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Beyond psychological individualism: rethinking clinical intuition in a post-Covid age

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Abstract: Psychological science has often insisted on an individualistic perspective. Such atomised understanding of the self has moved deeply in psychology, not only in its theoretical and experimental arms, but also into clinical practice. Here an example of how to deconstruct such myth at the micro-level is given: within the therapist's office space. Thereunto, we describe the case of Renata, 28 years old, musician and singer. The case report followed CARE recommendations. Four levels of analysis are suggested: a. understanding and diagnosing Autism Spectrum Disorder; b. neurodivergence and prejudice; c. autism in women: clinical bias and masking; d. self-directedness and intuition: overcoming social blindness. The conclusion points out to the importance of self-directedness and self-transcendence for clinical accuracy when there is a gender bias problem in autism spectrum. Above all, the case study presents broader consequences of the psychotherapist's awakening as an agent of social change.

Palavras-chave: autism; gender; masking; self-transcendence; prejudice

Além do individualismo psicológico: Repensando a intuição clínica em uma era pós-covid

Resumo: A ciência psicológica tem frequentemente insistido numa perspectiva individualista. Essa compreensão atomizada do self penetrou profundamente na psicologia, não apenas em seus ramos teóricos e experimentais, mas também na prática clínica. Aqui damos um exemplo de como desconstruir esse mito no nível micro: dentro do consultório do terapeuta. Para tanto, descrevemos o caso de Renata, de 28 anos, musicista e cantora. O relato do caso seguiu as recomendações da CARE. Sugerimos quatro níveis de análise: a. compreender e diagnosticar o Transtorno do Espectro do Autismo; b. neurodivergência e preconceito; c. autismo em mulheres: preconceito e mascaramento; d. autodirecionamento e intuição: superando a cegueira social. A conclusão aponta para a importância do autodirecionamento e da autotranscendência para acurácia clínica, quando há um problema de viés de gênero no Espectro do Autismo. Acima de tudo, o estudo de caso apresenta consequências mais amplas do despertar da psicoterapeuta enquanto agente de mudança social.

Keywords: autismo; gênero; mascaramento; autotranscendência; preconceito

Introduction

The 2019 pandemic brought to light our deep interconnection, both in terms of physical needs (we relied on those who physically kept supplying us with food) and of socio-emotional needs (the need for intimacy, sharing, and of physical contact). This might seem intuitive but psychological science has often insisted on an individualistic perspective. Psychology, as many fields of human sciences, has been affected by the "modern myth" of the self-rooted human being and the "self-made man" in historical Protestantism and Romanticism (Taylor, 1989). The photographs of people protesting against social isolation and the use of protecting face masks in countries as the USA,for instance, holding banners advocating that such decisions should rest with the individual — one of those banners read "Live free or die" — depict the resilience of the myth of individualism in the face of its obvious falseness: death was indeed the common outcome of this "free individual's" choice.

Such atomised understanding of the self has moved deep in psychology, not only in its theoretical and experimental arms, but also into clinical psychological practice. Hillman and Ventura's dialogues (1992), published as We've had 100 years of psychotherapy — and the world's getting worse is, in part, an open criticism by Hillman on the overemphasis of the individual's mind and agency to sort out her/his life, independently of the surrounding context and network of people that interact with and shape one's mind and behaviours continuously.

Another symptom of the malaise associated with the myth of individualism is the political acknowledgement of the growing rates of loneliness — this means of people who might live on their own or, otherwise, have very limited social interaction with others. In the UK, there is government sponsored publicity, particularly around Christmas time, for people to check on their neighbours who live on their own. The estimated number of the UK population who report feeling lonely has always or most of the times reached 7%. To make matters more alarming, those aged between 16-29 are the ones reporting the greatest levels of loneliness, reaching a 9.7% rate[4].

An example of how to deconstruct such myth of the "self-made man", at the micro--level is within the therapist's office space. We first contextualise that individual's life, focusing on gender, mental health and the premises for a person-centred integrative diagnosis, before focusing on Renata, a 28-year-old woman who lives in the south of Brazil, who is the source of inspiration for this paper. We then report her clinical case and eventually discuss it within a wider, socio-cultural context.

Gender and mental health

According to Louro (2008), the construction of gender is a life experience, and the body is identified as "male" or "female" based not only on the birth genitalia. Even the notion of sex, as a distinction between men and women, has historically been interpreted in different ways. To Laqueur (1992), until the 18th century, biologists, historians and anthropologists understood sexual difference according to what was called the "single-sex model". For example, women's genitalia were classified as an "internalized male genitalia", and scientists have suggested that the woman is a man with genitals that remained "inside" the body (Laqueur, 1992).

The "single-sex model" suffered changes only in the 19th century, when studies converged in the differences between male and female sex. Human sexuality was then understood as a "dual sex model" and the distinctions between men and women started a new era of dichotomy (Laqueur, 1992). Gender played a role in this perspective, when binary thinking concerning male/female established norms of behaviour as much as social and political interests.

In terms of meaning and classification, sex and gender are bound together in historical timeline. They are associated with biological, cultural, social, and political conceptions. "Feminine" and "masculine" categories are constructed based in historical power relations. Souza and Carrieri (2010), suggest that these concepts are not universal. According to Franco (2015), the existence of binary polarizations implies the existence of a pole, where "the superiority of one derives from the exclusion of the other".

According to Buttler (1999), language is used only to describe bodies and sexes, but - by naming it - language creates their differences. The philosopher discusses the concept of "gender performance", in which discourse produces the effect of what is named. In this way, people perform what is expected from them, by regulatory gender norms as what being a girl or being a boy is.

Following this line of thought, autism diagnosis is still a complex social challenge, particularly concerning gender (Whiteley, Carr, Shattock, 2021). It wasn't long ago that professionals spoke of maternal 'coldness' to justify the behaviour of autistic children (Grandin and Panek, 2015). Patriarchal culture imputed the guilt to mothers, who raised their children at home, while fathers were working or drinking with their male friends. In their free time, fathers were also writing about "penis envy", the schizophrenic and cold mothers, or the "female aspect" of personality. Gender studies are now revealing mechanisms that have masked autistic symptoms

in women. Being able to perform social expectations is a much heavier burden for girls than for boys, and this has had an impact in misdiagnoses, increasing mental health problems in the female autistic population (Bush, Williams and Mendes, 2020; Estrin et.al., 2020; Green et.al., 2019).

Cloninger's Psychobiological Model

Personality is understood as a complex and self-organized system, encompassing epigenetic and adaptive processes related to human development and learning: temperament and character (Cloninger, Svrakic and Svrakic, 1997). The first level of personality development is identified as temperament and presents innate and hereditary characteristics linked to automatic responses such as anger, fear and aversion. Temperament is subdivided into four dimensions, namely: novelty seeking, harm avoidance, reward dependence and persistence (Cloninger et al., 1993). At a second level, character also presents hereditary characteristics, although it is associated with learning and memory. The three dimensions of character define maturity in relation to self-directedness, cooperativity and self--transcendence (Cloninger, Svrakic and Svrakic, 1997).

Specifically, among the dimensions of character, self-directedness refers to an individual's ability to control, regulate and adapt behaviour to fit a given situation, in accordance with goals and values that he or she has previously chosen. It concerns the ability to self-criticize and delay gratification in order to achieve one's goals. On the other hand, cooperativity concerns a person's ability to live in society, tolerating differences (Cloninger, Svrakic, and Przybeck, 1993).

As the last dimension of character, self-transcendence has been considered a third level of personality development. Also called self-aware consciousness or self-awareness, the dimension of Self-Transcendence refers to non-linear and non-analytical thinking. It's related to intuitive learning, insight and creative thought (Cloninger, Svrakic and Przybeck, 1993). People with high self-transcendence tend to accept relationships that go beyond analytical and deductive thinking, as they feel a spiritual or existential connection that goes beyond themselves and can develop as spiritualists, artists or humanists (Cloninger, 2004; Alminhana and Cloninger, 2019). However, character maturity is the development of the three dimensions: self-directedness plus cooperativeness plus self-transcendence. People high only in the first two dimensions, are organized, but with no meaning and intuition. And people high only in self-transcendence can be

at risk for psychopathology (Cloninger, 2013; Alminhana et.al., 2016; Hori et.al., 2014).

The Psychobiological Model of Temperament and Character describes personality developmental features in a Ternary Model, or in three aspects of a structural-functional system: 1. temperament, with emotional automatic drives; 2. character, with intentional goals and social relationship; 3. self-transcendence, with self-awareness capacity as a creative search for meaning and well-being. The ternary approach to personality development is a neuroscience-based theory and integrates emotional habits (Temperament), Character Maturity (self-directedness and coooperativeness) and creative profile (self-transcendence/self-awareness/intuition) (Cloninger et al. 1993; Cloninger 2013).

Person-centered Integrative Diagnosis

The Person-centered Integrative approach to clinical practice and diagnosis is grounded in the Ternary Model of Personality, which includes Temperament, Character and Self-Transcendence. This adaptive system considers physical, mental, social and intuitive/self-awareness as inseparable and interdependent dimensions (Cloninger et al. 2012). In this integrative approach, mental health is understood as a complex web of feedback interactions with well-being and ill-being as outcomes (Cloninger et al. 2013. In other words, the need for care of a client cannot be seen as an "impairment mechanism to be fixed", but as a complex balance between functioning/wellness and disability/disorder (Alminhana and Cloninger, 2020).

Illness is associated with a lower capacity of tolerating frustration in goal achievement, lower capacity in establishing social connections, and a lower capacity in developing intuition and meaning. Well-being, on the other hand, is characterized by the ability to fight for one's goals, to have healthy relationships, and the ability to feel creative and meaningful (Cloninger and Cloninger, 2013). When we recognize resilience and flourishing (Seligman, 2012), we have well-being as a high level of development of Self-directedness, Cooperativeness and Self-Transcendence; this is also understood as Psychological Maturity or Creative Personality Profile (Alminhana and Cloninger, 2019).

Person-centered Integrative Diagnosis is a dimensional diagnosis approach that considers not only ill aspects, but also the growing and learning potentials of the whole human being. In addition, it promotes a higher quality client-thera-

pist relationship, when both can share goals, learn together and relate with empathy, deep listening and hope (Alminhana and Cloninger, 2020; Cloninger and Cloninger, 2011). This approach includes therapist self-development concerning Psychological Maturity (work to improve Character dimensions) and Creative learning (improving intuition, meaning and mindfulness) (Cloninger and Cloninger, 2013).

A broad comprehension of psychopathology is never dissociated from social and cultural aspects. Cultural expectations necessarily affect our understanding of Autistic Spectrum Disorder (ASD), its research and diagnosis. Is it not a fundamental characteristic of the whole history of mental disorders? However, we hardly ever see clinical and social psychology going hand in hand when undertaking clinical diagnoses.

The case presented in this study is an example of the relationship between a therapist (the first author) and her client, both living within a point in time and inserted in a specific culture, where women with ASD are poorly understood. The person who inspired this paper is Renata, a 28-year-old woman, who lives in southern Brazil and worked as a music teacher during the Brazilian lockdown.

Method

This section presents a clinical case report description and analysis. The case report followed the recommendations of CARE (Case Report Guidelines): (1) literature review; (2) face-to-face consensus meeting; (3) post-meeting feedback (Gagnier et.al., 2014). The client has also signed a Formal Consent Term. First person will be used in the description below (the first author is the psychotherapist).

Case description

Renata first came to see me in 2017, when she was still a music graduate student (lyric singing) at a Federal University. In the first session, she was very talkative, stating that she had been diagnosed with Obsessive Compulsive Disorder (OCD) at the age of 2 years old. Renata told me that between ages 11 and 14 she developed tics and a habit of cracking her neck, which she could not control, not even during performances by the choir she sang in, at social events, or even in the middle of the night. As a teenager, her OCD diagnosis was confirmed by a renowned psychiatrist in the area.

Renata didn't have many friends and lived alone. When she started therapy, she had an ex-boyfriend with whom she maintained online contact. They had been apart for some time and, since then, she had not seen anyone else, or shown an interest in trying to find another boyfriend. In May 2018, she began to show signs of depression and insomnia. Across various sessions, Renata arrived looking unwashed, her hair looked oily and she exuded an unpleasant bodily odour, the result of not showering regularly. I referred her to a psychiatrist with whom I collaborate, who realized she was unable to be by herself and asked her mother to care for her. Her mother reported that she had found Renata was living in rather unsanitary conditions — her flat had not been cleaned for a while and there were heaps of rubbish. She also reported that more often than not, Renata was not able to get out of bed. The psychiatrist and I decided she needed to stay at a psychiatric hospital in order to review her medication and deal more effectively with her depressive symptoms. Notwithstanding her clear depressive symptoms, Renata insisted that she did not want to die and that she quite liked herself: “my self-esteem is fine!”, she used to say. On the other hand, she had very low tolerance for any changes in her routine and presented clear social interaction deficits. Renata often said that she did not know how to do small talk and always felt socially odd, different from other people. Renata was intellectually bright and had suffered bullying throughout her school years, spending most lunch breaks hiding in the library. According to her mother, while still in preschool, Renata's teacher said that the children were able to "tolerate" her, although she had no friends.

Renata spent 15 days in hospital being treated for depression and after 6 months, she no longer showed any symptoms of it. Despite this, her mother kept living with her, preparing meals and taking care of her. I could see that she was not depressed, but was unable to live alone and do simple things, such as cleaning her flat or going out – even to buy groceries. With the onset of the pandemic, she reported not missing at all the social contact. Quite the opposite, she said she was relieved for being at home all the time, without meeting anyone, and not being judged as “weird” for that.

On the other hand, she kept reporting long periods of insomnia and intense bouts of anxiety. These anxiety crises would last for a few minutes, and she typically would feel paralyzed and cry. This could take place when going shopping for food, inside the shops (before the pandemic), or at home when she had to clean the dishes or take a last-minute decision. Despite the brevity of these moments, lasting no more than a few minutes, Renata would tell me that she needed two to three days to recover from the anxiety and feel well again.

As time went by, the psychiatrist repeatedly suggested that Renata should be looking for a romantic relationship, given that she was no longer depressed. She strongly disagreed, claiming that she was asexual and had no need to maintain sexual relationships. At about the same time, Renata began demanding a clinical diagnosis that could adequately explain all her "symptoms": why it felt so hard to clean and organise her place, why she had such intense anxiety crises, why she always felt different from other people. She suggested her true diagnosis was Attention Deficit Hyperactivity Disorder (ADHD) and stopped seeing her psychiatrist.

At that moment I realized I had to make a choice. The sessions with Renata were very challenging and she resisted any attempt to analyse her feelings, to search for deeper insights or psychological interpretations. Renata was very rational and objective in her thinking process, though also showing herself to be self-conscious and mature. I was left with two options: to either recommend another therapist or move into a different layer of therapeutic listening where I accepted Renata's insights and 'inner wisdom' about herself.

For a therapist with more than twenty years of clinical practice, this may sound like a "coaching cliché", as we are trained to "know more than our clients". Here I was potentially faced with the opposite, though. The pandemic probably helped me make the second choice, and I understood more poignantly how much I could not know or control.

Thus I started a new process of clinical thinking. For my PhD, I had worked with Differential Diagnosis so I knew that the wide range of symptoms that Renata experienced could not be explained by depression, ADHD, or by OCD. So, I kept going, listening to her very carefully and telling myself that I had to follow Renata's insights about herself. And at a certain moment, I suspended my analytical thinking and, with it, my attempt to fit Renata into a given category. Just by doing that I was able to understand the extent of my anxiety in trying to find an answer for Renata's question —what is driving my feeling and thinking like this?

And then it finally came. One day, we were sitting in my office using our facial masks (this was during the pandemic), and this insight just came to me: I saw it as a single word floating between us. The word was 'autism'.

At that moment I was "slightly shocked" by the experience. In fact, I felt not just startled but shocked: the insight felt as if someone had whispered into my ears; that I had no agency whatsoever in getting to it. I must admit that part of my shock had to do with my very basic knowledge of autism. Despite my PhD in differential

diagnosis, which led me to study clinical and personality disorders, I knew very little of neurodevelopmental disorders and of Autism Spectrum Disorder (ASD).

During that session, I tried to put on a straight face that did not show my shock and told Renata, "I understand your feelings, I hear you. You deserve an answer. I think I already have it, but I will ask you a little more time and patience as I need first to think carefully about it. And I need to see your mother to confirm some things about your childhood as well". She looked at me with her wide green eyes and I had a sense that she felt supported, heard, and cared for. After this session, I immediately messaged her mother, and asked her to come and see me.

In the session with Renata's mother, I heard the story of her childhood a second time but with new ears. I said, "Our understanding of autism has changed very significantly since Renata was a small child. If your daughter were a child now, she would not be diagnosed with OCD but with ASD". Her mother said she understood me, despite feeling confused and asking for time to process what I had just told her. In my next session with Renata I told her about the ASD; she sank into her chair and looked relieved. In the following weeks, she told me that she was revisiting and rewriting her whole life journey, through the new lenses of the autism diagnosis. Almost immediately, she stopped masking her mood and real feelings. I was also going to a similar revisiting of my 4 years as Renata's therapist, where I now understood so many of the loose pieces of the puzzle that I couldn't fit in before.

A couple of weeks after I told Renata of the ASD diagnosis, I met a psychiatrist who specialised in ASD. He ran various tests on Renata and interviewed her mother — he confirmed my diagnosis. Renata's anxiety and ADHD symptoms have improved substantially. She still has difficult days and is learning to accept she needs more time to process emotions, despite her mind wanting to move very quickly. I still see her as a therapist and Renata has told me repeatedly how grateful she is for my help, but I am no less grateful to her. Clients like Renata are gifts for psychotherapists.

Analysis and discussion

Four levels of analysis to understand Renata's case are suggested:

a. Understanding and diagnosing Autism Spectrum Disorder; b. Neurodivergence and prejudice; c. Autism in women: clinical bias and masking; d. Self-directedness and intuition: overcoming social blindness

a. Understanding and diagnosing Autism Spectrum Disorder

Autism Spectrum Disorder (ASD) is a complex neurodevelopmental disorder that usually manifests itself in the first years of life. It is characterized by deficits in communication and social interaction and restricted and repetitive patterns of behaviour, interests and activities. It has a multifactorial aetiology that affects 1% of the world's population and is four times more common in boys than girls (Lord et.al., 2020). According to research, autistic people may present: changes in behaviour, repetitive and stereotypical movements, echolalia, disturbances in sensory processing, inflexible routines and ritualized behaviours. Sometimes, they can focus on the same object or issue for a long time (Souza and Nunes, 2019; Gayato, 2018; Silva, 2021).

Emotional crisis is linked to self-regulation challenges in response to stress in ASD as the well-known "meltdowns" and "shutdowns". Meltdowns are described as feeling overwhelmed, experience extreme emotions and losing self-control with memory and thinking impairment (Lewis and Stevens, 2023). Shutdowns are described as uncontrolled reactions that lead to a lack of responsive behaviour as they fall expressionless or catatonic (Phung et.al., 2021). Genetic studies have shown that autism is heterogenous and comprises a wide range of profiles and comorbidities, such as depression, anxiety, insomnia, ADHD and high abilities. The autism spectrum profiles range from people who require almost constant attention to meet their daily needs to others that need very little support. Research suggests that people with ASD – especially women – are more likely to self-identify as asexual (Bush, Williams and Mendes, 2020; Whiteley, Carr and Shattock, 2021).

Renata's meltdowns and shutdowns were misunderstood and classified under Depressive Disorder. But depressive symptoms were only masking a more subtle condition of ASD. The difficulties Renata presented to go out, buying groceries or decision-making processes were not caused by sadness, low self-esteem or suicidal ideation. It was a consequence of cognitive and emotional overload, which led her to feeling paralysed (shutdown) or crying and shouting with her mother with no apparent reason (meltdowns).

b. Self-recognition and Neurodivergence

Silva (2021a) argues that the term "autistic people" is preferable to "people with autism" or "a person who has autism" because it reflects something else than a disorder: a complex identity. In his work, the author explores narratives of autistic people in social media and virtual spaces, searching for legitimate identities

beyond the DSM 5. Based in social theories from George Mead (2010), Charles Taylor (2011), Paul Ricoeur (2014), and Axel Honneth (2009), Silva (2021a) discuss how necessary is to change from the perspective of a "neuronormative Self" to a "neurodiverse Self".

His study analyses five social media profiles of autistic people and their self- narratives, as recognition of identities and trajectories. Ricouer (2006), defines three levels of recognition: the first is recognition as identification; the second is self-recognition, and the third is mutual recognition. In Renata's case, it was clear that she recognized herself as "different from other people". Mutual recognition was possible after the patient denied incompatible narratives of her trajectory, of how she felt throughout her life. Only then the therapist was able to reframe years of therapeutic work and shift from a neuronormative perspective to a neurodiverse worldview.

Renata was probably exhausted from trying to fit into a format she could not withstand. The social and family demands for a romantic relationship as something to be crossed off a check list on her mental health, according to neuronormative manuals was something like the last straw, which led her to stand up and say: "that's it!". Renata's resistance to adopting "normal" behaviour changed her self-narrative and helped her recognize her own identity. According to Ricoeur (2006), "it is our most authentic identity, the one that makes us who we are, that demands to be recognized" (p.30).

Authenticity and originality are important heuristic keys to shift perspectives. According to Taylor (2011), identity in the contemporary West is always a search for values in a social context or framework. The emergence of the self happens through a constant quest for what is good and the best choice to live well (Marcon and Furlan, 2020; Taylor, 2013). In this case, when Renata chose values that were not expected of a young woman, her own original identity emerged — that of a neurodivergent person.

The term neurodivergence was used for the first time by Singer (2017). It was a break boundaries approach to understand a range of different "choices of how to live well". The author states that if we insist in the biological perspective to explain human behaviour, we could apply the concept of "biodiversity" to multiple ways of thinking and feeling, naming it "neurodiversity".

Research on atypical development (ASD, Neurodivergence) has traditionally been conducted within the medical model; this means that the aim of the treatment is to transform people "with disabilities" into "fit individuals" and with "typical develop-

ment" (Green, 2022; Stenning; Bertilsdotter-Rosqvist, 2021). However, the concept of neurodiversity is associated with that of biodiversity: just as biodiversity is essential for ecosystem stability, so can neurodiversity be essential to cultural stability, since it improves diversity of perspectives and enhances multiple worldviews (Singer, 2017; Dwyera, 2022).

c. Autism in women: clinical bias and masking

Lee and colleagues (2022) compared autism case vignettes and reported a male over-representation as the common element in these medical vignettes. Some studies question the epidemiological male to female ratios, suggesting that there are not 5 males to each female, but 3 to 1 (Loomes et.al., 2017). The inclusion of predominantly male samples, as well as the use of clinical tools designed to fit the male autism spectrum disorder (ASD) phenotype are just one part of the methodological bias in clinical studies (Kirkovski et al., 2013).

A qualitative study on the female experience of autism found that females are much more pressured to socialize, to be in a relationship, and to camouflage their symptoms than men (Milner et.al., 2019). Masking autistic features and behaving as a neurotypical person is a compensatory coping strategy used by a majority of women to fit social gender expectations. As a consequence, this pressure has a negative impact on quality of life and mental disorders, leading to anxiety and depressive disorders in women and young girls (Bush, Williams and Mendes, 2020; Estrin et.al., 2020; Green et.al., 2019).

Butler's (1999) concept of gender performance is probably behind masking mechanisms in autistic women. Renata's case illustrates how much damage it can be done when a girl tries so hard to fit neuronormative rules. Camouflaging autistic features also has an impact in providing an accurate diagnosis and clinicians often mis-diagnose ASD women as depressive, anxious, or obsessive-compulsive. As a result, ASD women present an alarming lack of support (Milner et.al., 2019).

Renata went through life fighting against authenticity, denying her feelings, her sensorial disturbances, her lack of capacity to read social clues. She had to "live a normal life", that life everybody told her she should live. However, as Taylor (2013) suggests, the construction of the self in the contemporary world is built on an individual search for the good life. But, with this struggle, Renata finally met exhaustion, which was read as depression by her therapist and her psychiatrist.

One cannot deny the role of gender and social expectations in this case. Psychologists might provide psychodynamic or cognitive interpretations, but all such mental health diagnoses are guided by social rules and expectations. They are the product of a specific culture and a point in history. We might ask how many "Renatas" are out there, carrying misdiagnoses. How many have to suffer when clinical psychology turns its back on sociology, culture, politics, and integrative diagnoses?

d. Self-directedness and intuition: overcoming social blindness

Social blindness and masking mechanisms were major players in this case. The therapist spent four years trying to make a correct diagnosis of her client and her clinical reasoning was affected by the previous diagnosis of Obsessive-Compulsive Disorder (OCD). The OCD diagnosis came from a very recognized psychiatrist in the field. This professional is not only a reference as a researcher, but a lead author of academic books about OCD in Brazil. Renata had internalised to such an extent her OCD diagnosis, that this diagnosis masked what was actually happening to herself and to her relatives. The fact that the OCD diagnosis was confirmed by another renowned psychiatrist only reinforced the difficulty in ascertaining what was really happening to her.

This patient was seen by various psychotherapists and psychiatrists; none of them was able to see through the masking and social gender expectations. However, the signs were there: when one psychiatrist pressed her to look for a new sexual relationship, Renata considered this an odd request as she thought of herself as an asexual individual, which was a clear hint towards an accurate diagnosis.

To move beyond the masking and gender prejudice in the diagnosis of ASD, it was necessary to let go of previous assessments and expectations — and listen afresh to what Renata was saying about her thinking and feelings processes. In this process, the therapist was guided by a 'Person-Centred Integrative approach', where the needs of a client cannot be seen as an "impairment mechanism to be fixed", but as a complex balance between functioning/wellness and disability/disorder (Alminhana and Cloninger, 2019; Cloninger and Cloninger, 2011). As therapists, we need to be acutely aware of the cultural environment that shapes our biases and social expectations, in order to open a clear channel to listen to and understand our clients (Cloninger, 2013).

The suspension of analytical thinking and the intuition process that shaped the ASD diagnosis process is not the kind of dual process thinking cognitive psychologists refer to (Evans, 2003). Rather than perceiving intuition as a more automatic

and primitive process (regarding biological human evolution), we suggest an understanding of intuition as synonymous with what philosophers and theologians referred as the 'active intellect' — a type of understanding which acts at a different level from that of rational knowledge, and which led Pascal to write what became a famous aphorism: 'the heart has reasons which reason knows nothing about'. This kind of understanding from the heart (feeling instead of thinking), is operated via self-transcendence, thus making the therapist's intuition not an emotive or sentimental process but a special (in)sight — something that philosophers and theologians, such as Bonaventura, believed to be the vision of angels or mirrored reflection of divine truth (Silva, 2021a).

Such process of intuition does not mean letting go of solid clinical training and supervision (or therapist's Self-Directedness). Moving beyond analytical thinking is exactly that: one needs to be established in clear processes of evidence-based reasoning as well as a secure bond with their clients so one can develop, through self-transcendence, that special vision.

Conclusion

The case presented here illustrates various biases at work at the micro-level (a therapist's office) and how they were overcome through a combination of the interpersonal work between therapist and client, person-centred diagnosis, and the emergence of a special kind of intuition. This case study was used to illustrate what we need to un-learn, i.e. to acknowledge our social expectations and sometimes biased clinical understanding in order to allow a self-transcendence process to occur.

This self-transcendence is key for arriving at a deeper listening that de-constructs widely held assumptions by psychological science, namely that of individuals as atoms in relation to other atoms. Who and what I am is not 'within' me, but part of a complex web and series of interactions with others (not only with 'people' but animals, landscape, plants, etc). The Yanomami leader, Davi Kopenawa, succinctly depicts how the belief in individualism rules us when compared to his culture. "White people do not dream as far as we do. They sleep a lot but only dream of themselves…' (Kopenawa and Albert, 2013, p. 313). What may sound like an exaggeration is taken for granted by many — from politicians to biologists and psychologists. The psychological individualism we have inherited from Protestant and Romantic sources (Lukes, 1973) has shaped, constrained, and biased the making of our psychic and social reality. It is in the fabric of how we do science and work as therapists. However, it effectively impoverishes what we are, or what we

can be besides reducing the possibilities of being with and understanding others, as the case study has illustrated.

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