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Psychiatric Emergencies Revisited Between Institutions and Myth Writing: An Analysis According to a Psychoanalytical Approach

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Correction: in the originally published version, the second author was inadvertently omitted from the author list. The author list has been corrected in the present version.

Abstract:

This article analyses the psychiatric emergencies' clinic in order to identify a myth: the myth of care. Following a brief review of the literature, we draw on a qualitative institutional situation and a theoretical conception combining mythology, psychoanalysis and the institution. Our own conception of the myth of care is demonstrated here: in particular where the event is an emergency, the institution uses repetition to deal with the ineliminable, in other words a non-symbolic point. We discover that the curative ideal, explicitly illustrated by the myth of care, tends to objectify the emergency, whereas the objective is the discursive construction of a temporality. The conclusion of our analysis proves the non-symbolic point of the emergency, which paralyses an institutional temporality. Moreover, the way out would be to use myth as a relay of knowledge.

Keyword: psychiatric emergencies' clinic, myth of care, psychoanalytical approach to the institution, repetition of a non-symbolic point, construction of a temporality

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1. *Emergency services, an interface between discourse and timeless*

1.1 *At the dawn of the emergency department, from the pathological hero to the myth of care*

To date, the usefulness of general and psychiatric emergency services, in France, seems indisputable (Cohen et al., 2017, D.R.E.E.S. 2013, Cases & Salines, 2004). In the common sense, they are considered a guarantee of precise care and unfailing availability (Thomas, 2010), but current events show a completely different picture. Without giving an exhaustive list of all the problems facing French hospitals, which can easily be found in the national and local media, the hospital seems to be suffering from itself. Exceptional measures are being taken, and many authors have identified their shortcomings and possible improvements (Carli 2013, Grall 2015, Steg 1993). So how is it that a hospital service such as the emergency department, which was conceived and designed to deal with all emergencies, both heterogeneous and unconditional, can be in such difficulty?

Emergency departments and their healthcare professionals are often perceived as “saviours” or even “heroes” by patients and the general public when they perform clinical procedures that resolve a crisis or life-threatening emergency. This is why we find it so interesting to question this 'heroic' perception: how and why has such discourse persisted, both historically and in the present day? To explore this, we will bring together a few key authors who have worked closely on the concept of myth, including psychoanalyst O. Rank and anthropologist C. Lévi-Strauss.

In the footsteps of Otto Rank, the emergency also plays the 'hero' in its rescue missions. Since time is counted in the emergency, the notion of time is 'mythified' in its management, and its actors become heroes of time (Freud, 1921)[1]. As a counterpoint, our hypothesis would treat time as a veritable antihero, as the clinical extract below attempts to show.

From then on, we describe hospital practice as mythical, and even more so as a place of institutionalised care, the historicity of which follows the outline proposed by Rank's

[1] Myth is […] the step by which the individual emerges from mass psychology. The first myth was certainly the psychological myth, the myth of heroes” (Freud, 1921/2010)

work in *pathological heroes,* as “a path marked by a series of stages” (Losito, 2025, p. 79). Studying a number of Greek myths and looking for common features in the hero, Rank ended up drawing up the following list:

> "*the hero is a child of the most eminent parents; his birth is preceded by difficulties; the newborn is doomed to death or exposure, and is entrusted to the water in a box; he is saved by animals or people from lowly conditions; when he grows up, he takes his revenge, finds his parents, and is recognised as becoming glorious*" (Rank, 1909).

1.2. *From the pathological hero to the myth of care*

If we take an abbreviated historical reading of the emergency in its epistemic construction, it seems to follow the same logic: psychiatry is a child of more eminent parents, namely medicine for "diseases of the soul" and moral philosophy (Meissner, 2008). Its birth was preceded by difficulties, in the sense of a crossover between scientific and experimental disciplines (revolutionary thought; religion; science), as well as the management of madness with a view to societal reconstruction. She was a new-born baby doomed to death or exposure, in the sense of a new discipline studying the "insane" mind and its sometimes arbitrary therapies of the time, without the consensus of clinical and scientific colleges. She was saved by people from lowly backgrounds, namely the "madness" of the patients she took in, legitimizing her institutionalization. When it became great, it took its revenge and became glorious, in the sense that it was consequently institutionalized and became founded on the vestiges of philanthropism, a guarantor of what it welcomed and cared for. If this knowledge becomes truth as a myth with an intimate and ultimate meaning, then in order to be a pathological hero, one had to be able to 'deny' one's parents. In order to achieve its scientific status, psychiatry has had to 'disown' its clinical parentage in order to become prophetic and expert, "in the name of an internal need to ensure its security, for nothing is more frightening than fragmentation or the fear of the collapse of values" (Pigott, 2002).

Historically, emergency services have been institutionalized with the mission of *reception* as a kind of regulatory principle, starting with the French Revolution and in particular its reforms resulting from the hygiene committee or Pinel's moral treatment,

then Esquirol's proposed law, which we still inherit today from their work (Esquirol, 1838). However, the question of the emergency treatment of "diseases of the soul" in Antiquity and the Middle Ages has always involved this principle of regulating the "insane" in the community, in its expert side between "madness" and "reason" (Swain and Gauchet, 1994). Although the term 'insane' is not mentioned, care and treatment have always challenged clinicians in their interventionist and preventive urgency, whether medical, philosophical or religious; and, to name but a few, through the beginnings of nosographic classifications or confinement linked to the securitization and criminal law of 'incivilities' (Quétel, 2012). The 'insane' have shaped the prospects for social control of the city, which have led, over the centuries, to a large number of restrictive curative reforms. With a pressing constructionist slant on laws and projects, and even heroic in its exclusion of so-called 'deviant' behavior, the emergency approach to the 'insane' is part of a half-tone 'mythical' history, between normalization procedures and disciplinary power (Foucault, 1972).

The first forms of "internment" at the time (temples, prisons, religious hospices, etc.) were designed to admit anything that could be treated as an emergency, and thus became the main gateway to the general hospital when it was created (Collée and Quétel, 1987), by admitting what did not "fit" into the other hospital specialisations: "hospital emergency services seem to be exceptional facilities integrated into an ordinary structure" (Laïdi, 1999). In its definition, it would cover everything that did not fall within the scope of a pure medical speciality or whose cases were not admitted as "medical" emergencies (Thomas et al. 2006).

Over the centuries, as they have multiplied institutionally, emergency services have been prepared to deal with the heterogeneous nature of their caseloads, while at the same time becoming bogged down in their inability to respond properly to the missions they have been assigned historically, in the dialogue between madness and civilisation.

In other words, the governmental approach extended to health care, through the circulars and protocols that are supposed to maintain the emergency period, is transforming the way in which emergencies are perceived: when they occur, hospitals surround them with anticipatory protocols and preventive management that will no longer make emergencies

contingencies, while at the same time abolishing subjectivity and transferential dialogue (Gori and Del Volgo, 2014, Gori and Del Volgo 2011, Abelhauser et al. 2011).

1.3. *Towards the myth of care*

So why combine institutional practice with myth? For the last fifty years, the experimental and pharmacological use of psychiatric pathology has rigorously followed the status of 'quasi-mystical' knowledge (Pigott, 2002). This knowledge has become heroic under the influence of the hygienist ideal, and all the more so because it is defined in institutional terms, particularly when the duration of an emergency hospital stay is calculated as the average length of stay (ALS). Thus, this heroism is fueled by this ideal of care and space: as soon as an emergency is received and treated, it is immediately evacuated.

While the psychiatric institution offers care "for all", definable and localisable in time by protocols, the clinic seems to demonstrate a different temporality, more synchronic. In other words, the emergency witnessed by the subject establishes the conceptual impossibility of an emergency 'for all' and brings about a psychic reality 'out of time' through this event.

This impossibility of the emergency, strongly assumed to be indefinable and timeless, feeds a myth as a regulation of something that does not work in practice, and that is repeated. In other words, there is something about the emergency that cannot be represented, symbolised, spoken about or articulated. Thus, what is an unspeakable point of suffering for one person becomes a point of discomfort for everyone. This non-symbolic, obscure point, which resists symbolic articulation even in the individual sphere, manifests in the collective sphere as institutional deadlock, complaints or dysfunction.

Myth is then summoned to deal with this intractable, to absorb this irresorbable, to veil or hide this bottomless funnel. Therefore, the myth seeks only to compensate for what cannot be said or healed; in other words, it seeks to compensate for this non-symbolic point in question. However, a myth does not sustain itself, and it is the mythic discourse which, by taking over its formation, distorts it: from the myth of care, since each person in the institution carries the myth differently, while making it converge towards the same point, the ideal of care.

1.4. *Myth and amnesia*

But what then of the psychiatric emergency, where the paroxysm of a non-symbolic point finds its epic in the doubling of what cannot be said? The advent of a non-symbolic point of the one, translated into malaise for all, is redoubled because of the impossibility, in psychosis, of inscribing even an edge to this non-symbolic point, from which it could be isolated. It follows that, for the psychotic subject, in the phases of triggering and decompensation, everything is non-symbolic and unspeakable. In addition to what we have already seen, psychiatric emergencies should therefore also deal with this non-symbolic, with the risk of causing the institution to implode into a collective without an individual, since without an edge, there is no longer either an individual or a collective. In other words, the suffering of one no longer becomes the malaise of all, because if there is no longer one, there is no longer all, there is no distinction, no difference; there is only the undifferentiated. Is this not what Freud tried to demonstrate throughout his teaching, through the analogy between the child (ontogenesis) and prehistoric man (phylogenesis)? This analogy, however, is only authorized by the concept of repression, which marks the infantile as well as prehistory: "the human race has a prehistory [...] unknown that is, forgotten" (Freud, 1938). It is this amnesia, affecting both the child and prehistoric man - and described by Freud through the myth of the father of the primitive horde (Freud, 1913/2009; Roheim, 1940) - that makes it possible to link the field of the individual to that of the collective. It is also this amnesia - very close to what we have referred to as the point of reality - which, repressed, is reproposed at every period of life and history, under the vestiges of the return of the repressed (Abraham 1909, Rank and Sachs 1913). So, if we extend this analogy to the institutional field, the question would be: is there a repression at work, as a defence mechanism, also in emergency care institutions, a repression that comes under the myth of care? This myth should therefore deal analogously with the institution and the subject, who, for his part, founds his subjectivity in belief, the symptom and fantasies (Freud 1909a, Evans 1979). As a structure, myth then finds its prevalence in imaginary activity: it is in place of function, combinatorics and logic. Thus, in order to account for the question of Origin, myth is attached as a "theorical substitute" (Assoun, 2003).

Freud and Lacan, echoing Lévi-Strauss, posits myth as structuring the unconscious and linked to language; myth thus attempts to resolve the unspeakable of a non-symbolic point by recovering meaning. If it responds to primordial time (of the subject, of civilization), it is the matrix of present time as a structure of transformation transmitted by oral narration as a ritual, in order to "resolve a contradiction" (Lévi-Strauss, 1966) and requiring "in a way a passage which is as such impossible, which is a dead end" (Lacan, 1956-57). Myth "does not cease not to be written", founding the impossible of a non-symbolic point by setting knowledge and truth in motion: "myth is what gives a discursive formula to something that cannot be transmitted in the definition of truth" (Lacan 1956). In this sense, myth acts as a (symbolic) relay where discourse (symbolic, imaginary) is lacking. For Freud, myth has an etiological function through its narrativity. Let's try to exemplify the practice by using a myth.

2. *The use of myth in psychiatric hospitals*

2.1. *Cronos the Titan: at the origin of the world, the cruel temporality...*

The myth of *Cronos,* or its etymological variant *Kronos* (De Panopolis, 4th century BC; Sallustius, 4th century BC)[2] , is one of the founding myths of Greek mythology in the *Hesiodic* tradition: "the god of deceitful thoughts" (Hesiod 7th century BC), "the devious mind" (Homer, 762 BC) or "the progenitor of all" (Sallustius 4th century BC). (Hesiod, 7th century BC), "the devious mind" (Homer, 762 BC) or "the progenitor of all" (Sallustius, 4th century BC). Benjamin of the *Titans*, but also of the *Cyclops* and the *Hecatonchires*. Born of the sky and rain, of the earth and fertility, *Ouranos* and *Gaia* form the primordial and archaic conjugal union of the ages (Varrod, 2020). According to the same tradition, it was at the moment when life was created that man was born. It was

[2] For the purposes of this article, we will use the Greek mythological reference rather than the Latin one, the equivalent of which is represented by Saturn in Roman mythology. Another point of clarification: *Cronos* and *Chronos* are often confused linguistically and etymologically. The scriptural difference stems from their traditional origins, where *Chronos* comes from the *Orphic* tradition as the personification of the "hours of day and night". They are confused because both possess the symbolism of time and have the same apparent attribute, the sickle. *Chronos is a* liberator of happiness, fertility, celebration, harvest and glory for mankind. Representations of his figure vary in culture: either a wise, bearded human old man with an hourglass and wings; or a chimera with three animal heads. All in all, the true history of the myth is not easy to grasp, when the various bibliographical, historical and etymological sources are considered.

under maternal desire that *Cronos* was given a scythe/sickle/serp with a flint to sharpen it, where he "hated his burgeoning progenitor" (Hesiod, 7th century BC), to stop his father in his impulses, and free the "brotherhood". He did so and emasculated his father, who warned him that he too would soon be deposed by one of his own (Graves, 1958).
By freeing himself from the Father's grip, he freed his brothers and sisters, one of whom he married, *Rhea*. This incestuous union gave birth to many future gods: *Hestia, Demeter, Hera, Hades, Poseidon and Zeus*. Not forgetting the prophecy witnessed by his father, *Cronos*, in order to safeguard his place as all-powerful Father, decided to commit cannibalistic acts against his barely-born children, and to incarcerate the *Cyclops* in *Tartarus*. All were thus trapped to be incorporated or locked up, deprived of all freedoms, justified by his tyrannical base. Pregnant with her next child, *Rhea opted* for a tactic: she placed *Zeus in* his grandmother's nursery while he grew up. Eventually, he would be raised and fed by the *nymphs* in Crete. To make this stratagem work, she took a rock and wrapped it in swaddling clothes as a subterfuge, leading her husband to believe that it was her last heir. He promptly swallowed it, unaware of the deception set up by his companion. When *Zeus was in* his prime, he found a companion named *Metis*, goddess of cunning, who suggested that he give his father a powerful emetic so that he in turn could free his brothers and sisters. Zeus freed each of his siblings and those held captive in *Tartarus*. *Cronos*, realising that the prophecy was about to be fulfilled, declared open war on his children, which he eventually lost. *Cronos* was defeated and imprisoned in *Tartarus* (Schneck, 1968). The entire new brotherhood decided to found Olympus, where each of them would be god and master. Freed from their father's superstitious pleasure, they became immortal.

The myth of *Cronos* is no exception to a fateful destiny, whose prophetic mark is actualised in traumatic filial repetition between infanticide and parricide (Lévi-Strauss, 1964). Emasculation or vomiting could be the symbol of a new era of creation, a new time for each generation, from which the castrating cut and the oral rejection originate. If the conflict essentially concerns the relationship between the enjoying Father and the avenging Son (Bunker, 1953), it is important to remember that it is a devouring of the instant, which *Zeus* establishes as universal time (Wolf, 1972). If the gods are truly

immortal, humans will be prisoners of time, forced to contend with supreme disappearance, decay and oblivion. *Cronos,* despite his destitution, persists through his mythical heritage and his transparent cage: he remains "in the air of time", a linear and diachronic time that works against us, marching on unchecked.

2.2. *Care time today*

Urgency in particular raises the irremediable and tyrannical question of time working against us. The contingency of the emergency moment creates a “hole” in the institution: temporally on the one hand, because it brings a diachrony to a halt through a rupture; structurally on the other, because an accepted or thought belief is destroyed, a symptom made unbearable by a disturbing encounter. Through an encounter with a non-symbolic point, recourse to myth (re)cultivates the sense, in an emergency, of an institutional identity, rethinking its origin and its place in time and values. At the same time, it resorbs, in the collective, the impossible points of each individual. The unpredictable nature of emergencies undermines the reference of transmission, understood here as desire or narrative. It is the myth that tries to elevate them to the level of what is said, against a backdrop of the impossible to say. The hospital is increasingly absorbed by the vortex of the logic of results, and therapies could lose the use of the oral narrative of desiring transmission in favour of 'descriptive' practices.

The crushing of *Cronos* at the hospital no longer involves writing and rewriting, but dissipates and scatters in the mastery of meaning. *Cronos:*

"reconnects with the foundation of the myths by reminding us, at a time when scientific progress was going to completely reshape thought, of what science represses and which was carried by the myths" (Marret-Maleval, 2010).

If the reality of the emergency unveils a non-symbolic point by breaking into it, myth is in a paradoxical position: while on the one hand it covers, coats and veils the horror of a non-symbolic point, on the other it reveals the time of the emergency, dispelling it. This timeless urgency thus fosters a feeling of disquieting strangeness (Freud, 1919), coming up against the non-symbolic point and revealing all the fragility of the screen. This is precisely the conclusion we draw: "if myth traces the symbolic framework, it states the

truth where it is hidden: what constitutes its origin" (Abelhauser 2020, Evans 1979). And yet, as this “hole” is revealed, words are lacking and words are silenced: urgency outstrips time and fixes the unspeakable that is pointed out. Myth as a response to the non-symbolic point is an "attempt to articulate the solution to a problem" (Lacan, 1956-57), "[...] at the moment when it is needed to make up for the gap in what can be dialectically assured" (Lacan, 1960-61).

2.3. *“Medusian" clinic under emergency conditions*

In order to clarify our hypothesis, we propose a clinical excerpt from our institutional practice, within an admission or psychiatric emergency department. We will attempt to dismantle the respective temporal and symptomatic logics, isolating the signifiers that have been stated. To achieve this, we will draw on the myth of Medusa to explain the encounter between institutional temporality, which creates urgency, and the unique psychic temporality of a patient. These two temporalities have a symbolic impact, causing traumatic and even terrifying effects that recall the petrification in the myth and evoke the traumatic experience.

2.3.1. *The event*

The hospitalization of several drug addicts produced a discourse of *"paternalism" within the* team, in line with the objectives set by psychiatry, namely to "save" the individual, or the human being, the living being, before the subject (Foucault, 1974)[3]. This "paternalism" therefore translated into "suspicion" and "trafficking". Similarly, it had been assumed that some patients would "re-alcoholise". The department therefore took a clear-cut decision: everything had to be "controlled" and "searched": rooms, clothes, etc. The aim of the repressive framework was "*to remind people of the framework of care and the therapeutic goals of the institution, by emphasising the responsibility of the patients*". These searches - reminiscent of prison regimes - were intended to be carried out quickly, as they were deemed time-consuming, and interrogation was the key. Each patient was 'passed through', giving voice to the mortifying logic. Not satisfied with the expected

[3] In this regard, we refer to the neo-liberal logic that would resonate with a "we have to take care of the lost because it is important that each patient can quickly 'function' again" (Cf. Foucault, M. (1973-1974). *Le pouvoir psychiatrique, cours au Collège de France, 1973-1974*. Paris : Éditions Gallimard).

results in terms of *culprits*, this event spread throughout the institution, reorganising it from within. If this department felt 'fooled' at that precise moment, the response was colossal: with care lacking, recourse to security became necessary. Vigils were set up throughout the institution. The therapy of care is now replaced by institutional security, echoing the relationship between power, care and law that has marked the history of psychiatry, with the myth of the hero as guarantor of order and the repeated regulation of 'deviance' (Ridel, 2021).

2.3.2. *From a "rigidified" subjective*

M.A. had only been in hospital for a week, but he was already familiar with the ward from his previous treatment. We were able to follow him for a whole year, with individual interviews taking place when he was in and out of hospital, at intervals of around three or four months. M.A., who was in his fifties, was admitted to hospital following a break-up of his relationship, which had deeply affected him. Alcohol and cannabis were used to "forget" this impossible separation.

During this period of institutional “suspicion”, Mr A was also subjected to scrutiny. Although it did not last long, it was enough to plunge him into confusion and anxiety. As he went out into the courtyard to smoke a cigarette, he described in detail the enigma he perceived: a hole in his perception; an inexpressible incomprehension; a petrifying confusion. Two nurses hurried towards him, their looks expressing nothing but hostility. “They asked me to wait and said they were going to ask me to empty my pockets and then search me. They justified what was happening as if it were perfectly normal…”, he confides.

When the search was over, he was able to get on with his work, as nothing had been found on him. He was able to say: *"It was incomprehension that gripped me, what did I have to reproach myself for? Nothing, I was innocent, because I know why I'm here, I had no reason to have what they were looking for. They know me, but apparently that wasn't enough*. He continues: "*I experienced it as a police arrest, as if I were a liar, a culprit, and it affected me. I was targeted. I was lost for a few seconds, frozen, you see, on my feet without really understanding what was going on or what was wanted of me... it's the first time something like that has happened to me, it's not pleasant. Was I really one of*

the suspects? If I had that kind of problem, I'd still be able to talk about it. People don't trust me", he said in the end.

Although he always described himself as motivated and sincere, the incident during the search accentuated his melancholy. His words accurately describe the uncertainty and lack of sense of time experienced at this moment, as well as the petrification experienced when this unsymbolisable event occurred.

However, the therapeutic work enabled him to temporise and dialectise this event by drawing a link with the event of his romantic break-up: he would therefore use it as an example of a daily situation, like his romantic break-up, which "*brings him down every time*". All the same, we can hear the extent to which the signifiers chosen by the subject reflect this mortifying procedure of the institution.

3. *Discussion*

Is it therefore not legitimate to describe this practice in the “Medusan” sense of the term? Although this clinical example is limited in scope, it does indeed mobilise the actualisation of mythological discourse around the concept of urgency from theoretical and institutional perspectives. This example invokes the myth of care and its temporality with Cronos and Medusa.

The testimony clearly conveys the terrifying nature of this moment and its impact on him and others. This face-to-face encounter, in which he felt exposed and which unconsciously reminded him of other events, acts as a mirror, as if the subject were frozen and pierced by this enigmatic anxiety. Unable to move or make sense of it, accentuating at best a melancholic tendency in hindsight, the experience of this momentary flash had the effect of subjective mortification and a truly traumatic, petrifying impact. It is as if the caregivers, metaphorised by Medusa, had struck a fatal blow in a moment outside of time, as reported by the patient, without taking into account singular temporality. In a state of emergency, the hospital takes on this diminished and docile image, which the event itself “confronts with its petrification” (Pardo, 2010).

Through this emergency event, the institution has revealed the invisible, which had previously been masked by a false pretence. This situation corresponds to the revelation of a non-symbolic aspect that was previously a blind spot for the institution. Everyone

experienced it as a stiffening caused by anxiety due to this symbolic break, which was relayed by a more substantial imaginary.

There is nothing to reflect except, for each of the subjects, the slope to a disidentification that shakes things up.

This nursing over-moisture gives ″a terrifying image of a petrifying reality″ (Pardo, 2010). Doesn't institutional practice have this power to annihilate the subject, where M.A. has been reduced to a mortifying void? The institution that carries such a discourse is unable to transform this event into a narrative as a function of symbolic inscription. This impossibility, this undialectised remainder, thus acts as a symptomatic repetition because the intervention remains in an *urgent act of mythical heroism* without taking subjectivity into account.

The act of trafficking, in a place of psychological care, horrifies the institution, because it is already engaged in a battle against a non-discourse that aims at its limit. The clinical moment thus seems to have been missed in the place and in the link: this discursive modality has thus substituted the act of speaking for a frontal act without semblance, leaving the deadlock on a possible dialectisation, in the name of formalized security. Caught up in this conclusive haste to act, it deprives time for understanding, marking the event in an out-of-time.

4. *Is the hospital heading for a mythical epic?*

A return to the postulates of Otto Rank, taken up by Freudian conceptions of "*Mythenforschung*" or "psycho-mythology" (Freud 1897, Freud 1909b), seems to confirm our hypothesis of the close link between the study of myths and the psychiatric clinic (Rank, 1909). Without falling into a diagnostic reading of the institution, can we agree with Marret-Maleval, (2010) that these modern myths of science are a resurgence of primitive myths? Doesn't their reproducibility and contemporary creation reflect a difficulty in creating meaning for the hospital, based on its practices? As she shows, "mythical thought coexists with scientific thought insofar as it is the enunciation of what the latter excludes" (Marret-Maleval, 2010). It is indeed the unconscious knowledge of the subjects that underpins the paradox of the truth of myth:

"even the most obtuse operator does not see that all that can be said of myth is this, that the truth is shown in an alternation of strictly opposed things, which must be made to revolve around each other" (Lacan, 1969-70).

This truth can be approached in the clinic when the obstacle of scientific rationality, that is the subject is encountered. Even more so, when the time of this urgency tyrannizes the act that must be carried out.

By showing the 'myth in the hospital' in his return to the assiduous study of several of these, he demonstrates how institutional logics become intoxicated with a powerful imaginary when they touch on a point in time, even if it is a short one. If Freud gives us information about fiction of myth by the "*Entlarvung*" (the "*unmasking*"), it is because it concerns our practices: "[it] enables us to enjoy our own fantasies from now on without reproach or shame" (Freud, 1919).

Indeed, if myth is a matter of urgency, as we are seeking to demonstrate, it is because this myth represents the image of the 'hero of care' in the attempt to achieve a possible dialectic with the encounter with a non-symbolic point. However, this attempt, seeking at all costs a symbolic way out, misses the dialectisation and takes part in a mortifying repetition beyond the pleasure principle (Freud, 1920). Indeed, although the emergency aims for immediate satisfaction, it is never without its share of death drive; from which emerges the repetition compulsion in order to regain a certain mastery in practice, namely in emergency care and healing (Inderbitzin and Levy, 1998). However, the price paid for a sense of care is high: ruling out surprise, emergency services venture into a drifting epic, navigating murky waters and defending themselves from anything that might attack them. The result is a specular relationship that, missing the point, can lead to action.

What, then, would be the clinical teaching and therapeutic aim for the institution? If the day-to-day life of care institutions teaches us this, it's because the use of myth catches an impossible that wants to be said, but which instead passes through an action of the body, which can then engage a speech that was previously latent. Listening carefully to the myth, in practice, allows us to read it in a way that leads to a more 'conscious' reality of the institution, at best more appeased, assumed and explained. In other words, the use of myth helps to demystify the time that is running out. All in all, "the development of a

myth in a given period responds to the contradictions of the society that develops it" (Vernant and Vidal-Naquet, 1972).

In conjunction with myth, care could be based on the question of the 'desire to care' rather than this repressed anguish, at the very point where the emergency clinic resorts to the curative myth and the ideal. The opacity of the non-symbolic points governs where myth colours it from time to time, until it has saturated the nuances. Here we have to grasp the paradox: while it is coloured by the discourse of science, its practice reveals the knowledge of the unconscious and the repression. We can then bet on a different handling of time, through a creative effect that is particularly attentive to a subversion of its ideal of curative logics.

The allegory of the hospital titan swallows subjectivities to prevent him from being dethroned from his logic of mastery, whose patients threaten his destitution. The hospital without shortcomings, responding to all offers for the institutionalised emergency as a repeated diachrony, wants to conceal its flaws. Anzieu (1970) puts it better: "the statement of the fantasy underlying an anguish" (Anzieu, 1970). Logically, the use of myth gives a good account of the contradiction: if science wants conceptual meaning, its myth opacifies it in practice by "getting rid of the dynamism of the work of truth" (Lacan, 1969-70). Dedicated to the repetition compulsion that seeks to control healing and reception, the institution repeats this discursive logic, outside the dialectisation of subjectivity and time, where traumatic repetition can be assumed. The use of the myth of care attempts to inscribe a truth and a repeated knowledge on this remnant of a non-symbolic point. If we insist on the repetition of the mythical discourse of care, "it is because this truth is impossible to transmit as such, [...] that history tends to repeat itself" (Lucchelli, 2010). Unquestionably, on the basis of repetition, "the unconscious conveys myths" (Anzieu, 1970).

All admitted cases of emergency - whatever their singular manifestations - are cases of emergency in all its possible variability, and credit must be given to those who have seen the *Gorgon* at close quarters (Gaspard and Sauret, 2008). In our institutional practice, don't the conceptualisations of emergency care provide a way of reading anxiety as a human affect? The subversive vision rather assumes that anxiety is a subjective truth (as well as a collective one), which, in the intricacy of haste, confuses desire and demand. If

its appearance disturbs and dislodges the subject, it is nonetheless the most singular witness there is. Questioning it, beneath the cover of the myth, situates the whole therapeutic pivot to grasp the desire, through a symbolic question, dislodges a strongly anchored imaginary. Carefully, the clinician will have to look at Medusa, not in the eyes, or with the help of a mirror-like shield, but from the side. A *step to the side*, leading to the reintroduction of an everyday temporality.

Is it not the case that hospitalised patients, “through symbolic trials” (Losito, 2025, p. 97), are *"children of Cronos"* (Aubert, 2009), subjected to his dictatorship and reduced to their subjectivities? We're betting that in an emergency, time is irremediable, and singularity is just as irreducible. It invites us not to reduce ourselves to the haste of a knowledge that guarantees a truth, but to speak our own language in the face of desire. Agreeing on a common clinical approach, woven from creativity can lead all carers towards a less damaging symbolism, and find the ultimate golden fleece, namely - in the footsteps of Freud, Rank, Abraham, Lévi-Strauss and Lacan around myth, ours in that of the emergency - what differentiates “nature” and “culture”, “reason” and “unreason”. More than that, it's about questioning the gap between the two when a clinic is involved in an emergency or emergencies.

In conclusion, the conceptual mobilisation of myth in emergency practice teaches us that clinicians who are attuned to the unconscious understand that it disregards time, or at least does not consider chronological time. Thus, studying myth enables us to question the temporality of clinical discourse and actions in these specific situations. By removing the pretence that myth maintains as a symptom, clinicians can pay more attention to psychic temporality and its traumatic effects in an emergency situation.

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