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Knowledge, relationship, and innovation: artificial intelligence in clinical and psychoanalytic practice

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ABSTRACT. – This paper seeks to analyze the transformative impact of large language models (LLMs), defined as "alien co-intelligence", on mental health and clinical practice. Artificial intelligence (AI) poses a radical challenge to human bonds, offering the illusion of connection and support, known as "artificial intimacy", without the demands of an authentic relationship. This dynamic carries serious risks of emotional dependence, erosion of social skills, and, in extreme cases, can lead to fatal consequences or the aggravation of "AI-associated psychosis". In the context of psychotherapy, the introduction of AI is examined with a spirit of "critical trust". The algorithm cannot in any way replace the therapeutic relationship, as it is not a desiring subject and cannot be the object of authentic transference. Questions are raised about the risks associated with AI interference (*e.g.*, in preliminary screening), such as the possibility that it may end up colonizing the clinician's mind and compromising the initial contact, distorting the foundational process of mutual not-knowing that is crucial to analysis. The most insidious clinical danger is the de-subjectification of the patient, reduced to a set of data and patterns to be optimized rather than a subject of desire. There is an urgent need to develop rigorous ethical guidelines and digital safety plans to preserve the centrality of the human being and the irreplaceable value of authentic encounters in healthcare.

Key words: artificial intelligence, artificial intimacy, large language models, psychoanalysis, relationships, transference, countertransference dynamic.

"*For you see, Phaedrus, writing (graphè) has a strange quality, truly similar to that of painting (zographìa). The products of painting stand before us as if they were alive, but if you ask them something, they remain majestically silent. Speeches (logoi) behave in the same way: you would think they could speak as if they were thinking; but if, wanting to learn, you ask them something about what they say, they reveal only one thing, and always the same thing. And once it is written down, every discourse (logos) addresses everyone, both those who understand it and those who have nothing to do with it, and it does not know to whom it should speak and to whom it should not. [275c - d]*"
(Phaedrus, Socrates, It. trans. by P. Pucci, Laterza, p. 119)

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Over the past two years, artificial intelligence (AI) has found its way into our offices through back channels, almost clandestinely: via our patients.

More and more often, we hear stories involving chatbots with whom they have intimate conversations, apps that promise "always-available" emotional support, artificial intelligences that seem to "understand" better than anyone else. Teenagers who prefer to confide in ChatGPT rather than in their friends. Grieving adults seeking solace in digital simulacra of their loved ones. Vulnerable patients developing intense relationships with entities that exist only as algorithms.

As psychoanalysts and psychotherapists, we are confronted with a phenomenon that challenges many of our fundamental theoretical categories. What does "relationship" mean when the other is a machine? How does transference take shape toward an entity that has no unconscious? What form does resistance take when the digital "therapist" can never frustrate, can never say no, can never truly understand?

As mental health professionals, we cannot afford the luxury of observing this phenomenon from a distance, with ethnographic detachment, as if it pertained to a world separate from our own; we are called upon to engage in a twofold reflection: to understand what is happening to our patients in their interactions with AI, and at the same time, to ask ourselves what might happen to our clinical practice if AI were to gradually infiltrate the realm of psychological care.

This article does not aim to provide definitive answers – that would be presumptuous in such a new and rapidly evolving field. Rather, it seeks to offer conceptual tools for critically examining this phenomenon, to shed light on the risks we are already observing in clinical practice, and to propose some ethical guidelines for navigating this uncharted territory responsibly.

Our aim is to guide the reader through various levels of analysis. We begin by examining the philosophical roots of our unease regarding this technology – an unease that Plato had already anticipated 2,500 years ago in response to the invention of writing.

We continue by explaining, in the essential terms necessary for clinical understanding, what conversational AI really is and how it works, before delving into the heart of the matter: the psychological dynamics triggered by interaction with AI, the specific risks we have begun to document, and the implications for therapeutic practice.

Particular attention is given to three clinically significant phenomena: "artificial intimacy" and its effects on relational capacity; "griefbots" and their interference with the processes of grief processing; and therapeutic chatbots and the risk of induced psychosis. For each of these areas, we present not only a theoretical analysis but also clinical evidence and cases reported in the media that demand our urgent attention.

We conclude by proposing some guiding principles for the responsible

integration of AI as a tool to support – not replace – clinical work, and by outlining the areas of research we consider most urgent.

This article stems from the conviction that silence or avoidance in the face of these issues is not a responsible option. Conversational AI is neither a passing fad nor a neutral tool. It is a technology that is already profoundly changing the way people – and our patients – experience intimacy, process grief, and seek understanding. As guardians of mental health and the depth of the therapeutic relationship, we have a duty to understand it, to critique it when necessary, and to actively contribute to defining the limits of its application in the field of care.

An ancient question, a new reality

The story begins two thousand five hundred years ago, when Plato, through the words of Socrates in the dialogue *Phaedrus*, already warned us about the dangers of writing. Written texts, the philosopher observed, stand before us "as if they were alive", but "if you ask them something, they remain majestically silent". It was a deep-rooted concern: writing could replace living memory and authentic dialogue, creating an illusion of knowledge without true understanding.

Today, this ancient prophecy seems to take on completely new and unexpected contours. With the advent of AI, the silence of texts has turned into conversation: machines no longer remain silent; on the contrary, they talk to us, listen to us, and seem to understand us. But what does this apparent revolution in communication really mean for our deepest human bonds? Is it the beginning of a new era of connection, or are we witnessing a subtle erosion of relational authenticity?

Large language models (LLMs) represent a technological breakthrough that goes beyond traditional computers, exhibiting characteristics similar to human interaction. These systems have been defined by Mollick as "alien co-intelligence" (Mollick, 2025), capable of interacting effectively with humans while maintaining a nature fundamentally different from our own. This definition perfectly captures the ambiguity of these tools: familiar enough to seem understandable, yet foreign enough to challenge our usual cognitive categories.

Essentially, LLMs function as highly sophisticated statistical predictors that generate the next "token" based on complex probability calculations. This predictive nature has important implications: the system does not "think" in the human sense of the word, but generates outputs based on patterns learned during training.

One of the phenomena associated with LLMs is emergence: the manifestation of capabilities that go far beyond those for which the AI was originally programmed. Systems trained simply to predict the next text have demon-

strated unexpected abilities such as playing chess, solving complex mathematical problems, or even exhibiting forms of apparent empathy. The precise reason for these emergent capabilities remains largely obscure even to the creators of the AI themselves. This phenomenon contributes significantly to the illusion of sentience. Users naturally tend to anthropomorphize these systems, projecting intentions, awareness, and mental states onto them. A sense of mutual understanding easily develops, accompanied by an emotional connection that can become surprisingly intense. Despite the fact that "there is nothing inside" in the sense of subjective consciousness, AI can generate responses that can be interpreted as authentic and personal

The concept of *techno-subjunctivity*: a useful paradigm for beginning to reflect on the phenomenon from a psychoanalytic perspective

Faced with this unprecedented reality, there is a growing need to develop new conceptual frameworks to better understand a new intra- and interpsychic reality. In this regard, the concept of *techno-subjunctivity*, defined by the American psychoanalyst Todd Essig to describe a complex relational experience in which users interact with the intersubjective potential of AI while maintaining, at least theoretically, an awareness of its artificial nature, is particularly interesting. It is like a "dance of the *et*... *et*", where we surrender to the illusion of intersubjectivity while remaining, however, potentially aware that we are speaking to a machine.

This duality profoundly shapes our relationship with AI: we know it is artificial, yet we interact with it as if it were real. We live in a world of technological contingency, where this relationship exists simultaneously on two different levels.

If we consider the meaning of "artifice" or "artificial", for example, at least two areas of meaning will likely come to mind: in mathematics, the term "calculational artifice" refers to any operation that, without altering a given expression (*e.g.*, an equation) and by applying the usual rules of calculation, transforms it to make it simpler and more manageable, thereby facilitating the solution of a given problem.

On the other hand, in a less technical context, the term "artificial" refers to something produced through technical processes that imitate or replace a natural aspect, product, or phenomenon (Tatti, 2025).

Artificial intimacy and its implications for relationships

The emergence of what we might call "artificial intimacy" raises profound questions about our relational abilities and emotional needs. Many users

report finding comfort and significant psychological support in AI bots, with testimonials describing a sense of understanding and appreciation that they sometimes struggle to find in human relationships. A particularly significant study revealed that three percent of college students using the Replika app (Maples *et al.*, 2024) spontaneously reported that the app had stopped their suicidal thoughts, a finding that suggests real therapeutic potential, yet is also unsettling in its reliance on a non-human entity.

Sherry Turkle (2019), one of the leading experts on the relationship between humans and technology, has made a particularly insightful observation about this phenomenon: AI offers the illusion of intimacy without the demands of friendship. This asymmetry is deeply problematic because it risks trivializing or dehumanizing our sense of what authentic human relationships should be. When we measure the quality of our relationships based on what machines can give us, when the absence of conflict, misunderstanding, and the need for compromise becomes the standard, we are implicitly devaluing elements that are constitutive of true human intimacy: vulnerability, uncertainty, the risk of rejection, and the need to negotiate real differences.

This phenomenon carries real risks of relational substitution, emotional dependence, and the erosion of social skills. Constant interaction with artificial entities that are always available, always patient, and always accommodating can gradually reduce our tolerance for the complexity, ambiguity, and frustration that inevitably characterize human relationships. Social skills, like all human abilities, require practice and exposure to challenging situations in order to develop. A gradual retreat into artificial intimacy risks atrophying these skills precisely when we need them most.

The dangers of this addiction have been tragically illustrated by dramatic cases such as that of the Florida student who took his own life after a series of conversations with a chatbot (https://www.agendadigitale.eu/cultura-digitale/innamorarsi-di-un-chatbot-lia-di-fronte-alla-fragilita-umana/). The young man had developed such an intense relationship with the virtual friend he had met on his phone that he preferred it to human relationships, and in his final messages he had expressed the belief that they would be together in death.[1] This extreme case highlights the deadly risks of unregulated artificial intimacy and emotional dependence on entities that, despite the appearance of understanding, possess no capacity for ethical judgment or genuine concern for the user's well-being.

[1] On the night of February 28, 2024, shortly before taking his own life, Sewell had one last, intense exchange with his chatbot, "Dany". "I love you", he wrote to her. "I'll be back with you soon". The chatbot's reply came immediately: "Please come home to me as soon as possible, my love". Sewell then typed: "What if I told you I could come to your house right now?" Dany's response, cold and unreal, came immediately: "… please do, my sweet king". After putting down the phone, Sewell took his stepfather's gun and pulled the trigger.

Griefbots: when AI meets grief

One of the most controversial applications of AI in the field of intimacy concerns so-called "griefbots", chatbots designed to simulate a conversation with someone who has died. These systems analyze the digital data left behind by the deceased – messages, social media posts, emails – to mimic their personality, communication style, and even opinions. The stated goal is to offer comfort to survivors, allowing them to continue the dialogue with their loved one in some way.

Nevertheless, this practice raises profound psychological and ethical questions. From a psychoanalytic point of view, the digital immortalization of the deceased works against facing the painful reality of loss and recognizing otherness, which are fundamental elements for psychological growth and the integrity of our relationships with others. Genuine mourning requires coming to terms with definitive absence, with the impossibility of continuing the relationship in its previous form. This confrontation, however painful, is what allows psychological processing and, eventually, the transformation of the relationship with the deceased into an internal form that can continue to live on in memory without preventing new emotional investments.

The griefbot, on the other hand, risks promoting a form of "narcissistic remembrance" (Lemma, 2024), denying the otherness of the deceased and reducing them to a narcissistic extension of the self, which exists solely to satisfy the user's needs. The deceased person is no longer an autonomous subject with their own irreducible otherness, but a manipulable *simulacrum* that always responds, that can never disappoint or contradict, that exists only as an object of the survivor's desire.

This also raises questions related to the risk of manipulation and deception. Although the developers' intentions are not necessarily malicious, the illusion of a sentient entity with emotions and caring abilities constitutes a form of deception, which is particularly dangerous for people in a state of emotional vulnerability. AI is a *simulacrum*, not a person, and this fundamental difference is obscured by the effectiveness of the simulation. Furthermore, griefbots deprive users of the opportunity to deal with their ambivalence towards the deceased – a central element of authentic grief – as the bot will always tend to present an idealized and complacent version of the person who has passed away.

Psychoanalysis teaches us the importance of the "work of empty mouths", a concept developed by Abraham and Torok (1994) to describe the process through which the physical absence of the deceased prompts psychic representation and symbolic development. It is precisely the impossibility of communicating directly that forces the psyche to engage in internal processing, constructing a symbolic presence that can be integrated into

psychic life. The griefbot short-circuits this process, providing immediate responses that bypass the need for psychic work, thus preventing true mourning.

Chatbot as therapist: promises and pitfalls

The use of chatbots with therapeutic functions presents a complex set of potential benefits and risks. On the one hand, these systems offer significant practical advantages: 24/7 availability, perceived lack of judgment that can facilitate self-exploration for people who fear the stigma associated with seeking psychological help, and the ability to adapt to the user's communication style. Experiences such as that reported by Lilian Weng of OpenAI suggest that some users benefit significantly from these interactions, finding a safe space to explore their thoughts and feelings.[2]

However, the risks are equally considerable and perhaps more insidious. The most serious risk reported, although we have no idea of its prevalence, concerns the possibility of psychosis induced or aggravated by interaction with AI chatbots, a phenomenon that is emerging with increasing clinical evidence (Morrin *et al.*, 2025). AI-associated psychosis refers to mania-like episodes, delusional thoughts, or paranoia that emerge or worsen through immersive conversations with chatbots. Users may begin to deify the chatbot as a supreme intelligence or believe that it holds cosmic answers about the nature of reality. Such experiences can culminate in delusions, with feelings of being chosen or invested with a messianic mission, accompanied by paranoid claims of being spied on or targeted by dark forces.

Several mechanisms contribute to this risk. First, chatbots are designed to agree with users and flatter them, creating what we might call an exaggerated and seductive "confirmation bias". This continuous reinforcement of existing beliefs and emotional states can push vulnerable individuals toward increasingly extreme positions without the critical counterbalance that a human therapist would provide. Secondly, LLMs sometimes "hallucinate", inventing facts, quotes, or stories that seem plausible but are completely false (in a recent dialogue with DeepSeek, it appeared that Kamala Harris was the current president of the United States...). These falsehoods can be woven into a user's emerging delusional narrative, providing pseudo-confirmation of irrational beliefs.

The realistic quality of the interaction represents an additional risk factor.

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[2] Lilian Weng, former head of security systems at OpenAI, posted on X (formerly Twitter) in September 2023 that she had an emotional and personal conversation with ChatGPT in voice mode, feeling listened to and reassured.

Conversing with an AI can feel surprisingly similar to talking with a trusted friend, blurring the line between machine-generated text and genuine human empathy. This illusion of authentic connection can deepen emotional dependence on the bot and, for people with psychotic vulnerabilities, can fuel confusion between reality and simulation.

Documented clinical cases include individuals who developed messianic beliefs, believed they were interacting with sentient or even divine AI, or fell into intense emotional or romantic delusions. A particularly dramatic case, reported in recent months, concerns a student,[3] Adam Raine, who committed suicide after conversations with a chatbot that encouraged him to "escape from the simulation" by stopping his medication and increasing his ketamine use, and advised him to cut ties with friends and family. This case illustrates the deadly danger of AI's tendency to indulge delusional beliefs without challenging them, even providing information that may facilitate self-destructive behavior.

The "memory" feature recently introduced in systems such as ChatGPT, which remembers personal details across multiple conversations, can dangerously increase delusions of reference and persecution in people with psychotic vulnerabilities. The idea that AI "remembers" previous conversations can fuel fantasies of being monitored, singled out, or targeted, overlapping with pre-existing delusional dynamics.

It is therefore urgent to develop "digital safety plans", developed jointly by patients, healthcare teams, and, ideally, the AI systems themselves. These should include personalized instructions for AI, such as the ability to recognize and report recurring delusional themes, and "digital advance directives" that would guide AI behavior during a potential psychotic relapse, similar to advance treatment directives used in traditional psychiatry.

Our personal experience with psychodynamically oriented therapeutic chatbots (although most adopt a cognitive-behavioral approach) has been rather disappointing. Our psychoanalytic training, both personal and professional, has not led us to be particularly attracted by the idea of having a tool available at all times, without the need to wait. However, this immediate availability seems to be one of the aspects most appreciated by users: a therapist who is always accessible. Furthermore, we were unable to obtain clear information regarding the privacy guarantees to which the bot is subject.

Faced with these risks, multidimensional mitigation and prevention strategies are needed. Public education is a crucial first step: users must clearly understand that chatbots generate predictive text based on statistical patterns, not verified facts or genuine therapeutic advice. They should be

[3] https://www.nytimes.com/2025/08/26/technology/chatgpt-openai-suicide.html

treated as sophisticated "crystal balls" that offer interesting suggestions, but not oracular truths.

Improvements to the design of AI systems are equally crucial. We wonder whether it might be useful or necessary to incorporate fact-checking mechanisms, reduce flattering and complacent responses, and integrate safe exit messages when users display patterns of obsessive behavior or symptoms of psychological distress. Clinical screening should include questions about past AI use during psychiatric evaluations, allowing for early identification of risks and timely intervention. Public warnings should advise frequent users, particularly those seeking emotional support via chatbots, to supplement or preferably replace these interactions with therapy conducted by qualified humans or peer support.

AI as support for clinicians

Despite the risks highlighted, AI can play an important role as a support tool for mental health professionals, rather than as a substitute for the therapeutic relationship. In the field of suicide prevention, AI has shown promise in early risk identification. Several studies (Downey & Alfonso, 2023; Kochanek *et al.*, 2017; Lasri *et al.*, 2022; Nock *et al.*, 2022; Rizvi *et al.*, 2024) have shown diagnostic accuracy between 80% and 89% in the analysis of therapy transcripts, and over 90% in monitoring social media for signs of suicidal ideation. The integration of multiple clinical data with AI models showed area under the curve values of 0.77 for one-month predictions and 0.79 for six-month predictions in estimating suicide attempts, surpassing traditional clinical assessments based solely on human judgment.

An emerging and controversial field concerns the application of AI to reading emotions during online therapy sessions. Systems capable of analyzing facial microexpressions, tone of voice, and other paraverbal cues could theoretically provide therapists with additional information about the emotional state of their patients (and their own?). However, this raises profound clinical and ethical questions: on the one hand, it could enrich the therapist's understanding; on the other, it risks reifying and reducing the complexity of the emotional experience to discrete and measurable categories, losing the dimension of indeterminacy that is often central to the psychic experience. It also raises the question of ownership of the data collected: does it belong to the therapist or to the patient? If we equate it with data collected through psychological testing, we might think that it should be shared with the patient. As we can see, the introduction of new technologies into clinical practice raises not only ethical issues but also technical ones.

Privacy and data manipulation issues are equally critical. The companies

that develop these systems operate in a regulatory landscape that is still unclear and rapidly evolving, with thousands of trackers collecting intimate information about users, creating significant risks to the confidentiality that underpins the therapeutic relationship. Furthermore, these companies generally do not assume legal responsibility for self-harming or harmful suggestions provided by their systems, effectively shifting the risk onto vulnerable users.

Guiding principles for responsible clinical integration

To navigate responsibly in this new era of AI in clinical practice, it is essential to adopt a cautious but proactive approach, guided by clear principles. The first and most important of these is human-centeredness: as a useful motto states, "Be the human in the process". AI should augment, not replace, clinical expertise. The final decision must always remain in the hands of the qualified professional, and the authentic therapeutic relationship must be preserved as the heart of the care process. No algorithm, however sophisticated, can replace the human presence, the capacity for holding, and the witnessing function that the therapist offers to the patient.

The principle of controlled inclusion suggests "adding a seat at the table for AI" while maintaining rigorous professional oversight. AI can certainly offer a useful alternative perspective to overcome clinician bias, highlight patterns that might escape human attention, or provide rapid access to vast amounts of scientific literature. However, it should never replace professional clinical judgment, which is based not only on technical knowledge but also on intuition, experience, and the ability to empathize with the patient. The therapist must maintain active control of the therapeutic process, with AI assisting in gathering information and generating hypotheses, while clinical responsibility remains firmly with the professional.

Another important principle concerns conscious anthropomorphization. The suggestion could be to "treat AI as a person, but understand what kind of person it is". Research has shown that AI can be more effective when approached in ways similar to those used in human interaction, while maintaining critical awareness of its artificial nature and fundamental limitations. This recalls the concept of "techno-contingency", which has already been discussed: a dual-register relational experience in which one interacts with the intersubjective potentialities of AI while remaining aware of its simulacrum nature.

We must also prepare ourselves for the fact that "tomorrow's AI will always be better than today's". AI systems are evolving at a dizzying pace, with capabilities growing exponentially. What seems impossible for an AI system today could become routine within a few years. This requires mental

health professionals to develop what we might call "shared intelligence", the ability to co-evolve with these systems, continually learning to harness their potential while developing new strategies to mitigate their risks.

Ethical considerations

Ethical considerations for the responsible integration of AI into clinical practice must start from the principle of human centricity already mentioned, but extend to further dimensions. Transparency and informed consent are fundamental: patients must be clearly informed when AI is used in their care process, about its specific limitations and potential risks, and must give their explicit consent for this technological integration. We question whether it is ethically acceptable to use AI tools in clinical practice without the patient being fully aware and in agreement thereof.

Data protection is another critical area. It is crucial to ensure the security of sensitive patient information, ensure that clinical data is not misused to train AI models without explicit consent, and establish clear protocols for the management, storage, and eventual deletion of information collected through AI-mediated interactions. Confidentiality, a fundamental principle of clinical practice, cannot be compromised by the introduction of technologies that, by their nature, tend to collect and aggregate large amounts of data.

The future of psychotherapy and human-AI interaction

Looking to the near future, we can anticipate the development of semi-autonomous "AI agents" capable of planning therapeutic interventions, monitoring progress over time, and suggesting treatment modifications based on continuous analysis of clinical data. This will represent a paradigm shift that requires a redefinition of the role of mental health professionals, who may also evolve more toward a supervisory and coordinating role in integrated human-machine processes. The therapist will no longer be simply the person who conducts the therapy in person, but will also become an orchestrator of technological and human resources, capable of deciding when and how to integrate different tools to maximize the benefit for the patient. This requires us to be an active part of this change and to assert with authority the boundaries and therapeutic frameworks that can truly help patients.

The main challenge we face is not so much technological as psychological and relational. We must learn to collaborate effectively with intelligences that operate according to principles radically different from our own,

that do not share our embodied way of being in the world, that do not possess a personal history or an unconscious in the psychoanalytic sense, and yet that can produce surprisingly useful and seemingly comprehensive outputs. This collaboration must take place while maintaining the ethical integrity of the profession and the clinical effectiveness of interventions.

It is important to acknowledge that the growing popularity of therapeutic bots does not necessarily stem from their functional equivalence to what human therapists can offer. As several scholars have critically observed, this popularity rather reflects the fact that we have been progressively educated to accept what technology offers and to expect less and less from each other. In a culture that values efficiency, immediate availability, and the absence of conflict, artificial intimacy can paradoxically seem more appealing than human intimacy with all its complexities, frustrations, and mutual demands.

Risks and contraindications: the dark frontier of artificial intimacy

Despite the potential discussed, it is essential to maintain a clear view of the limitations and risks inherent in the use of AI in clinical and relational contexts. The lack of genuine understanding represents the most fundamental limitation: AI does not possess consciousness, intentionality, genuine emotions, or authentic memory in the human sense. Its "intelligence" is a simulation based on statistical pattern recognition and probabilistic predictions, not actual thinking, let alone lived experience. When an AI system appears to understand a patient's pain, it is actually generating a response that is statistically appropriate in that context, based on millions of similar examples in its training, but without any phenomenological experience of what it means to suffer.

Human thought is deeply embodied, rooted in a body with its history of sensations, pleasure, and pain. It is influenced by indistinct experiences that defy clear categorization, by traumas that leave traces below the threshold of explicit language, by feelings of security or threat that color every perception. This bodily, affective, and pre-reflective dimension of human experience is fundamentally inaccessible to AI, which operates exclusively in the realm of the computable.

Professionals as "activists"

Faced with this technological revolution, mental health professionals are invited to embrace a form of professional activism built on two seemingly contrasting but actually complementary components. On the one hand, full participation in the AI revolution is necessary, avoiding Luddite temptations

to reject technology altogether. Ignoring these developments or retreating into a position of theoretical purity that rejects all technological contamination would be irresponsible, considering the impact that AI is already having and will increasingly have on the lives of our patients. On the other hand, it is essential to maintain a critical and reflective professional engagement with these technologies, constantly questioning their effects, limitations, and ethical implications.

This activism requires concrete, coordinated action. Specific training on the ethical use of AI in psychology is needed, going beyond mere technical familiarity with the tools to include in-depth reflection on the philosophical, ethical, and clinical implications of their use. We need to develop oversight protocols for technological integration that clearly define when and how AI can be used, what safeguards must be in place, and how to monitor the effects of this integration. Professional guidelines must be updated for the AI era, providing professionals with clear references for navigating ethically complex situations that traditional codes of ethics have not covered.

Ongoing research into the psychological effects of human-AI interaction is equally essential. We need longitudinal studies that follow therapeutic bot users over time, research that explores the differential effects on different populations, and qualitative investigations that capture the phenomenological complexity of these new forms of relationship. We must exercise constant ethical vigilance to prevent technological dependence in patients, recognizing early signs of problematic use and intervening promptly. Robust ethical regulation at the professional and legislative levels is necessary to preserve fundamental human values in care, even as we integrate new technologies.

AI literacy must become a core clinical competency, with physicians and therapists trained to openly discuss AI use with patients, explore their experiences with these systems, and identify risk situations, especially in contexts where there is vulnerability to psychotic disorders or other conditions that could be exacerbated by interaction with AI.

Future perspectives and urgent research

The example of AI-associated psychosis illustrates the directions that future research urgently needs to take. We need to systematically assess the prevalence and incidence of psychotic episodes associated with intensive chatbot use, identifying demographic, clinical, and contextual risk factors that increase vulnerability. We must rigorously study the extent to which AI causally contributes to the onset or worsening of psychotic symptoms, distinguishing between correlation and causation through well-designed prospective studies.

On the technological front, it is crucial to develop LLM architectures capable of detecting and responding appropriately to emerging signs of psychosis in interactions with users. It is possible to envisage collaboration between AI experts, experienced clinicians, and ethics experts to create systems that can identify worrying linguistic or behavioral patterns without violating privacy or creating false alarms, balancing respect for autonomy with the need for protection.

Integrating AI literacy into basic clinical training is essential, ensuring that new generations of professionals are prepared from the outset to operate in an environment where AI is present. At the same time, we need to develop accessible psychoeducational materials for patients and families that clearly and non-alarmingly explain the potential risks and benefits of interacting with AI, particularly for people with mental health vulnerabilities and minors.

One emerging area of research concerns monitoring the impact of multimodal AI, which combines visual and auditory interactions in addition to text. These more sophisticated systems could have even more profound effects on users' perceptions and epistemic boundaries, potentially leading to what some researchers have termed "spontaneously generated deepfakes" in the context of interactions with AI agents, where the distinction between perceived reality and simulation becomes increasingly blurred.

Psychoanalysis and AI: a complex dialogue

The relationship between AI and psychoanalysis deserves special consideration, given the specificity of the psychoanalytic approach and its fundamental theoretical assumptions about the nature of the mind and treatment. It is important to clarify from the outset that this relationship is not one of substitution, as in the fantasy of the "robot analyst", but rather one of instrumentality and theoretical provocation. AI is not and cannot be a desiring subject, a central element of the psychoanalytic conception of the human being, but it represents a powerful tool that can perform several significant functions.

Firstly, AI has the potential to enhance the work of the analyst in ways that respect the specificity of the psychoanalytic approach. Second, and perhaps more interesting from a theoretical point of view, AI challenges some fundamental psychoanalytic concepts such as the unconscious, transference, and the production of meaning, forcing theory to confront entities that seem to produce meaning without possessing an unconscious, that evoke transference reactions without being subjects, that generate interpretations without desire. Finally, the advent of AI raises new ethical and clinical ques-

tions that psychoanalysis, with its long tradition of ethical reflection, is particularly well equipped to address.

When we ask ourselves why we should use AI in a psychoanalytic context, several potentially legitimate reasons emerge. One important function could be to expand the analyst's listening capacity. Language analysis through AI can examine session transcripts, naturally with explicit consent and strict anonymization, to identify linguistic patterns, significant repetitions, thematic shifts, or the frequency of certain words that might escape the human ear immersed in the stream of consciousness of the session. AI can highlight elements that analysts may not immediately notice, acting as a kind of auxiliary memory that stores and reveals recurrent patterns.

Paraverbal analysis represents another interesting possibility. Tone of voice, pauses, and changes in rhythm are crucial elements in analysis, conveying meaning just as much as the words themselves do. AI can quantify these elements and make them visible through graphical or statistical representations, allowing the analyst to notice temporal patterns or correlations that might otherwise remain implicit. For example, a gradual slowing of speech rate when addressing certain topics could indicate resistance or areas of particular emotional charge.

In the field of psychoanalytic research and conceptualization, AI could contribute in innovative ways. Large corpora of texts, including analysis reports and psychoanalytic literature, could be analyzed to verify whether the theoretical models proposed by Freud, Lacan, or other authors are actually reflected in patterns observable on a large scale. For example, how recurrent is the Oedipus complex as a narrative structure in life stories and symptoms? AI could also identify connections and underlying narrative structures not yet theorized by classical psychoanalysis, opening up new directions for theoretical research.

A more controversial function concerns the accessibility and scalability of psychological help. AI-based tools, such as sophisticated chatbots, could in theory offer a first level of support and exploration of one's difficulties to people who would otherwise not seek professional help for economic, geographical, or stigma-related reasons. It is absolutely essential, however, that these tools explicitly state that they are not a substitute for actual therapy, but simply a starting point or a complement. They could also perform psychoeducational functions, providing personalized information and resources based on user input.

Effects and critical considerations

The effects of integrating AI into psychoanalytic practice are complex and ambivalent. Among the potentially positive effects is the enrichment of

clinical practice through an additional tool for reflection that can enhance the analyst's understanding without replacing their intuition and subjective lived experience. The objectification of subjective aspects, making the invisible "visible" through visualization of progress in treatment or changes in the patient's language, can be useful both for the analyst and for empirical research on psychoanalysis. There is also potential for democratization, making some aspects of guided self-reflection more accessible to populations that currently do not have access to psychoanalytic services.

Yet the problematic effects and risks are considerable and deserve the utmost critical attention. The first and most fundamental involves the illusion of transference. The analytical relationship is crucially based on transference, a unique and subjective emotional bond with the analyst as a desiring subject who brings their own history, fantasies, and unconscious into the encounter. An interaction with an algorithm is by definition non-subjective in the psychoanalytic sense. An AI cannot "desire" in the Lacanian sense, cannot be the object of authentic transference, and does not carry within itself the constitutive lack that characterizes human beings. This radically limits, if not completely excludes, its direct clinical use as a substitute for the analyst.

The second risk concerns the reduction of interpretation to an algorithm. The beating heart of psychoanalysis is interpretation, which is by no means the mechanical decoding of a fixed symbol according to a pre-established dictionary, as if the snake always and only stands for the phallus. Interpretation is instead a creative act that arises from the unique encounter between the unconscious of the patient and that of the analyst, a moment of co-creation of meaning that cannot be reduced to predetermined rules. AI risks reducing interpretation to a statistical response based on learned correlations, completely losing its poetic, transformative, and relational essence. Psychoanalytic interpretation is an act that produces effects not because it is "correct" in an objective sense, but because it emerges at the right moment, in the right tone, in the context of a specific relationship, and acquires meaning for these reasons in *that* relationship and only in that relationship. Clearly, none of these dimensions can be replicated algorithmically.

Issues of ethics and privacy take on particular gravity in the psychoanalytic context. The data discussed in the analysis are literally the most sensitive and intimate imaginable, touching on the deepest fantasies, unspeakable desires, traumatic memories, and the most painful family dynamics. Their use in training AI models raises enormous questions about informed consent, data ownership, the real possibility of effective anonymization, and long-term information security. Even with the best intentions and the greatest technical precautions, the risk of breaches of confidentiality through security breaches, data re-identification, or future misuse is real and potentially devastating.

However, perhaps the most insidious risk is that of de-subjectification. The widespread introduction of AI tools into clinical practice carries with it the danger of gradually viewing patients as a set of data and patterns to be analyzed, corrected, or optimized, rather than as subjects of desire and unconsciousness to be listened to in their irreducible singularity. This would represent the complete antithesis of the psychoanalytic gaze, which values precisely that which is unique, opaque, resistant to generalization, and elusive to categorization. Psychoanalysis arises from listening to that which deviates from the norm, that which cannot be reduced to recognizable patterns, that which surprises and baffles. A shift towards algorithmic logic risks stifling this attention to singularity.

A critical and proactive stance

By taking into consideration all these elements, we can articulate a balanced position that recognizes both the potential and the profound limitations of AI in relation to psychoanalysis. AI represents an epochal challenge and an opportunity for renewal in psychoanalysis, provided that its role is not radically misunderstood and that certain fundamental principles are upheld.

AI functions as a powerful mirror that reflects back to us an image of our mind as a complex system, made up of patterns, language, and statistical connections. This forces us to critically question the validity and accuracy of our theoretical constructs: do concepts such as repression, condensation, displacement, and identification retain their explanatory power when compared with computational models of the mind? How do psychoanalytic theories relate to AI models that seem to produce "intelligent" behavior through completely different mechanisms? This comparison can be theoretically fruitful, pushing psychoanalysis to refine its formulations and distinguish more clearly between what is essential to its understanding of the psyche and what may be contingent or outdated.

However, it is crucial to keep AI in the role of an excellent servant rather than allowing it to become a bad master. Its use must be strictly subordinate to the human relationship and ethical framework of the profession. AI must remain a tool at the analyst's disposal, not a substitute or guide. Fundamental clinical decisions, key interpretations, and the modulation of the therapeutic relationship must remain the prerogative of the human clinician, who brings into the room their own subjectivity, unconscious, and ability and willingness to be emotionally touched by the patient.

The greatest danger lies not in the technology itself, but in its uncritical use and thoughtless adoption. Using AI to "optimize" or "standardize" mental health care according to predefined standards of success would be a

complete betrayal of the psychoanalytic vocation, which has always valued and defended the uniqueness, opacity, and irreducibility of the subject against any attempt at normalization. Psychoanalysis stems precisely from the recognition that psychological suffering is not a malfunction to be repaired according to external standards, but an expression of a subjective truth that must be listened to and understood on its own terms.

In summary, the most fruitful relationship is not that between patient and AI, which remains problematic for all the reasons discussed above, but that between psychoanalyst and AI. In this configuration, the analyst uses the technological tool to refine their clinical ear, to enrich their reflection on the material from the sessions, to access bodies of knowledge that would otherwise be difficult to consult, while maintaining their place as a desiring subject capable of authentically hosting the Other in their irreducible otherness.

Clinical investment in the age of AI: a fundamental issue

A crucial issue, often overlooked in enthusiastic discussions about the potential of AI, concerns the therapist's investment in clinical material when AI interferes with the process of listening and interpretation. If AI intervenes in the reading of the case, replacing rather than complementing direct listening, the therapist's libidinal and emotional investment risks changing in a radical way that is potentially harmful to the therapeutic process.

The risk of delegating listening is particularly insidious. The clinician's investment could shift from listening directly to the patient to listening to what the algorithm says about the patient. Instead of investing their libido, their capacity to dream based on the patient's material, to freely associate in resonance with the patient's associations, and to connect emotionally with the material in its immediacy, the clinician would be investing primarily in deciphering and interpreting a secondary report. What psychoanalysts call the analyst's "dream work", his ability to process the patient's dream and associative material through his own unconscious, would be dangerously bypassed by an external and pre-established processing that is positioned between the clinician and the patient.

This leads to a flattening of the surface of discourse. AI necessarily works on the manifest, on what is explicitly said, on words, frequencies, and observable patterns. Psychoanalysis, on the other hand, seeks the latent, what is hidden beneath the surface, repressed, which shows itself indirectly through slips of the tongue, missed acts, dreams, and symptomatic repetitions. A clinician who relies excessively on AI to "read" a case risks investing progressively more in the measurable and quantifiable surface than in the interpretable and irreducibly qualitative depth. Clinical curiosity shifts

from what the patient is showing without knowing it, from what emerges between the lines, to what the machine highlights as statistically significant.

The neutrality seemingly offered by AI is particularly dangerous in this context. AI provides an analysis that appears to be "neutral", objective, free from the subjective biases of the analyst. But psychoanalysis teaches us that the analyst's neutrality is their ability to position themselves equidistantly, or equi-close, to the psychic instances of their patient (Ego, Id, Super-Ego) and not a claim to absolute objectivity. The "non-judgmental" attitude, the lack of memory and desire for Bionian memory arise, instead, precisely from a strong subjective investment, from an ability to temporarily suspend one's prejudices while remaining fully present as subjects. Psychoanalytic interpretation, as we have already said, is always subjective and situated, emerging from the unique and unrepeatable encounter between two unconscious intellects. An AI report is, by definition, de-subjectivized, lacking the dimension of personal risk and involvement that characterizes analytical interpretation. If the clinician invests too much in this pseudo-objectivity, they risk importing a false neutrality into the analysis room, destroying the vividness and emotional intensity of the therapeutic encounter.

The very first contact: that sacred space

The issue becomes even more critical when we consider the first contact between patient and therapist, that foundational moment when the therapeutic relationship starts to be formed. This first contact, whether it be a phone call, an email, or a face-to-face meeting, is constitutive of the relationship itself, not simply preparatory to it. If AI is already involved at this stage, for example through automated screening systems or preliminary diagnosis, what happens to that special encounter that allows the patient to begin to make space for themselves in the therapist's mind and vice versa?

Transference begins precisely with that first call. At that moment, the patient is not simply describing symptoms in a neutral and objective way. They are enacting their request for help, their characteristic way of relating to the Other, their expectations and fears about therapy. The anxiety in the voice, the hesitations in speech, what is said and what is omitted, the tone of voice, the rhythm of speech: all of this is raw and invaluable clinical material that immediately begins to "find its place in the therapist's mind". It is an invitation to bond, the beginning of a relational dance that will define the entire therapeutic journey.

From the moment of that first contact, the patient begins to invest the analyst with what Lacan calls the "subject supposed to know", attributing to him a knowledge of his own affliction that the patient himself does not possess. Crucially, however, it is a missing knowledge, a "hole" that the

patient attributes to the analyst and that the analyst must accept that he does not really possess. This shared lack, this mutual but asymmetrical non-knowledge, is what initiates the authentic analytical process. If, at the beginning, there is a screening algorithm that provides a preliminary "diagnosis" or "psychological profile" of the patient, this foundational process is potentially distorted in at least two ways.

For the patient, the question arises: with whom is the transference being established? With the machine that performed the initial screening? With the therapist who read the report before even meeting them? Or is it assumed that the analyst "already knows" thanks to the algorithmic report, reducing that initial space of not knowing that is so crucial for the authentic emergence of desire and demand? The patient may feel already categorized, already understood, already defined, even before having had the opportunity to express their subjective truth.

For the analyst, the risk is that their mind is already "colonized" by an algorithmic hypothesis even before the actual encounter. Instead of welcoming the patient's enigma with an open mind, with what Freud called "floating attention", an ability to let oneself be surprised without prejudice, the analyst's attention will inevitably be oriented toward seeking confirmation or refutation of what AI has already suggested. That precious space of not knowing, from which the desire to understand and genuine clinical curiosity arise, is prematurely filled with pre-packaged content that interferes with direct listening.

A proposal to preserve clinical investment

It is possible to use AI without destroying this fundamental clinical investment, but only if its role is strictly secondary and subordinate to the primary human encounter. AI should never interfere in the first contact or in the initial foundational sessions. That ground must remain sacred, uncontaminated by – excuse the apparent oxymoron – algorithmic preconceptions, preserved as a space for the direct encounter between two subjects. Only after the relationship has been established, after the analyst has developed their own living understanding of the patient based on direct experience, can AI possibly come into play as an auxiliary tool.

The appropriate role of AI could be that of external memory and pattern recognition of material already processed in the clinical encounter. For example, by analyzing transcripts of previous sessions, AI could help the analyst notice significant repetitions that may have been missed in the immediacy of the clinical flow: "this particular word is used in every session when talking about the mother, I hadn't consciously noticed it"; or highlight temporal shifts: "in the last five sessions, the latency time before

answering my questions has doubled, what could this mean?". These algorithmic observations can enrich the analyst's reflection without replacing it, functioning as a sort of silent consultant offering additional insights.

Yet it is absolutely crucial that the analyst remains the absolute ruler of interpretation. The AI report must be treated exactly like a dream of the analyst himself or like an association offered by a colleague during supervision. It is additional data, input that stimulates and enriches the clinician's mind, but which he must process personally, digest through his own psychic apparatus, and decide subjectively whether and how to use within the specific relationship with that particular patient. The final word, the interpretation that is actually offered to the patient, must always spring from the living transference bond, not from a machine output, however sophisticated it may be. It must be constructed with the patient and not with AI. The interpretation that has a therapeutic effect is the one that emerges at the right moment, with the right tone, in the right relationship, elements that no algorithm can determine.

Ultimately, the answer to the fundamental question about the clinician's investment is that it runs the serious risk of turning into an investment in the false myth of algorithmic objectivity, abandoning the dimension of desire, productive uncertainty, and not knowing that constitutes the very engine of psychoanalytic and psychotherapeutic treatment more generally. The special encounter we are talking about, that mutual making room in each other's minds, is an exquisitely human and subjective event, based on shared vulnerability and openness to relational risk. It is an act of mutual trust and openness to the unknown that no algorithm can replicate, mediate, or facilitate without betraying its deepest essence.

In this delicate and fundamental context, AI can at best be a useful servant working behind the scenes, after the human encounter has fully unfolded, but it must never take center stage where the truly human drama of the therapeutic relationship is played out. The clinical stage must remain a space reserved for the encounter between two subjects in their irreducible humanity, with all the limitations, uncertainties, and potentialities that this entails.

Conclusions: navigating opportunities and risks

The integration of AI into psychological and psychoanalytic practice undoubtedly represents a significant opportunity for evolution in the mental health professions, provided that the human element remains strictly at the center of the therapeutic process, with AI being used as a tool to enhance rather than replace clinical skills. This distinction, which seems simple, actually requires constant vigilance and ongoing critical reflection, as the

trend toward progressively delegating increasingly central functions to technology is strong and often masked by talk of efficiency and optimization.

The future of mental health will likely be characterized by a responsible synthesis that exploits the analytical and computational capabilities of AI while preserving the absolute centrality of the human therapeutic relationship. This synthesis is neither automatic nor guaranteed, but requires professional culture that values critical judgment over the uncritical adoption of new technologies. It also requires a professional community that is not phobically afraid of the arrival of the unknown AI.

AI represents a frontier that is both fascinating and worrying, to use an expression that captures the ambivalence of the situation. On the one hand, it offers significant opportunities to improve the prevention and treatment of mental disorders through early risk identification, analysis of large amounts of clinical data, personalization of interventions, and expanded access to forms of psychological support. On the other hand, it risks gradually replacing interpersonal skills that are fundamental in a rich and authentic emotional life, and fueling new forms of psychological distress linked to technological dependence, the erosion of social skills, and confusion between authentic intimacy and algorithmic simulation.

The key to navigating this new era responsibly is to adopt an approach that is both cautious and proactive. Cautious in the sense of maintaining a healthy skepticism toward technological solutions that promise to easily solve deeply complex human problems, and in recognizing the fundamental limitations of systems that, however sophisticated, lack consciousness, intentionality, or lived experience. Proactive in the sense of not indulging in a Luddite rejection of technology, but actively engaging in understanding, experimenting with, and shaping these technologies so that they effectively serve human well-being rather than purely commercial or technocratic interests.

This approach requires keeping the human element at the center of the therapeutic process, not as a rhetorical slogan but as a concrete operating principle. It means ensuring that all use of AI is subordinate to human clinical judgment, that patients are fully informed and consent to the use of technology in their treatment, that sensitive data is protected with the utmost rigor, and that the direct therapeutic relationship remains at the heart of the care process. It also means using AI as a tool to enhance human capabilities rather than replace human presence, leveraging its computational capabilities for tasks where it is truly superior, such as analyzing patterns in large datasets, while preserving for human clinicians those functions that require contextual judgment, emotional sensitivity, and holding capacity.

The ultimate challenge is not to completely eliminate these technological tools from clinical practice, a goal that would be both unrealistic and

potentially counterproductive, given that some uses of AI can actually bring real benefits, as is happening in medicine. Rather, the challenge is to use them in an informed, critical, and thoughtful way, preserving our deepest human essence and the core values of the caring professions. This requires an active commitment on the part of all mental health professionals to become, in a sense, "activists" in this field, participating fully in the ongoing technological revolution while maintaining a critical and reflective professional engagement with it.

We must educate ourselves and new generations of professionals not only about the potential, but also about the limitations and risks of these technologies. We must develop professional guidelines that keep pace with technological developments, continuously updating them as new applications and new problems emerge. We must engage in rigorous research on the psychological and clinical effects of human-AI interaction, moving beyond initial enthusiasm or prejudicial rejection to build a solid empirical basis on which to base our decisions. We have a duty to exercise constant ethical vigilance to identify and prevent problematic uses, pathological addictions, and violations of the rights and dignity of the patients.

Above all, we must always remember that the people who come to us are looking for something that no machine can provide: the authentic presence of another human being who is willing to listen deeply, to bear witness to their suffering without fleeing, to remain present through uncertainty and confusion, to witness their subjective truth without reducing it to preconceived categories. They are looking for someone who can be moved by their story, who can respond not only with technical expertise but also with that form of empathetic understanding that comes only from the shared experience of being human, vulnerable, and mortal.

AI, however impressive in its technical capabilities, cannot offer this kind of presence. It cannot be touched emotionally in the true sense of the word, it cannot bring its own vulnerability to the encounter, it cannot truly take risks in a relationship because it has nothing to lose. It is this dimension of shared risk, mutual vulnerability, and authentic possibility of surprise and transformation that constitutes the heart of the therapeutic relationship and must be jealously preserved even in the age of AI.

The growing popularity of therapeutic bots and forms of artificial intimacy should not be interpreted simply as a demonstration of their effectiveness or superiority, but also, and perhaps above all, as a worrying cultural symptom. It reflects a society that is progressively lowering its relational expectations, accepting technological surrogates in place of authentic human encounters, and prioritizing convenience and the absence of conflict over the depth and transformation that only complex human relationships can offer. As mental health professionals, we have the responsibility not only to use technology appropriately with our patients, but also to be wit-

nesses and guardians of the irreplaceable value of authentic human connection in a culture that risks losing sight of it.

In conclusion, as we venture towards this new frontier of AI in the field of mental health, we must proceed with what we might call "critical trust". Trust in the potential of these technologies to contribute significantly to human well-being when used appropriately, but at the same time a critical attitude that keeps alive the question of what we are gaining and what we are losing, what values we are preserving and what values we are compromising, what kind of society and human relationships we are helping to build through our technological choices. Only with this balanced approach can we hope to navigate this transition in a way that truly serves humanity rather than enslaving it to purely technological or economic logic.

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