself and the illness. The introduction of medication is perceived as a conflict with the nurturing mother, akin to ingesting medicine instead of breast milk.

Baudouin's exploration of Saint Christopher, ferrying Jesus across a river (Baudouin, 1987), underscores the centrality of borders in the psyche. The screen shielding us from the divine gaze can transform into the border, introducing a rule (the introduction of the third) that facilitates the transition between psychic spaces.

The pilgrim who crosses the bridge crosses the border and chooses to pay the price of his choice, "il dazio", the gabelle, and to pass from one place to another. The patient also has to pay the price to heal (the analytical pass is an example), but the opposite is also true, "ammalarsi fa bene", (getting sick is good) according to George Abraham (Abraham & Peregrini, 1991). The choice to get sick can protect against a more severe illness, or at least the patient's subconscious may think so. Healing sometimes passes through the reversal of this conviction, and it may not be an easy path.

In a recent paper, Demongeot tells us about the boundary between illness and health, with the patient moving from one condition of illness to another of health with the help of caregivers and medications, and also (and especially) with their own help (Demongeot, 2009, 2024).

The "fury to heal" is a vital motivator, especially for the young doctor or doctor-to-be. The studies are hard, and even when they are not, in some fortunate cases, faith in our healing power helps and motivates. Nevertheless, we must not exaggerate; the profession of a caregiver must necessarily compromise with the reality of the disease and the patients and our reality as caregivers who are humanly prey to fatigue and discouragement.

Healing is also a matter of choice, not our own, but of the patients. We caregivers and the patients, in short, all of us, have a minimal margin of maneuver between the personal unconscious, the collective unconscious, Nature and Nurture, and the current status of medical science. We are the clay vessels between the iron pots of Don Abbondio (Manzoni et al., 1995).

Nevertheless, there is a moment when we decide to give ourselves the means to heal (even when we talk about somatic illness indeed!): we ask for help, we accept to be sick, we take the trouble to follow treatment, pharmacological or psychotherapeutic, and we organize ourselves to arrive on time for appointments. In short, we accept constraints and rules, and by so doing, we choose to try to heal or at least to get better or less badly.

The choice to stay sick or, more positively, to accept what we are with our suf-

fering is also a boundary to cross towards a reality that seems livable to us. Why not? The aspiration of "Being happy" is not all good if it hides the absolute need for a smile from the mother (or rather the maternal imago). This imperative may imprison us in the "tyranny of our narcissism" (Lehotkay, 2020).

Making choices seems particularly delicate nowadays since every choice implies renouncing the neglected alternative. Even deciding a gender has become a matter of contention. Using the concept of Nature, or "natural", may seem a good remedy against the anguish of exercising "free will". Free will—whatever it is—often seems the skin of a pot of milk ready to boil over. However, Nature also has unforeseen excesses, and above all, the very definition of Nature is problematic. We get lost in doubt as soon as we try to use it in practice.

To invoke Nature to justify our choice would be, on reflection, like saying that it is the river under a bridge or the sea that divides two lands, which forces us to move from one place to another. In reality, the voyager decides whether to cross the border between two places.

7. Finally, Do We Need to Treat?

As psychanalysts, we pledge our allegiance to a "school" (Freudian, Lacanian, Jungian, and so on) and to its Master. Our diagnosis and the consequent therapy depend, in part, on the teachings of the school. So, we may argue, after what we said above, that it depends also on the "illness" of the Master. Of course, our work will be different if we are psychoanalysts, academically trained, or working in a treatment center where we have completed our practical training. As for the diagnosis, it depends, as we have just said, strongly on our "obedience". In case we are psychiatrists, our "obedience" comes from the academic tradition of the institute where we have specialized. The glasses through which we look at the patient have different colors and lights and lead to very different diagnoses if, for example, our training has been accomplished in a university or University Hospital and with which orientation such as systemic, somatic, psychodynamic, analytical, or rather oriented toward community medicine or other.

Let us give an example. We think that the diagnosis of borderline personality disorder depends more on the physician's "school" than the actual patient's condition (American Psychiatric Association, 2000, 2013; OMS, 1994, 2018). The diagnosis of borderline personality disorder describes the more apparent symptom—the patient's difficulty in interacting with others—rather than the etiological substance of the disorder, i.e. the reason why the person has these difficulties in their social life.

An individual's difficulty in interacting with others, or more generally with the environment, can have different reasons. There can be a developmental disorder, a neurotic block, a psychotic profile, or post-traumatic stress, among other reasons. What matters more is that, depending on the root cause, the remedy proposed can even become iatrogenic. If, for example, the patient suffers from Asperger's syndrome, and the therapist stubbornly insists on treating a neurosis,

not only will the patient surely not improve, but their condition may worsen. The overstimulation connected with a neurosis treatment will have the effect of exhausting rather than helping the patient.

As with Dionysus, who cures pain with wine, the remedy can be helpful in the short term but harmful in the long run.

We report here a reflection of our colleague on this matter (Zecca, 2023): "Generally, we have difficulties in accepting diversity such as gender or sexual. Asperger's patients are carriers of neurological diversity, i.e. their outlook on the world is different. However, this poses a serious problem in treating them. What does it mean to treat such patients? We believe we are victims of a remnant of nineteenth-century positivism. There would be only one type of man or woman who can adapt well to reality. Still, some have suggested that, from an evolutionary point of view, high-functioning autistic individuals benefit their species because their brain allows them to be hyperspecialized in one area, which benefits the group. So, is 'converting' them to non-autistic individuals synonymous with healing? Making them overadapted?!"

We sometimes forget that homo sapiens was not the only hominid at one time and that other forms of humanity existed, and that we can find in the genome of homo sapiens. We share 3% to 5% of the genome with Neanderthals. Undoubtedly, the Luzon, the Denisov man, and many others before had their own psychic workings, possibly different from ours but no less "normal".

The concept of healing has gone through a long evolution. What we must heal and what we must accept and consider "normal", even at the cost of a societal and cultural change, has changed considerably. Physical handicaps were supposed to be rooted out by eugenics. Although today we consider this abhorrent, proponents of eugenics have persisted well after the horrors of the Second World War up until a few decades ago. Forced sterilization in several Western countries has continued in the 21st century (NWLC, 2022). The American Psychiatric Association (APA) considered Homosexuality as an illness till 1973. Only in that year the APA eliminated the classification of "homosexuality" from the second edition of its Diagnostic and Statistical Manual (Bell, 1994; Drescher, 2015). Till very recently, the medical profession has treated hermaphroditism or intersex conditions have been treated with non-consensual gender-affirming care (surgery and hormone treatment) (Earp et al., 2023; Thomas, 2004). The attitude toward gender-affirming care has radically changed in the last decade, and it is now starting to be banned by major institutions (HRW, 2017). We believe we should also similarly revise the limits and opportunities of treating high-functioning Asperger's syndrome patients.

8. Clinical Vignette 1: Martine

It is helpful to give some clinical examples to clarify our reflection. Here, we present a first vignette.

Martine was 40 years old when she arrived at our consultation. She imme-

diately presents herself as a scientist, having completed extensive studies and looking for work after returning from Chicago, where she obtained her Ph.D.

She gives the impression that she is 20 years younger than her age, not only in appearance but in a certain youthful clumsiness in the perception of hierarchical scales and rules of propriety. Moreover, we suspect that the reason that she returned to Switzerland, although with a very honorable doctorate or even more, comes from her inability to elbow her way through, which is essential in the academic world, but also, in a less Machiavellian way, to create a network with colleagues and professors, to create alliances and collaborations with the other ongoing research activities even if outside of her academical work.

Martine also evokes homesickness and the need to live with her mother, who, having divorced since Martine's childhood, had never rebuilt her life and lived alone.

In this patient's story, we feel much varnish, cliché sentences, and a reluctance to tell her story outside an established script.

Martine consults because she feels alive without really living. She had a fairly long relationship in Toronto with a man she describes as very childish, focused on his gardening hobby, especially cacti, of which he regularly bought rare specimens, paying the price. After more than four years, the relationship stagnating and academic life drying up without an offer of a postdoctoral position, Martine had decided to return to Geneva, where her relationship with her mother, which had always been a stormy one, turned into a conflict with repeated ruptures and bitter arguments.

These facts happened 20 years ago, and care at that time was rather classically psychoanalytic, with anxiety hysteria at the center more than constraint anxiety.

If we think about it, Freud's constraint anxiety is very similar to Obsessive-Compulsive Disorder (OCD), which is now more clearly seen as one of the three poles of the frequent comorbidity triad of Asperger's syndrome, Attention Deficit Hyperactive Disorder (ADHD) and OCD (Galli Carminatiet al., 2023d). However, at the time, the focus was on the repression linked to the classically sexed Oedipus complex as the principal cause of anguish.

We focused Martine's therapy on connecting her emotional world to her appreciation of reality, helping in the management of negative emotions to improve social exchanges, providing much psychoeducation, and working on her loyalty toward her mother and her negation of her father.

It was not going so badly. Martine had found a job in the public service, not really challenging or stimulating but safe and decently paid. The relationship with the mother had improved, with occasional bouts of anger. It seemed that "real life" was far from Martine's reach, as she oscillated between the self-satisfaction of being able to avoid the "annoyances" of married life, the serenity of a stable workplace, the pleasure of her walks in the middle of nature… and the feeling of missing out on something elusive.

Having children, already because of the advancing age, remained in an emo-

tional limbo, like the rest, oscillating between the wisdom of not getting into the worries of parenthood and regret of not being able to dare live it.

Martine found satisfaction in her volunteer activity as a hiking guide and had even been elected president of the "Club des Centipedes", of which we had become a support member. It was a mistake on our part because mixing therapy with real life is absolutely to be avoided, and we are living proof that good intentions remain intentions but are not necessarily good.

After a long, quiet period at work, a management change had put Martine in a problematic situation because governance followed the zeitgeist, and she remained too nostalgic for the past to accept what she called "the environment".

Martine had fallen into a state of mild depression, discretely described as reactive, but which was, in fact, rather a recrudescence of her chronic depression.

Martine's relationship difficulties made us reconsider a neurotic diagnosis, and we asked for an evaluation of Asperger's syndrome, which resulted clearly positive.

This rethinking of the diagnosis resulted also from the evolution of our clinical stance. We had realized that certain neurotic aspects were spilling over into a borderline personality disorder—not to mention that Freud's hysterics have evident borderline traits. We started suspecting that these symptoms, which were stubbornly unshakeable even after several years of therapy, were much deeper than the good old remotion, even deeper personality disorder. We became more and more convinced that they were much older, "anchored in the flesh", and deserving their real name of developmental disabilities.

The difficulties encountered at work certainly came from a change in governance but also from her profound inability to adapt to changing realities. There had been problems with some colleagues and research partners. The atmosphere was becoming very tense. Martine had started to sleep poorly, to eat badly, and to isolate herself. We decided to prescribe her sick leave, which we knew would be long.

Martine also felt that our "soft" approach did not help her move forward in her personal life, so we decided to cover the administrative part related to her sick leave but entrust the psychotherapy to another therapist.

The expected evolution was not long in coming. Martine was able to start a relationship with a man around her age (Martine was over fifty). She was enjoying her apartment on the banks of the Sérine, and everything seemed to be going well, or at least better.

The long-awaited normalization was happening. Not in our opinion, however, since we remained, despite the promising start, very little convinced of this so-called normalization.

The reason was that, with time and some experience, we had observed that the energy recharge, the "psychic batteries", so to say, of people with Asperger's syndrome, is very defective and that some withdrawal is necessary not to exhaust oneself.

After returning to work, Martine left the therapist and resumed psychothera-

peutic follow-up with us. During her process of change, there had unfortunately been the death of her father, who, while conspicuous for his absence throughout Martine's life, was nevertheless an essential existential entity.

At the same time, there was also an unpleasant administrative procedure for a silly neighborhood dispute. Martine refused to pay a fine and decided to "fight" it in court. She won her case but at the price of suffering severe stress.

The family of the deceased father had surfaced, in our opinion, mainly to prevent Martine from claiming her part of the inheritance, but according to Martine, in a surge of sympathy and sincerity.

No matter how delicately we tried to turn the handlebars "in our direction", our cautious attitude seemed to annoy Martine, who finally felt perfectly normal, with her relationship ongoing, the father's family very present, on reasonably good terms with her mother, the apartment on the Sérine well invested, the gradual return to work on the way, the presidency of the Centipede Club in full swing.

All this led to tensions rather than appeasement in the therapy, and the opening to a listening space remained perilous. Martine felt she was healed and did not need us so much anymore, and she probably had reasons to feel that way, or, at least, her reasons.

After she expressed her desire to change psychiatrists because she felt that we no longer understood her, we agreed to stop the therapy. This decision came as a relief because we, too, were overwhelmed by her increasingly sustained and noisy manifestations of dissatisfaction.

So, we advised her to continue with another therapist. We left our position as a supporting member of the "Centipede Club" by remaining a simple member and decided to step back from an active role.

Some time passed, and a message to the members of the Club informed us of Martine's sudden resignation from the role of president. She informed us that she was on sick leave, probably for a short period, and we understood that the relationship with her partner seemed to be fraying as the links with the father's family. In short, we felt that Martine was returning to the point at which we left her at the time of her long absence from work.

In reality, however, Martine was not worse off for that.

Martine had regained her level of stability on her own, accepting that her real needs were to live more simply, with an existence that may be more monotonous but less complicated and, above all, less stressful.

"Healing" Martine had been iatrogenic. The effort to live a "normal" life burned through her resources at an unsustainable rate. In the end, she had to revert to her "abnormality" to find solace.

9. Clinical Vignette 2: Augustine

Augustine consulted us after a long journey with different therapists since adolescence.

She complained of being very tired and finding everyday life complicated and

tedious at the same time. She received a psychiatric disability pension for her personality disorder. She had committed several suicide attempts during her adolescence and early youth, but she did not succeed, more out of unparalleled luck than a lack of will to end her life.

Her rigid attitude, pathogenic perfectionism, a tendency to complicate her life by getting lost in the details, and obsessive thoughts ("a bike in her head")—that she admitted to having all the time, and which made her sleep poor in duration and quality—prompted us to insist for an evaluation for Asperger's syndrome, which turned out to be positive.

Augustine did not believe it. She pretended to be "normal", sick but normal. The twists and turns of her perception of normality were sometimes so impenetrable that we could not launch into learned and useless explanations. We just told her that we were going to deal with her sickness.

Augustine had been married to a man about her age for five years; they were in their early thirties, and she deeply desired to have children and start a family.

Mainly due to her chronic fatigue, we considered the possibility of adjusting the antidepressant treatment without danger to the child, but the inevitable overload of a pregnancy and an additional child were also factors we had to consider.

Augustine had become pregnant, but she had a miscarriage followed by another one, and finally, the pregnancy developed normally, and the fetus was growing well. In the end, there was the indication of a cesarean section, which Augustine did not easily accept. Indeed, a cesarean section did not fit into her plan of normality and upset her.

The baby one came into the world perfectly fit and healthy.

As was easily predictable, the adjustment to the child's needs was very tiring for the young mother: it was not only the fact of having the charge of a very dependent infant but, above all, the constant tension generated by the absolute obligation to be a good mother.

No matter how hard we tried to explain to her that being a "good enough" mother is more than enough, the standards she set for herself put her on her kneecaps.

With this with the little girl who was not yet a year old, she had decided that it was time to have a second child, and this child had come into this world.

Augustine was so tired during the second pregnancy that she had to urgently arrange a day mother, which she had vehemently refused before.

A second cesarean section went better than the first, and Augustine accepted it more willingly.

To her credit, Augustine did everything she could to live up to the challenge of raising two infants, and indeed, they were growing up well.

Augustine's couple was becoming increasingly a couple of good parents and less and less a couple. Augustine, on the one hand, wanted to become a mother with all her heart. On the other hand, she suffered from a heartbreaking nostalgia for when she traveled the planet with her backpack on her back.

These two Augustines were at war, and we tried to make them, if not friends,

at least fellow travelers. Our work consisted of support, support, support, and more support.

Augustine, now a mother, mourned her mother who had died young and remained in a complicated relationship with her father, a very clumsy person, but deep down present and helping, in his own way, all aside, but there, alive and healthy.

Augustine and her mother had often conflicted, especially in adolescence and early youth, and they could never resolve their divergence.

The father and the mother had an aversion to "shrinks". They, too, thought it essential to be "normal", and there was no question of bending their stance and accepting that they or their daughter had defects, let alone congenital disabilities, which was the case with Augustine.

Asperger's syndrome is a way of being that sometimes presents advantages on a cognitive level but has significant disadvantages in the management of emotional stress, especially in the management of social exchanges.

Also included in the follow-up was a nurse who, having set off on his high horse had had to his credit the profound humility and intelligence of adapting to Augustine's rhythm and of understanding that, more than high horses, it was necessary to move at the speed of a quiet turtle.

In this developmental disorder, the stress becomes chronic in response to the personality development disorder, appearing as a borderline personality disorder, which has at its center, let us not forget, an insurmountable difficulty in managing distance from the other.

Speaking of us, we had learned, thanks also to our inconclusive affair with Martine, to better manage distance from the patient in the therapeutic setting without trying to help patients at all costs by mixing, even with some caution, the therapeutic space with everyday life.

We also understood that the "imperative to heal" risks being a projection of our narcissism—the constellation of the archetype of the "great healer", as Jung would put it. Ultimately, perhaps it is more important to "hold our patient's hand", gently aging with them, without trying to "cure" at all costs. Unlearning to treat the illness is unnatural for someone with primary training as a medical doctor. It is a strange apprenticeship to acquire the patience of "doing nothing" to do—if not well—at least decently. Not healing for healing's sake is not easy.

Augustine's couple was faltering. The relationship with her school-age daughter was also taking a very confrontational turn, like that of Augustine and her mother, which Augustine understood well and, therefore, feared.

An attempt at couple's therapy ended in a rejection. They considered a separation, but this could lead them to an even more difficult situation, among other things, economically, by having to find an apartment for their husband.

After yet another bitter quarrel with her husband about her permanent exhaustion, Augustine realized that she needed help raise her daughter. This admission of need seemed to us a fundamental step forward in accepting her situation. She had made a long journey from refusing to share her daughter with the

day mom to ask for help from a child psychotherapist.

Probably in connection with her little daughter's first preschool experiences, we had the chance to rework Augustine's school experience. This work allowed us to revisit her career and, above all, to recall the strenuous efforts of Augustine's parents and herself, still a child, to be a good student, their/her need for her to do well at school, whatever the cost, proving her worth, despite her almost daily anxiety attacks.

We also found, and this time with permission to find them accurate, the opinions of two therapists, one a child psychologist, the other a professional counselor who had strongly advised Augustin, in the face of her exhaustion, one to repeat a class and the other to work no more than part-time.

Daily life remained exhausting for Augustine, and after a period of serious altercations followed by a vacation, spent in part alone from her husband and quite serene, the two spouses were in the process of facing reality. They started to accept—with resignation, certainly, but also with a newly found "existential serenity"—that each had their worries, that they were not "normal", and that they had to consider difficulties as facts and not as injustices.

Augustine took her life with a little more calm, accepting that she was a mother with problems but understanding that having children was in itself a big success, having desired them so deeply.

For our part, we continue to listen to her, sometimes giving advice, which we probably should not, supporting her, and telling us that we have a weird job sometimes.

Augustine is painfully aware of her "difference", and she blames herself for not being adequate. She suffers because she is not able to be happy in an inextricable feedback loop where the more unhappy she is, the more unhappy she becomes. We are just trying to stay close to her, reminding her that it is fine to be unhappy, most "normal" people are, it is OK to "miss one", and for once, feed her kids with prepared food, many "normal" people do. It is also OK to be tired, overwhelmed, and lost. We are trying to "slow the pace" and allow her to regain her bearings, which seems very far from the idea of healing.

10. Conclusion

We realize that in this paper, we took a very long detour to make our point. We went on a journey that began with the myths of Dionysus and Aesculapius, whose fire brought dazzling light but also death for their human mother. We described Dionysus and Aesculapius as the two poles of the healer archetype.

We continued our story with an unorthodox look at the three prominent "fathers" of psychoanalysis and their vision of the psyche, of course, through the veil of our own psyche.

We identified in a quasi-archetypal manner, the three Masters with three different mental disorders. We then argued that if the diagnosis, as well as the therapy that follows, depends on our obedience to the Master's doctrine—and therefore his illness—keeping a safe intellectual distance from our doctrinal training

and convictions is an excellent way to avoid damage to the patients, but also to ourselves. When dealing with somatic illness, the Aesculapian way, nowadays embodied by the medical protocols, has shown its effectiveness—if used with appropriate judgment. On the contrary, when dealing with psychic illness, it is instead Dionysus, the mystical healer, who should guide us in psychotherapy. We should consider the Masters' imposing intellectual constructions as a "toolbox" rather than a set of recipes to apply "coûte que coûte" at all costs.

Martine and Augustine cannot be "healed" in the usual sense of this word. To heal, they would have to change their view of the world. However, we believe that the root of their illness is developmental—Asperger's syndrome—and possibly neuronal (Galli Carminati et al., 2023a). Changing, i.e. "normalizing" their view of the world, would pose an impossible challenge. Any such attempt on our part would mean telling them—or at least making them feel that—"You ought to…" in one form or another. This imperative would just add stress to their condition, making them even more unable to cope. We, as healers, must accept their abnormality as normal so that they, too, can accept it and, from there, find suitable strategies to survive. In a sense, we should become part of an "ecological niche" around them, where their condition is tolerable. We should become the screen and the border with the "normal" world and be the "ferrymen" that allow them to move between the two realities as painlessly as possible.

The "fury to heal" is a good start, especially for the youth during their studies. Then, we learn to apply abstinence because the job of a caregiver consists of compromises with the reality of the disease, the patients, their entourage, and our own reality. In short, we may find ourselves with very little room for maneuver.

To explore this subject further, it would be interesting to perform a longitudinal study of individuals with early and late diagnoses. The objective would be to see whether "classical" psychotherapy has helped or rather hindered these patients. A possible bias of such a study is that severe cases tend to be diagnosed earlier, while mild cases can "hide" their condition much longer. There is also a gender difference, as women tend to be culturally more "compliant" and, therefore, to be diagnosed later when their status has become more severe. The evolution of the psychiatric attitude toward Asperger's syndrome, which is detected and diagnosed much more frequently today than even in the recent past, could correct the bias in the younger population. Today, there is much more attention to this syndrome—and less stigma attached—and diagnoses are made more easily. A longitudinal study started now, and comparing patients treated with classical psychotherapy or not could yield valuable results.

When working with patients with Asperger's syndrome, abstinence becomes a primary necessity. When faced with a developmental disorder, or in general with a type of development that needs calm and the lowest possible stress level, our position should be to listen and preserve the framework around the patient.

Our desire to heal may quickly become iatrogenic if we blindly follow the patient's—legitimate but unrealistic—desire to be "freed" from the illness. We need to keep the support in a central position in the patient's care. It is unnecessary,

and even dangerous, to imagine and lead the patient to hope for unrealistic change.

Disclaimer

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The authors declare no conflicts of interest regarding the publication of this paper.

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