

The Self and alien self in psyche and soma

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Abstract: This paper compares presentations of disorders of the sense of body ownership and agency from psychoanalytic and neurological perspectives to demonstrate similarities in symptomatology proposing these similarities arise from adjustments in Friston's generative model of self-organization and selfhood. The implications for the analytic model of the Self, for clinical practice and for neuroscience research are considered. Patients with narcissistic disorders use projective defences resulting in a disordered sense of what belongs to whom. This applies to mind and body of self and other and is central to understanding transference and countertransference. Clinical observations of this disordered sense of ownership and agency mirror findings in neurological disorders. This paper proposes that in both neurological and psychological disorders Friston's 'internal generative model' of selfhood is adjusted. Further to this whilst this adjustment may be either neurogenic or psychogenic, the final neural mechanism and symptomatic outcome are similar. On the basis of these observations the paper compares the concept of the Self from Jungian and psychoanalytic perspectives. Finally, the implications for the concept of the death instinct and Britton's concept of Xenophobia are explored along with the implications of these observations for clinical practice.

Keywords: death instinct, generative model, narcissistic disorder, personality disorder, psychoanalysis, psychodynamic neuroscience, self, sense of agency, sense of ownership

Introduction

It is perhaps self-evident that one of the most striking differences between the brain and other bodily organs is its unique property: having a mind. There is an established tradition of studying the brain from two perspectives, both as a bodily organ with its neuronal structures, physiological functions and neurochemistry and in its functional presentation as the mind, the subject of experience dating back to Freud's comparison of organic and hysterical paralyses (Freud 1893) and his Project for a Scientific Psychology (Freud 1895/1950). The current iteration of this tradition is the developing

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field of psychodynamic neuroscience, a form of interdisciplinary dialogue between neuroscientists and clinicians. For many, however, the relevance of these disciplines to one another remains obscure. One of the aims of this paper is to demonstrate the importance of this dual perspective. This is not an attempt to provide spurious validation of psychoanalytic ideas, nor to persuade neuroscientists that the mind is not only as an emergent or epiphenomenal property of the brain but also more or less inseparable from neurological functioning itself and therefore critically missing in hypothesis testing in neuroscience research. Whilst either of these outcomes might be welcome, the objective here is to demonstrate the potential of bringing observations from both perspectives alongside one another in order to develop new ideas relevant to clinicians and neuroscientists.

I will use this interdisciplinary method to compare my clinical observations of patients with severe narcissistic disorders with neuropsychological and neurological observations of disruptions and disorders in the sense of body ownership and agency. I will use these observations to reconsider some theoretical concepts about the Self and the developing capacity to distinguish self and other. The discussion will go on to consider some gaps in our existing conceptual framework with reference to phenomena which have been attributed to the Death Instinct in the Freudian and Kleinian tradition or more recently termed psychic atopia by Britton (2003b). I will describe how distortions in the sense of what belongs to whom in narcissistic patients manifest both in somatic symptoms and in the transference. Finally I will discuss the implications for analytic practice. I will start by giving an account of two patients. All identifying information has been removed or changed to preserve confidentiality.

Akinesis

Miss X first became depressed after meeting a person she wanted to marry. Until that point the focus of her existence was on the attentive, sensitive responsiveness to the perceived needs of others. Whilst she had long believed she wanted her own life and family when the opportunity arose she couldn't take it. She could not sacrifice the needs of the people she looked after to pursue what she wanted, feeling their lives depended upon her availability. She felt, 'it's their life or mine'. Once this became clear she felt killing herself was the only way out of a life compulsively caring for others. It became apparent during psychotherapy she was unable to function unless others were present. In the absence of demands she simply stopped. As soon as the door closed behind her and she was alone at home she sat unmoving for hours until the time came to go to an appointment, a meeting or work. These 'demands' provided the motivation to move again.

In psychotherapy groups she was articulate and thoughtful about others, without talking about herself. Once she had settled in something occurred at the end of a session. The moment of leaving arrived and the other group members left but Miss X remained motionless and unable to speak. The therapists confirmed the session had ended and left the room. Half an hour later she recovered spontaneously and left. This became a regular occurrence. Trying to describe her feeling at the end of sessions Miss X said her mind was racing at those moments, too fast for her to capture or articulate a thought. This static or akinetic mute state sometimes arose when she reached the door to the outside of the building, the transition between inside and outside. On one occasion Miss X did not emerge from this state for several hours. Finally when the time came for staff to go home Miss X needed assistance to leave the building. By now familiar with this I asked Miss X to stand, instructed her to lift her legs in turn in order to walk and escorted her in this puppet like way to the outer door of the building. When she reached the threshold after a sharp intake of breath she began sobbing then composed herself and returned home.

The foreign body

At the time I saw Miss Y she had been detained under the Mental Health Act as an inpatient receiving Cognitive Therapy for several years but remained too unwell to be discharged. According to Miss Y her childhood was unremarkable. Apparently her parents looked after her well but she described them as 'practical people who did not understand emotional difficulties'. In her early teens she developed obsessional thoughts. Later in her mid-teens she was sexually assaulted. After the assault she started to take overdoses and cut herself. She wanted to amputate her arms and bought an electric carving knife for that purpose, so she was admitted to an adolescent unit for several months. This was the first of many admissions. In hospital her determination to hurt herself led staff to restrain her. The situation would escalate resulting in extended admissions. As a consequence, she had spent much of her adult life in hospital.

I saw Miss Y for assessment. She was brought from the ward by two nurses. She was smartly dressed but had one arm in plaster, the other wrist was bandaged. As she talked she seemed determined to persuade me to help her and anxious she might say something to make me decide I could not. This was to be avoided at all costs, as failure led inevitably to self-punishment. She pressed me to ask questions as she could then feel confident she was giving me what I wanted, being intensely anxious when left to volunteer information.

She assured me of her commitment to gain control of her impulse to hurt herself but added she found she could not do so without staff being present to prevent her. If she was alone, or for a moment recognized she needed someone else and they were not immediately available, the urge to harm

herself became uncontrollable. As she put it, once she started to 'think negatively' the consequences were usually inevitable. If she kept her mind occupied or attended to what other people wanted this took her mind off her wish to hurt herself for a while.

Despite her professed wish to talk, I could not get her to attend to the feeling which came before she hurt herself. If I approached the subject, she talked compulsively about the importance of thinking positively. She reminded me of the plastic surgeons who repaired her damaged wrist saying the repair must be protected. In the same breath she described her immaculate home and the importance of preserving this place outside hospital. She urgently sought a way to return to the undamaged life she left behind when she was assaulted. In this way she alternated between wanting to cut off the difficulty and leave it behind and wanting to attend to it so she might recover.

She talked about the rape, committed by a police officer. The rape itself had not been the most difficult part. When she tried to press charges the police closed ranks, the doctors did not take physical evidence correctly, and in the end the case was dropped. She said she was most angry with herself for failing to resist his advances. She attacked her arms because she felt 'she should have been able to push him away'. She despised their weakness and wanted to amputate them. If I gave her a pen I asked, did she know exactly where on her arm the amputation should be? She said she did and could draw a line on her skin where she wanted it amputated.

Jungian, psychoanalytic and neuroscientific concepts of the Self

The concept of the Self as an archetypal unifying whole comprising both psyche and soma is what distinguishes Jungian metapsychology from psychoanalysis (Jung 1951/1968). Jung (*ibid*) described somatic and psychic bases for the ego which he described as the centre of consciousness but not the centre of personality. The centre of personality he labelled as 'the Self'. As Fordham said, in psychoanalysis the self is seen as that part of the ego which refers to self-feeling only or to self and other described in terms of object relations (Fordham 1971). Fordham contributed the developmental perspective conceptualizing the infant as an individual primary self, a psychosomatic whole, both the source and sum of what it might become.

To analytical psychologists the self is a concept which expresses the wholeness of the human being, and the division of the whole into body and psyche, as we know it in adult life, is a development of it. The self is therefore more than a psychological concept and as such it cannot be directly observed. It can, however, be inferred, represented symbolically, and is a relevant postulate in infancy in the ways I have outlined.

(Fordham 1971, p. 180)

Fordham (1971) observed that very young children had a fundamental organization underlying even disintegrated states. He observed children under age two, who scribbled circles just prior to starting to use the word 'I', or prior to presenting as centred and coherent individuals for the first time. Fordham understood these circles to be representations of the primary self. Whilst under ordinary circumstances the Self cannot be observed, the phenomenon of a self-boundary delineating inside from outside becomes evident in both specific neurological disorders and the disordered sense of what belongs to whom which arises as a consequence of projective processes in analytic practice with patients with narcissistic disorders. A recent development in neuroscience research proposes the mathematical principles through which all life forms organize themselves within a boundary. The parallel between the psychological experience of the self and the biological 'template' goes beyond superficial similarity.

Karl Friston, a prominent neuroscientist, uses mathematical models, specifically Bayes Law and the laws of physics, to describe the principles by which the brain functions. Drawing on the ideas of the 19th Century physicist and physician Hermann von Helmholtz, he describes the brain as a hierarchical 'inference machine' (Helmholtz 1867). By this he means the brain does not passively receive perceptions of the world through the senses. Instead it infers hidden causes for perceptual events and uses these to construct a dynamic internal, generative model of the world. In this way what we 'perceive' is an hallucination of how the world is rather than the world per se.

One might ask how this is relevant to ideas about the Self. Friston proposes that all life forms oppose the second law of thermodynamics (Friston 2010) which states that, with time, energy tends to progress towards its least organized form i.e. heat. This relentless progress towards a state of disorganization is termed entropy.

Friston suggests large macromolecules which preceded the development of lifeforms on earth acted as a random dynamic system which, as a consequence of their interactions, formed themselves into a boundary circumscribing internal and external spaces (Friston 2013). To demonstrate this he used Bayesian algorithms to simulate the electrochemical state of the primordial soup. When a computer ran this simulation, virtual particles appeared to form themselves, as predicted, into a circular boundary. This circular structure is called a Markov Blanket (Pearl 1988). The interior maintains its internal equilibrium based on the information received through the boundary which opposes entropy. The enclosed particles behave as if inferring, using Bayesian logic, the nature of the changing environment which lies outside the boundary.

Friston suggests these internal states and their Markov Blankets are models of prototypical biological systems and the predecessors of life forms. They are the mathematical template upon which biological systems operate. This is the case from the simplest to the most complex organisms. Each cell membrane

maintains the equilibrium of its interior just as the body as a whole is organized to maintain homeostatic equilibrium. Evolutionary progression leads to more sophisticated elaborations of this template. Friston understands the brain in these terms: as a large ganglion of nerves sitting between the sensory and motor systems adaptively sampling the environment to minimize uncertainty about the causes of sensory inputs in order to maintain the internal milieu.

Friston's model, the Free Energy Principle, has profound implications (Friston 2010). He proposes the brain predicts what our eyes see before the data is received from the retina on the basis of the internal generative model. The prediction is then matched with what we actually perceive, the divergence between predicted and actual sensation being termed 'prediction error'. The error is used to update the generative model, much of which Friston proposes takes place during dreaming sleep (Hobson & Friston 2014). The better the prediction, the better the fit between the model and perceived reality. Adjusting the internal generative model takes place through a hierarchical cascade. Lower levels of the hierarchy process simple data, for example sensory stimuli; higher levels process integrated sensory data such as object recognition where the highest levels include mental imagery. It appears the brain is intolerant of unfulfilled expectations and so structures its model of the world and motivates action in such a way that more of its predictions are correct. It is thought that in mental disorders the model is not updated but the perception of the external world is adjusted resulting in hallucinations and delusions (Griffin & Fletcher 2017).

Most relevant to the proposal in this paper, Friston suggests self-definition is dynamic and inferential, the model generating predictions about what's most likely to be 'me' (Braun et al. 2018). He describes a dynamic boundary of the organism reflected in the structure of the brain (and therefore the mind) within which the stability of the interior is maintained. Whilst not disregarding the vast neuroscientific and philosophical literature on types and levels of self-awareness (Neisser 1988; Leary & Buttermore 2003; Vogeley & Fink 2003; Morin 2006), the focus of my interest here is on boundary phenomena of the self, the development of the self/other distinction and the disruptions of the self/other boundary in narcissistic disorders.

Neuroscientific accounts of the sense of body ownership and agency appear most relevant here especially with respect to understanding the sensory and motor data which forms the basis upon which the brain determines whether the body belongs to the self or not. Each of these senses, that of body ownership and agency, arise from distinct but interacting brain systems and have their own generative model (Braun et al. 2014; Tsakiris 2010). If there is not a good fit between the 'model' and perceptual experience or action, the person can experience part of their body as not belonging to them or may feel they are not in control of their actions.

At this point I should make clear that, broadly speaking, the body is represented in two ways in the brain. In effect, the brain has two perceptual

surfaces, one perceives what is going on in the interior of the body, the viscera, the other perceives what is going on in the outside world. Behind these two surfaces hierarchical neural networks perform inference about what is going on interoceptively and exteroceptively. The interior and exterior of the body are represented in entirely different ways in the brain. The interior is represented in lower brain centres (brain stem, subcortical nuclei and limbic structures) which generate consciousness, affect, and the sense of the self as the subject of experience, the affective and conscious position from which we perceive the world. This is the subjective body. The outer surface of the body, both skin and musculature, is represented on the outer cortical surface in the sensory homunculus. In neuroscientific terms this is the objective body which we see in the mirror and are aware of as an object in the world. The subjective body, (the subjective self) is not learned but present from the beginning of life. The fact that the objective body belongs to the self, however, is learned so that in ordinary circumstances during development the boundary of the self comes to coincide with the skin.

It has been demonstrated that the location of the boundary of the self and the sense of body ownership and agency are surprisingly plastic and can be manipulated experimentally (Tsakiris 2010). In the rubber hand illusion the sense of ownership is adjusted by placing the subject's arm out of sight, a rubber limb being placed in the line of sight. The subject's hidden hand and the rubber hand are stroked simultaneously. After a minute or so the person feels the rubber hand belongs to them. The same phenomenon occurs when the experiment is undertaken with the whole body and surprisingly even with the face in the enfacement illusion (Tsakiris 2008; Blanke & Metzinger 2009; Sforza et al. 2010).

The sense of agency is the experience of initiating and controlling an action distinguishing self-generated actions from actions generated by others (David et al. 2008; Moore 2016). The fact that this too can be manipulated was demonstrated in the active rubber hand illusion. The subject can either initiate their own and the rubber hand's movement or have it passively moved by the experimenter leading to mis-location of the sense of agency outside the self (Braun et al. 2014; Kalckert & Ehrsson 2014).

The sense of ownership and agency of the objective body is disordered in certain neurological conditions. Karen Kaplan-Solms and Mark Solms (2000) studied and undertook psychoanalytic psychotherapy with people who suffered brain injuries and strokes. Some had lesions in the right cerebral hemisphere. Strokes of the right brain produce left sided paralysis. The symptoms of lesions in the right hemisphere differ markedly from those on the left. Following a left hemisphere stroke the devastating consequences of the event are recognized and patients unsurprisingly become depressed as they mourn the loss. Patients with right sided strokes in contrast seem unaware of or minimize the fact that the paralysed limb doesn't work and may confabulate to explain the discrepancy between their evident disability and

their assertion that the limb functions normally. Neurologists call this unawareness anosognosia. Some express hatred or disgust for the paralysed limb and may attack it, a phenomenon known as misoplegia. Some have somatoparaphrenia, denying the paralysed limb belongs to them, believing it to belong to someone else.

For example, Figure 1. is a self-portrait by a woman with a right hemisphere stroke who thought her paralysed limb was her daughter, a condition the author describes as daughter somatoparaphrenia (Morin et al. 2005). It can be seen that she has drawn her daughter's skirt and legs in the place where her hand should be.

Vilayanur Ramachandran (1994) observed that when he undertook a routine neurological test (the 'caloric test') with patients with right hemisphere strokes pouring ice cold water into their left ear, their anosognosia temporarily disappeared. Where patients had previously denied they were paralysed they now acknowledged their paralysis and became distressed, admitting they had known all along but had not been able to face what had happened. Both the insight and the distress disappeared again some hours later when the effect of the ice-cold water wore off. On the basis of this observation, Ramachandran arrived at the view that anosognosia was a psychological defence. In their studies Kaplan-Solms and Solms (2000) found the presence of the psychoanalytic therapist had a similar effect. The denial of the paralysis broke down, patients becoming distressed about their loss. However, this awareness was not sustained in the therapist's absence. They made the following psychoanalytic observation of a man with a right hemisphere stroke.

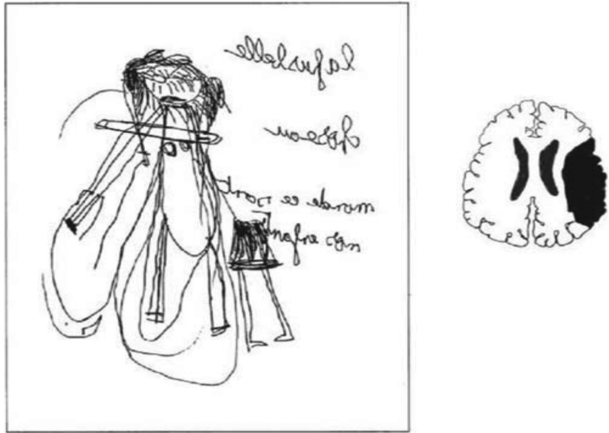


Figure 1. Daughter somatoparaphrenia. Morin, Thibierge, Pradat-Diehl, Mazevet (2005)

Mr. C presented as aloof, egocentric and imperious, oblivious to the world around him except insofar as it affected his own wellbeing. He appeared unable to see things from the other person's point of view, eschewing social convention. He only took the initiative to address a complaint. He took nothing in and never expressed gratitude, seeming to have withdrawn into a cocoon of self-sufficiency, and yet, he was simultaneously very needy and demanding. He was hypochondriacal and intolerant of frustration of any kind, expressed mostly to the nursing staff, whom he treated as though they were combined into one big mother, whose function was to meet his personal needs immediately. His intolerance of frustration was also expressed towards his arm and his rehabilitation regime. He expected and demanded to make a total and complete recovery. He seemed to harbour an intense need to regress, to be looked after and cared for, and yet consciously abhorred dependence and vulnerability of any kind. He closely resembled 'his majesty the baby', in a word he was narcissistic. He treated the left side of his body in the same way he did the nursing staff, as though it was another piece of external reality which refused to do his bidding. It was therefore an annoyance, but otherwise of no interest to him.

(Kaplan-Solms & Solms, pp. 162-63)

Kaplan-Solms and Solms (2000) thought the neurological symptoms of the right hemisphere syndrome were a defence against loss. Freud stated in *Mourning and Melancholia* (Freud 1917), when that which is lost is related to narcissistically, as though it is still in reality part of the self, the loss is defended against, resulting in melancholia. Mourning only takes place when the person who has been lost is already recognized as separate from the self. Kaplan-Solms and Solms (2000) further argued that in right hemisphere lesions, the loss is dealt with in a narcissistic way because the part of the brain, in which whole objects are represented, is damaged leaving intact the pre-existing part object representations. I would add that the right hemisphere develops in a relational context during a critical period in the first three years of life and is thought to be the locus of representation of early relational experience (Schore 2002). Hence when this area of the brain is damaged the loss can be recognized in the presence of the therapist, but the internal representation in the therapist's absence is lost along with the capacity to mourn. Kaplan-Solms and Solms (2000) went on to explain the loss of the sense of body ownership seen in somatoparaphrenia. The authors describe how Mr C had redrawn the boundary of his bodily self, excluding the paralysed limb, which like the nursing staff, was experienced as part of the external world, and no longer part of him. Nursing staff and the paralysed limb are chastised like disobedient servants for not doing the patient's bidding. Only those parts of the body which remained under his control were felt to belong to him and were loved accordingly.

This also explains misoplegia, the limb being hated for its otherness to the extent that the patient attacks it. It is this redrawing of the psychosomatic boundary and the correspondence between the way of relating to the body as

either 'self' or 'other' and the way of relating to others as either 'self' or 'other' which is of interest to psychoanalytic clinicians.

Going on to the second neurological condition, apotemnophilia is a paraphilia characterized by sexual attraction to amputees sometimes associated with an overwhelming desire to seek amputation of a healthy limb. Ramachandran et al. (2008) who undertook a small study of people with this condition, found they could draw a line on the limb at the point they sought amputation. Below this line the limb was felt to be 'over present' having an exaggerated stress response when touched. Ramachandran found an 'inadequately activated' or absent brain body image (somatotopic) map for the affected limb (McGeoch et al. 2011). So the actual body did not correspond to the brain body image. Like misoplegic patients with right hemisphere strokes, the limb was not only a source of discomfort because it was attached to the body but did not feel as though it belonged to the self; it was hated and had to be got rid of so that the actual body conform to the somatotopic map.

The sense of body ownership and agency is distorted in psychological disorders too. In analytic work we are familiar with the sense in which what belongs to whom is fluid between patient and analyst. This ordinary analytic phenomenon is most extreme in patients with severe narcissistic disorders where the sense of body ownership and agency are mis-located in the transference, resulting in diverse psychosomatic presentations. These may include eating disorders, body dysmorphic disorder and functional motor disorders. Britton (2020) described the interpersonal projective defences giving rise to these presentations. These defences arise in the first instance in the context of the infant's state of absolute dependence, during which they must come to terms with the reality that the other is at once needed, good and separate.

Where this can't be negotiated, the baby resorts to pathological projective identification as a defence. Britton describes acquisitive and attributive projective identification, which are key in the development of narcissistic disorders (Britton 2003a, Britton 2003b).

In acquisitive projective identification the mental and bodily attributes of the other are treated as though they truly belong to the self. The boundary of the self is extended to include the other, self and other being experienced inside the same skin. Otherness is denied or attacked and two minds are felt to be one. This could not be described as an identification with the other but a state of psychosomatic identity. Clinically patients in this state are regressed, commonly becoming non-verbal. Thinking and movement slow down (psychomotor retardation in psychiatric terms) at the furthest extreme coming to a stop at which point the patient may appear unable to initiate movement. This type of projective identification was first described by Rosenfeld (1987) who called it thin skinned narcissism. This 'thin skin' describes the interpersonal and sensory boundary of the self which can all but disappear

with sensitized visual and auditory perception and overwhelming affect which cannot be put into words. As Britton (1998) puts it, in acquisitive states objectivity is intolerable.

In attributive projective identification, painful, threatening or dependent attributes of the self are disavowed and treated as though they belong to the other. The connection with the disavowed part is denied, one mind is felt to have become two. In this instance the boundary of the self is redrawn to exclude the disavowed part. This not only happens in relation to other people but also to parts of the body. The patient is pseudo-independent, feeling they need nothing, not even food and drink, but maintaining a connection with the disavowed part by compulsively providing for the other. They may be over-active mentally and physically, and grandiose, being identified with the breast that provides all. This is Rosenfeld's thick-skinned narcissism in which the boundary of the self appears insensitive and impenetrable. This occurs both interpersonally and with regard to sensation and affect. In attributive states subjectivity is intolerable. Patients cannot be the subject of their own experience but speak articulately about themselves without affect as though they are a professional talking about a patient who is not in the room.

It can be seen that there is a change of location of the boundary of the psychosomatic self in acquisitive and attributive states. In both instances the presence of another e.g. the analyst is an absolute requirement to manage claustro-agoraphobic anxieties. The other is both the source of the anxiety and the means of managing it. In acquisition two minds/bodies become one where in attribution one mind/body becomes two. In acquisitive projective identification the analyst is experienced as belonging to the self so long as s/he remains under the control of the patient and does nothing to elicit conscious awareness of the reality of their separateness. This is a state of psychosomatic identity. Conversely in attributive projective identification the boundary of the psychosomatic self contracts, excluding unwanted parts of the self which are projected simultaneously into the analyst and into parts of the body which signify weakness or dependence upon the external world. These body parts are then disavowed and felt to be 'other'. This may be the case in body dysmorphic disorder in which case the patient pursues surgical procedures to remove the offending body part and may feel compelled to amputate the troublesome analyst too.

In anorexia nervosa the attribution is to the body as a whole. Being the source of appetite and the need for resources from the external world which cannot be provided by the self, the body is equated with dependence, weakness and the infantile aspects of the self. It is therefore disavowed and experienced as out of control. It remains a foreign body until such point as every bodily function, especially appetite, is brought under control through starvation, excessive exercise and purging, at which point, usually in an extreme state of emaciation, the body finally feels as though it belongs to the self.

These defences drive a claustro-agoraphobic cycle in which the drive to get inside the object (acquisition) alternates with the need to escape (attribution). This can lead to a cycle of hospitalization and disengagement from mental health services as was the case with the two patients I presented earlier Miss X and Miss Y.

Miss X's akinetic mute states occurred at points of separation or transition between inside and outside. I understood this to be an acquisitive defence in which she retreated inside her object which became apparent at the point of separation when opening the door to leave or closing it behind her when she arrived home. She said, when alone she was like a puppet whose strings had been cut. All her life she had been motivated by the demands of others who represented her disavowed absolute dependence. When this defence arose in the transference, her state of psychosomatic identity with me was such that she felt she was part of my body and the movement of her limbs was motivated by me. Her sense of agency was located in me. In this instance the mis-location of agency was psychologically motivated in contrast with the experimental manipulations of agency described above.

Where Miss X consistently sought escape from her claustrophobic existence through suicide, Miss Y's presentation was unstable. Her self was more obviously divided and in conflict with itself. She oscillated between wanting to induce a state of identity with me in the form of complete agreement (acquisition) and the need to escape from that acquisitive place inside the object, hospital, me. She equated the hand that was unable to resist the violation by her assailant with the 'weak' needy part of herself that needed the constant presence of others, which she wanted to amputate. That violation represented her own violent acquisitive intrusion into her object, which she felt unable to resist. She then sought to get rid of the hand to escape life imprisoned inside her object. Like the apotemnophilic patients, Miss Y could delineate exactly the point at which her arm no longer felt as though it belonged to her. In this instance again the mis-location of ownership was psychologically motivated.

Britton (2003b) defines narcissism as originating in intolerance of otherness or to use his term, a xenophobic impulse or psychic atopia. This may arise from the infant's own intolerance or as a consequence of the m-other's inaccuracies in meeting the infant's needs. The evidence presented in this paper appears to bear out his observation. The disorders of body ownership seen in the right hemisphere syndrome and apotemnophilia are associated with hatred towards, attacks upon and a wish to get rid of, those parts of the body which are experienced as a foreign intruder inside the territory of the bodily self. In narcissistic patients the body is violently attacked when either it or others are consciously recognized as being outside the patient's control.

Clinically, it seems the boundary of the psychosomatic self is drawn on this basis. Mental and bodily functions of self or other which fall under the control of the self are experienced as belonging to the self and are loved.

Those aspects which are not under the control of the self are defined as ‘other’, foreign and hated. The boundary of the psychosomatic self is therefore drawn and redrawn according to what the narcissistic patient is in control of or not. In neuroscientific terms this can be thought of as an adjustment of the generative model of the self. I base this observation on the fact that the somatic presentations are involuntary and profound. For the patient who cannot move, this is not a phantasy of not being able to initiate movement; they are really unable to do it. The defence has brought about a physical bodily consequence, a fully psychosomatic phenomenon.

It is perhaps by now apparent that the way in which narcissistic patients relate to their bodies corresponds with the way they relate to the analyst in the transference and to others in general. This has important implications for clinical work with patients with somatic presentations arising from narcissistic disorders.

Discussion

The brain is the psychosomatic interface, the location of both immaterial functions such as consciousness and fantasy and material neuronal activations. The relationship between the subjective phenomenon of the mind and the bodily organ remains obscure. The question of how the essential property of mind, consciousness, arises in the brain is addressed by Solms and Friston (2018), taking us some considerable distance towards understanding the relationship between brain and mind. Defining the laws that explain both the physical and psychological manifestations of consciousness they assert that consciousness is quintessentially interoceptive, arising primarily from the endogenous arousal processes and qualia which are mediated by Panksepp’s (1998) basic emotion command systems. These endow affective qualities of pleasure or unpleasure to the experience of convergences with or deviation from the homeostatic set point. They go on to explain how many of the fundamental properties of mind including consciousness arise as a consequence of the laws of physics and the possession of a Markov Blanket. Critically the Fristonian framework includes the concept of precision, which can be summarized as the neural representation of uncertainty. Precision determines the extent to which perceptions are treated as reliable and so the extent to which they are used to update the generative model. In psychological terms I am suggesting adjustments of precision may equate with the extent to which the generative model of self/other boundary is based upon realistic perceptions of the location of the skin or upon affective imperatives regarding the separateness from and dependence upon the other. In this way precision may provide an empirically testable explanation for a bidirectional relationship between mind and brain, psychogenicity and neurogenicity.

This offers a means of understanding a common observation in psychoanalytic clinical practice, namely the emergence and resolution of psychosomatic symptoms in the transference. The distortions in the sense of what belongs to whom in narcissistic disorders apply both to the body as other and the analyst as other simultaneously. Once this is recognized the somatic symptom can be taken up or acted upon directly in the transference. The two cases presented in this paper illustrate this.

Miss X's acquisitive state of identity with me coincided with her loss of agency. However, her presentation was concrete. In this state, triangular space, in the sense that Britton (1998) describes it, had collapsed and symbolic function was lost. Interpretation alone at this point, being verbal, would have been an intervention at the wrong level. So in this instance the analyst responded through action. The form this action took recognized that the somatic symptom (akinesia) occurred in the context of the time boundary (the end of the session) and the spatial boundary (leaving the building), implying that these boundaries represent the analyst's/mother's body, the concrete mother. In the first instance the response was to leave the room on the understanding that physical proximity was likely to worsen the sense of claustrophobia, and to make clear the session was over. Subsequently the analyst demonstrated and verbally conveyed their analytic understanding of the significance of the symptom through action that provided the required agency to convey the patient to the door.

Miss Y fluctuated between acquisition, her perceived need to perfectly fulfil the analyst's supposed expectations, and her attributive need to disavow and amputate the weak dependent part of herself, or not talk about the problem. This resulted in the ebb and flow of her somatic symptom from one moment to the next in the session. Her anxieties about getting trapped inside or outside the analyst's body or the concrete container of the hospital drove these psychosomatic projective states. The action required in this instance was to recognize her need for physical containment outside hospital in the form of supported accommodation, alongside relational containment in a psychotherapeutic day programme to contain claustro-agoraphobic crises. In this physical context progress towards a more symbolized and eventually interpretive form of therapeutic work can take place. For Miss Y, once both claustrophobic and agoraphobic sides of her projective states were addressed by the move out of hospital whilst retaining a full-time staff team in supported accommodation, the panic-driven need to amputate the weak part, which kept her in hospital, began to dissipate along with the somatic experience of the alien hand. The internal conflict had yet to be addressed or resolved in the relationship with the therapeutic team; this would be the substance of the therapeutic work during the years that followed.

Profound regression requiring admission and flights into health leading to disengagement are typical of the acquisitive and attributive defences. Distinguishing between acting as required by the concrete presentation of the

patient and enactments of counter-transference hatred, such as the wish to walk away, can be difficult. This therapeutic work is best supported in psychotherapeutic teams in the public sector where peer-supervision is part of routine practice. A form of psychotherapeutic psychiatric management that treads the line between enactments, in which the patient is either trapped or dropped, contains the psychotherapeutic work.

In the analytic psychotherapy itself acquisitive and attributive states can be identified by their characteristic countertransference. These have been described by Britton (2003a) and Perelberg (2003). Spatial aspects of the transference predominate, all other symbolic meaning being subordinate to the overwhelming importance of inside and outside, relative closeness or distance, size (smaller or larger) and speed (slower or faster) (Rey 1986). Both the way in which the patient uses the space in the room and speed of speech and tone of voice, from the patient towards the analyst and vice versa, convey more about the transference relationship than the content of what is said. The fluctuations in the somatic symptom from moment to moment form part of the concrete embodied relational dance between patient and analyst which may be felt and enacted for an extended period before words begin to take over as the main means of communication.

Finally, I will turn to the neuroscientific and psychoanalytic observation stated above, namely, in narcissistic disorders:

That which is controlled by the subject is loved and felt to be part of the self, that not controlled by the subject is felt not to be part of the self, foreign and hated, the line defining the boundary of the self being drawn between the two.

(Mizen 2015, p. 375)

This observation invites a reconsideration of the concept of the Self along with those phenomena which led Sabina Spielrein and subsequently Freud to propose the death drive, Klein the death instinct and finally Britton to propose a xenophobic impulse or psychic atopia (Spielrein 1912, Freud 1920, Klein 1932, Britton 2003b). Britton recently undertook a similar exercise whilst reworking his thoughts on narcissism with neuroscience developments in mind (Britton 2020).

I suggest that Jung's concept of the Self, alongside the historical developments in thinking about the death drive or instinct, each account for different aspects of the self. However, none of our analytic or neuroscientific theoretical frameworks fully account for the phenomena described here.

This can best be summarized as follows:

1. The Self: Internal states and their Markov Blankets model a prototypical boundary between the inside and outside of all organisms. The phylogenetic template upon which the sensorimotor apparatus and

generative model of the self are built conforms to this mathematical principle. I am suggesting this psychosomatic boundary, being the skin in the bodily self and the exteroceptive representations of the objective body and the external world in the brain, is the basis of the Self in the Jungian sense comprising the organism as a whole. This concept does not account for the hatred of otherness observed in narcissism.

2. The Nirvana principle: The Nirvana principle described by Freud (1920) as the tendency of all instincts and life processes to remove tension and seek the stability and equilibrium of the inorganic state, corresponds with the minimizing principle within the Fristonian model. As stated above, it appears the brain is intolerant of unfulfilled expectations and so structures its model of the world and motivates action in such a way that more of its predictions are correct.

The motivating drive in the Helmholtz machine is to minimize surprise or prediction error which equates with average free energy and entropy. Friston proposes that if the brain were ever to succeed in eliminating surprise completely, there would be no further need for consciousness. In this sense the ultimate goal of mental life is unconsciousness or a state in which the regenerative model perfectly predicts external reality (Solms 2013).

3. Destructiveness: In dual instinct theory destructiveness and envy are considered manifestations of the death instinct. For clarity it is important to distinguish 'destructiveness' where the primary objective is to destroy a perceived or real threat to survival, from that in which the primary objective is to destroy what is experienced as good. The latter could be defined as 'destructiveness proper' and might otherwise be described as envy. Destructiveness must be distinguished from aggression, which the neuroscientific evidence suggests is a biologically endowed affect. Aggression in this sense is neither creative nor destructive, its effects arising from the use to which it is put (Panksepp 1998). Whilst clinical experience leads us to the conclusion that wishing to destroy things simply because they are good is very much part of mental life, envy is a relatively sophisticated or cognized affect, which, unlike aggression, is not one of the basic affects or drives which have been identified by neuroscience research at this point. It would then be incorrect to call this a drive.
4. Xenophobia: Britton's (2003b) 'Xenophobic impulse' or psychic atopia is an accurate description of the phenomenon of hatred of otherness described in both the neuroscientific studies and the clinical studies in this paper of relating towards disavowed aspects of the self. However, there is little to suggest that this form of territoriality in mental life is either an instinct or drive. For the sake of comparison, Panksepp's SEEKING system is a subcortical system which motivates behaviour to satisfy appetite whether that be thirst, hunger or sexual appetite. Some authors have commented on the correspondence between the SEEKING system and Freud's theory of a libidinal drive (Yovell 2008). Panksepp (1998)

also described the RAGE system which would be classified as a drive and is thought to mediate inter-male aggression and dominance behaviour. This form of geographical territoriality, or a sense of possession of a mate, does not provide an adequate explanation of the phenomena observed in mental disorder. Most obviously, the hatred of foreignness described in this paper is not confined to males. Further to this the delineation between self and other appears critically dependent upon who (self or other) is perceived to be the agent and the extent to which self or other fall within the control of that agent. Whilst dominance and submission are features of this behaviour, the biological systems which drive the establishment of dominance hierarchies amongst animals do not seem to adequately explain it.

It seems then that for the time being we lack a comprehensive clinical and neurobiological model to account for these observations although there are some promising lines of enquiry. Psychoanalytic observation of narcissistic patients uncovers the extent to which the boundary of the self is affectively charged and is felt to delineate a territory, and that the boundary is projected into the external world as the basis for territorial behaviour. Britton (2003b) uses the term 'psychic atopia' to refer to a hypersensitivity to psychic differences in narcissistic patients. A similar neuroscientific concept is 'intolerance of uncertainty' (Wigham et al. 2014). Studies of children with autism who demonstrate this intolerance of uncertainty indicate that the difficulty may arise from problems inferring hidden causes for perceptual events. Finding points of intersection between these psychoanalytic and neuroscientific concepts offers at least the possibility of expanding our explanatory repertoire.

Conclusion

This paper describes some psychoanalytic and neuroscientific observations about the psychosomatic self in health and disease. There is surprising consilience between analytic models of the mind and neuroscience models of the brain, underlining the importance of dialogue for both disciplines. Some implications of these observations for psychoanalytic practice with patients with psychosomatic presentations have been outlined, along with some implications for our model of the Self and the remaining gaps in our understanding.

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TRANSLATIONS OF ABSTRACT

Cet article compare les présentations des troubles du sens de la propriété du corps et de la capacité d'action selon les perspectives psychanalytiques et neurologiques afin de montrer les similarités dans la symptomatologie. L'article suggère que ces similarités proviennent d'ajustements dans le modèle générateur de Friston de l'organisation et du

sentiment de soi. L'article s'intéresse aux implications pour le modèle analytique du soi, pour la pratique clinique et pour la recherche en neurosciences. Les patients qui ont des troubles narcissiques utilisent des défenses projectives qui produisent un sentiment troublé de « quoi appartient à qui ». Ceci s'applique à l'esprit et au corps - de soi et de l'autre - et est central dans la compréhension du transfert et du contretransfert. Les observations cliniques de ce sentiment troublé d'appartenance et de capacité d'action reflètent les découvertes sur les troubles neurologiques. Cet article suggère que dans les troubles neurologiques et dans les troubles psychologiques le 'modèle générateur interne' du sentiment de soi de Friston est ajusté. De plus, bien que cet ajustement puisse être soit neurogène soit psychogène, le mécanisme neural final et le résultat symptomatique sont similaires. Sur la base de ces observations l'article compare le concept du Soi des points de vue Jungien et psychanalytique. Enfin les implications en ce qui concerne le concept de pulsion de mort et le concept de Britton de Xénophobie sont étudiées aux côtés des conséquences de ces observations pour la pratique clinique.

Mots clés: sentiment de propriété, sentiment de pouvoir d'action, neurosciences psychodynamiques, psychanalyse, trouble de la personnalité, trouble narcissique, modèle générateur, soi, pulsion de mort

In diesem Aufsatz werden Darstellungen von Störungen des Gefühls für die eigene Körperlichkeit und die körperlichen Handlungsfähigkeit unter psychoanalytischer und neurologischer Perspektive verglichen, um Ähnlichkeiten in der Symptomatik aufzuzeigen. Es wird vermutet, daß diese Ähnlichkeiten aus Anpassungen in Fristons generativem Modell der Selbstorganisation und des Selbstseins resultieren. Die Implikationen für das analytische Modell des Selbst, für die klinische Praxis und für die neurowissenschaftliche Forschung werden betrachtet. Patienten mit narzißtischen Störungen verwenden projektive Abwehrmechanismen, was zu einem gestörten Gefühl dafür führt, was wem gehört. Dies gilt für Geist und Körper des Selbst und des Anderen und ist zentral für das Verständnis von Übertragung und Gegenübertragung. Klinische Beobachtungen dieses gestörten Gefühls von Eigenständigkeit und Entscheidungsfreiheit spiegeln Befunde bei neurologischen Erkrankungen wider. Im Beitrag wird vorgeschlagen, daß sowohl bei neurologischen als auch bei psychischen Störungen Fristons 'inneres generatives Modell' des Selbstseins angepaßt wird. Während diese Anpassung entweder neurogen oder psychogen sein kann, sind der endgültige neurale Mechanismus und das symptomatische Ergebnis ähnlich. Auf der Grundlage dieser Beobachtungen wird das Konzept des Selbst aus Jungianischer mit dem der psychoanalytischen Perspektive verglichen. Schließlich werden die Implikationen für das Konzept des Todestriebes und Brittons Konzept der Fremdenfeindlichkeit zusammen mit den Implikationen dieser Beobachtungen für die klinische Praxis untersucht.

Schlüsselwörter: Gefühl für Eigenständigkeit, Handlungsfähigkeit, psychodynamische Neurowissenschaft, Psychoanalyse, Persönlichkeitsstörung, narzißtische Störung, generatives Modell, Selbst, Todestrieb

Questo articolo confronta le presentazioni dei disturbi del senso di proprietà e di “agente” del corpo da prospettive psicoanalitiche e neurologiche per evidenziare le somiglianze nella sintomatologia, proponendo che queste somiglianze derivino da aggiustamenti nel modello generativo di auto-organizzazione e individualità di Friston. Vengono considerate le implicazioni per il modello analitico del Sé, per la pratica analitica e per la ricerca neuroscientifica. I pazienti con disturbi narcisistici usano difese proiettive che risultano in un senso disordinato rispetto a cosa appartiene a chi. Questo si applica alla mente e al corpo del Sé e dell’Altro ed è fondamentale per comprendere il transfert ed il controtransfert. Le osservazioni cliniche di questo senso disordinato di proprietà e di “agente” rispecchiano quanto rilevato nei disturbi neurologici. Questo articolo propone che sia nei disturbi neurologici che psicologici viene adattato il “modello generativo interno” dell’individualità di Friston. Inoltre, mentre questo aggiustamento può essere sia neurogeno che psicogeno, il meccanismo neurale finale e l’esito sintomatico sono simili. Sulla base di queste osservazioni l’articolo confronta il concetto del Sé da prospettive junghiane e psicoanalitiche. Infine vengono esplorate le implicazioni per il concetto di istinto di morte e per il concetto di xenofobia di Britton, insieme alle implicazioni di queste osservazioni per la pratica clinica.

Parole chiave: senso di proprietà, senso di “agente”, neuroscienza psicodinamica, psicoanalisi, disturbo della personalità, disturbo narcisistico, modello generativo, Sé, istinto di morte

В данной статье сравниваются представления о нарушенном чувстве собственного тела и агентности с психоаналитической и неврологической точек зрения. Демонстрируется сходство симптоматики, объясняемое скорректированной генеративной моделью самоорганизации и самости Фристон. Рассматриваются следствия этого для аналитической модели самости, для клинической практики и нейробиологических исследований. Пациенты с нарциссическими расстройствами используют проективные защиты, что приводит к нарушению понимания того, что кому принадлежит. Это относится к сознанию и телу, своего и другого, и является центральным для понимания переноса и контрпереноса. Клинические наблюдения случаев нарушения чувства самости и агентности подтверждают данные исследований в области неврологических нарушений. В данной статье предполагается, что как при неврологических, так и при психологических нарушениях «внутренняя генеративная модель» самости Фристон нуждается в корректировке. Более того, хотя эта корректировка может быть как неврогенной, так и психогенной, конечный нейронный механизм и симптоматический результат схожи. На основе этих наблюдений в статье сравниваются концепции Самости в юнгианской и психоаналитической парадигмах. В заключение рассматривается, какие следствия описанное выше имеет для концепции инстинкта смерти и концепции ксенофобии Бриттона, а также для клинической практике.

Ключевые слова: чувство собственного тела, чувство агентности, психодинамическая нейробиология, психоанализ, расстройство личности, нарциссическое расстройство, генеративная модель, самость, инстинкт смерти

El presente trabajo compara presentaciones de trastornos de la sensación de agencia y posesión del propio cuerpo desde perspectivas psicoanalíticas y neurológicas para demostrar similitudes en sintomatología, proponiendo que estas similitudes emergen de ajustes según el modelo de autoorganización e identidad de Friston. Se consideran las implicancias de la práctica clínica y de investigaciones en neurociencias para un modelo analítico del self. Pacientes con trastornos narcisistas utilizan defensas proyectivas que resultan en un sentido desordenado de qué pertenece a quién. Esto aplica a la mente y al cuerpo de uno mismo y del otro y es central para la comprensión de la transferencia y contratransferencia. Las observaciones clínicas de este trastorno del sentido de agencia y posesión reflejan hallazgos en trastornos neurológicos. El artículo propone que, tanto en trastornos neurológicos como psicológicos, el 'modelo generativo interno' de la identidad de Friston es adaptativo. Además, mientras esta adaptación puede ser neurogénica o psicogénica, el resultado sintomático y el mecanismo final neural son similares. Sobre la base de estas observaciones, el trabajo compara el concepto de Self desde las perspectivas Junguiana y psicoanalítica. Finalmente, se exploran las implicaciones del concepto de instinto de muerte y el concepto de Xenofobia de Britton, junto a las consecuencias de estas observaciones para la práctica clínica.

Palabras clave: sentido de posesión, sentido de agencia, neurociencia psicodinámica, psicoanálisis, trastorno de la personalidad, trastorno narcisista, modelo generativo, self, instinto de muerte

心灵和躯体中的自我和异类自我

本文从精神分析和神经学的角度比较了关于身体所有感和身体能动性呈现出紊乱感时的表现,以证明其症状学上的相似性,并提出这些相似性都是来自于弗里斯顿的“自我组织”和“自我性”的生成模型所说的调整。文章考虑了这一理论对自我分析模型、对临床实践和神经科学研究的影响。自恋症患者由于使用了投射性防御,导致其产生关于什么属于谁的无序感。这可以适用于理解自我和他人身心、是理解移情和反移情的核心。对这种所有权和能动性的紊乱感的临床观察也映射出神经失调研究领域中的发现。本文提出,在神经和心理障碍中,都发生了弗里斯顿所说的自我身份的“内部生成模式”的调整。此外,虽然这种调整可能是神经源性的,也可能是心理源性的,但最终的神经机制和症状结果是相似的。在这些观察的基础上,本文从荣格和精神分析的角度对自性的概念进行了比较。最后,本文探讨了相关的死亡本能概念和布里顿的仇外心理概念,以及这些观察与临床实践的关系。

关键词:自我所有权感,能动性感受,精神动力,神经科学,精神分析,个体失调,自恋失调,一般模型,自我,死亡本能
