Archaic Twinship and Projective Identification

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The concept of archaic twinship transference (Kohut, 1996, p. 34; Lee, 1993) describes a clinical experience similar to Melanie Klein's (1946) construct of projective identification. One form of this experience is where the patient relentlessly and persistently bombards the therapist with criticisms and verbal abuse, traditionally described as sadistic attacks that are impervious to interpretations. The goal of this paper is to show how the archaic twinship concept, although similar, differs from projective identification and how these theoretical differences alter the approach to treating patients Kernberg (1975) calls borderlines and self psychologists categorize as severe self disorders. In what follows, we shall briefly discuss (1) archaic twinship transferences, (2) projective identification, and (3) offer a theoretical critique of projective identification.

1. Archaic twinship transferences

The idea of a twinship transference developed out of Kohut's reconceptualization of Freud's construct of narcissism and his discovery of the narcissistic transferences (Kohut, 1971, 1977, 1984). He saw a person's twinship experience, along with others, as a means of transforming a self's archaic grandiosity into the human qualities of empathy, humor, wisdom, acceptance of death, and creativity (Kohut, 1966). He discovered this twinship transference through a patient with a fantasy of a genie in a bottle. This genie was conceived as an essential likeness to whom the patient could relate whenever she felt unsupported and alone. At first, Kohut thought such a

twinship experience was an expression of a mirror transference but later recognized that twinship was a transference with its own line of development from archaic to mature forms (Kohut, 1984).

Kohut (1984) summarizes the twinship transference:

> Within the context of the transference, an outline will gradually come to light of a person for whom the patient's early existence and actions were a source of genuine joy; the significance of this person as a silent presence, as an alter ego or twin next to whom the child felt alive (the little girl doing chores in the kitchen next to her mother or grandmother; the little boy working in the basement next to his father or grandfather) will gradually become clear [p. 204].

In this model of twinship, the preadolescent child experiences himself as a twin to the parent. In contrast, when an archaic twinship transference occurs, the patient does not twin the parent but wants the opposite: to experience the therapist as a twin who enters and shares his world. As Kohut (1996) explains,

> in the twinship transference the patient experiences you like himself: his thoughts seem to be present in you also, and what's going on in him he feels is going in you too. When he feels distant, you are distant from him too. When he is enraged, he feels you are enraged too [p. 34].

Kohut continues, "Why is this behavior not a projection?" Taking notice of the work of Glover (1943) Kohut (1996) points out

> that one can speak of projection only when there is already a clearly structuralized mental apparatus present. To put it in terms of the problems of narcissism, there is no projection as long as the I and the You are not yet separated" [p. 34].

Mr. N is a case in the self-psychology literature involving an archaic twinship transference. He is a gifted musical composer who was treated by Brandchaft (1988) over a 15-year span for an "intractable depression" that became severe and disabling after any success. During these depressions, Mr. N experienced despair, believed that his fate had already been determined, and thought that he had an incurable and global defect.

Mr. N's treatment was made difficult by his belief that the analyst was critical of him for feeling depressed and that the analyst was burdened by this depression. Brandchaft gradually evolved a strategy of holding Mr. N's despair in check and sustaining his own hopeful attitude by working hard to understand Mr. N's experience and his own response to it, and not attempting to alter Mr. N's mood. By way of demonstrating his understanding of Mr. N's experience, Brandchaft experienced Mr. N's depression to an attenuated degree. He says:

> Repeated experiences of shared affect, though without confirmation of his perspective, had the ultimate effect of establishing for Mr. N the necessary conditions for a feeling of safety and harmony that subsequently carried over into other affect states and made the understandings I could convey assimilable [p. 138].

Exposed to Brandchaft's consistent stance of sharing Mr. N's depression in an archaic form of twinship, Mr. N. began to experience a bond and a belief that he could overcome his depression. He also eventually acknowledged that his analyst's hope had sustained him. Whenever Brandchaft was disappointed with Mr. N or lost confidence in himself, Mr. N experienced a loss of the bond and saw himself as a victim, unable to work. Only by persistent reinstatement of the therapeutic

bond through the analyst's renewed feelings of hope could Mr. N regain a sense of buoyancy.

Because of this therapeutic experience with Mr. N, Brandchaft is convinced that:

> the deepest source of depression in Mr. N...was the underlying belief that no tie
> could be formed and no pathway sustained in which the central strivings to give
> meaning to a life of his own and the disheartening internal obstacles he
> encountered could find empathic resonance and understanding so that he might
> ultimately prevail [pp. 149-150].

There are other forms of the archaic twinship transference. Patients with such transferences often have functioned as selfobjects in childhood to a parent and been traumatized by the experience. Three imposed experiences (Lee, 1992, 1993) are those such as selfobjects of blame, abuse and identity. Although the function of being a selfobject of abuse most resembles the description of projective identification, the concept of archaic twinship is inclusive and offers a broader range of selfobject functions than projective identification.

2. Projective identification

Melanie Klein (1946), the pioneer British theorist, first used the term projective identification. She saw projective identification as an intrapsychic mechanism whereby, in fantasy, a child expels the bad parts of the self into the mother to be rid of unwanted aggressive drives. Describing the primitive mechanism of projective identification, Klein says:

The...attack [on the mother] derives from the anal and urethral impulses and implies expelling dangerous substances (excrements) out of the self....Together with these harmful excrements, expelled in hatred, split-off parts of the ego are also projected...into the mother.  These...are meant not only to injure but also to control and to take possession of the object [p.8].

Kernberg (1975) discards Klein's concrete body terms, but maintains a view that projective identification is a defensive mechanism against the self and object representations that have been derived intrapsychically from aggressive drives.  He says:

Projective identification is a primitive form of projection, mainly called upon to externalize aggressive self and object-images; "empathy" is maintained with the real objects onto which the projection has occurred, and is linked with an effort to control the object now feared because of this projection [p. 80].

Kernberg also links projective identification to Racker's (1957) concept of complementary identification, which was first expressed by Helen Deutsch in 1926 (p. 311).  Complementary identification involves more than interacting as if the therapist is a transference object; it sees the patient as inducing emotions in the therapist and in himself similar to those of past interactions with a parental image.  For example, "a primitive, sadistic mother image may be projected onto the therapist while the patient experiences himself as the frightened, attacked, panic-stricken little child" (Kernberg, 1975, p. 81).  The patient then provokes the therapist to feel, and sometimes, to act sadistically.

Although Kernberg made no major alterations to Klein's construct of projective identification, he contributed important ideas about the management of this transference. Based on clinical experience, he was convinced that therapist passivity leads to inevitable treatment failures with patients who use projective identification. In treating a borderline, he thinks that

> a high price was paid when the therapist tried to stay away from the latent
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> negative transference and attempted to build a therapeutic relationship with the
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> patient in an atmosphere of denial of that negative transference .... Serious acting
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> out or even interruption of the treatment followed periods in which the therapist
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> thought the patient was "building up identification" with him...while the patient
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> remained emotionally detached [p.82].

Kernberg refers to patients whose behavior, out of a sadistic need to control the transference object, is not modifiable. Any attempt to set limits on this acting out or confronting the patient with the implications of this behavior brings forth angry outbursts and an interruption of treatment. According to Kernberg, hospitalization is then needed to block the transference acting out and protect the therapist from chronic and insoluble situations. Hospitalization avoids, says Kernberg, the destructive, vicious circles of projective identification and distorted introjective identification of the therapist as discussed by Heimann (1955).

Kohut's and Kernberg's views conflict. With narcissistic patients Kohut encouraged a long period of empathic immersion, often necessary before a mirroring or idealizing transference emerged. He accepted, for example, the idealization of the patient without interpretation. Kernberg sees Kohut as reinforcing narcissistic transferences that he considers are pathological formations used by the patient to avoid unneutralized aggressive drives and to compensate the patient for profound disappointments in childhood. Kohut, on the other hand, thinks that

narcissism is not necessarily pathological, but a form of arrest along its own line of development. The fact that Kohut's empathic immersion and concomitant passivity did not produce the vicious projective and introjective circles and dire sadomasochistic consequences predicted by Kernberg, begs for explanation.

Chessick (1977) thinks that Kohut and Kernberg are discussing two different populations. The narcissistic patient who gets through the sophisticated intake procedures of a Psychoanalytic Institute is different from borderline patients seeking psychotherapy from therapists struggling to make a living and, he might have added, different from the more difficult borderline cases who were referred to The Menninger Foundation where Kernberg was able to hone his theory of treating borderlines.

Clearly there are borderline patients without a well-developed sense of self who are not able to respond to supportive, kindly and benevolent measures, and who have a proclivity towards creating chaos. Some of these severe borderlines may need hospitalization to contain their re-enactments. If these enactments are an acting out they may be as a consequence of mistakes made by psychotherapists in initially attempting to treat such patients using inadequate theory.

Other than treatment involving passive acceptance or hospitalization, there is a third option - interpretive treatment using an understanding of the way such patients easily establish archaic twinship transferences. When the archaic "sadistic" behavior of borderline patients is interpreted as projecting bad introjects into the therapist, these patients sometimes report shameful feelings of being condemned. On the other hand, when the hostile behavior is interpreted as a strong need to share childhood experiences and experience the therapist as a twin, many patients moderate their behavior, allow bonding, and improve borderline symptoms reduce markedly.

3. Theoretical Critique of Projective Identification

Stolorow and Brandchaft (1988), who regard projective identification as the major construct of Kleinian metapsychology, challenge its theoretical adequacy even though this challenge tends to threaten the whole Kleinian system. They raise the question "whether Kleinian metapsychology deserves to be regarded as an enduring paradigm or whether it should take its place with dual instinct theory as a passing phase in the development of psychoanalytic science" (p. 37). Agreeing with Stolorow and Brandchaft, what ensues critiques projective identification under five headings: (a) drive theory, (b) mechanistic theory, (c) objectivism (d) individual mind theory, and (e) theoretical dissociation.

(a) Drive theory

In the theories of Klein and Kernberg, projective identification presupposes a Freudian view of drive theory. In projective identification, the constantly pressuring, powerful aggressive drive in the form of a patient's bad introjects are projected on to the therapist. Yet once drive theory became discredited by the arguments of such theoreticians as Schafer (1976), Klein G. (1973), and Holt (1976) to become a peripheral position in modern psychotherapy theory, projective identification lost its original meaning. If a drive or its derivative is only activated under special conditions, as is now proposed, what is projected?

If projective identification's purpose is supposedly to rid a patient of the effects of an unwanted drive, as Klein and Kernberg argue, what motivates if drives are no longer the major motivating force for human behavior? According to Kohut, motivation for behavior commonly

described as projective identification, comes from the cohesion inducing processes associated with a twinship experience. Under this new theory drives emerge on a self-organization's center stage only when they reflect its organizational breakdown. Tomkins speaks in similar terms in healthy adaptive functioning, where drives are immersed in a contextual network of affects. Tomkins also thinks that assertiveness comes scripts that developed for the affect of anger and not from an aggressive drive.

(b) Mechanistic theory

In deriving the projective identification construct, Klein also accepted Freud's mechanistic ideas about the mind. To Klein, objects such as introjects, exist in some kind of "internal space." And with the idea of an introject/object, projection may be envisaged as launching projectiles across space from one person to another. This spatial view, however, presupposes two persons who have individuated and developed self-boundaries from which to project, whereas clinical experience suggests that when the process called projective identification takes place, patients consider the therapist as an extension of themselves. If this extension takes place, how can the process be projection. And further, if the process of projective identification is entirely intrapsychic and, therefore, is not influenced by the characteristics of the therapist or the therapeutic interaction as Klein and Kernberg claim, why is projection needed. If, on the other hand, therapists are able to function as selfobjects, that is, as extensions of the patient, there are no individuated self-boundaries and hence the process of launching projections across self-boundaries, becomes unnecessary.

(c) Objectivism.

Stolorow and Brandchaft (1988) believe the major weakness of projective identification is its assumption of an objective reality that is distorted by projections and introjections. As an example, they refer to the experiences of Rosenfeld who, in working with psychotic patients, claims that

> the psychotic's fear of his own projected instinctually derived aggression...creates the paranoid experience and that the definitive treatment requires analytic focus on the projected contents so that the distortion of reality involved in the psychotic transference can be gradually overcome [p. 37].

Using their own experiences with psychotic patients Stolorow and Brandchaft reply:

> We found that when we viewed the persecutory perceptions as distortions, the intensity of the paranoia increased and the images of endangerment became progressively more concrete. In contrast, when we investigated the persecutory transference feelings from within the perspective of the patient's own subjective frame of reference, and recognized that they contained symbolically encoded depictions of damaging early developmental traumata that were being replicated with the analyst, dramatic changes occurred. In the process, we became aware of how our own way of conceptualizing, interpreting, and responding to the patient's state of mind had unwittingly played a role in codetermining both the further course of the therapeutic interaction and the intensification of the patient's manifest psychopathology [p. 37].

(d) Individual mind theory

Stolorow and Atwood (1992) think that the central myth of contemporary Western Culture is the "Isolated Individual Mind." They think that

> The omnipotence of the individual mind reaches its pinnacle in certain versions of Kleinian object relations theory, most notably in the clinical application of the concept of projective identification [p. 15].

They then refer to Kernberg (1975) whom they claim transforms Klein's (1950) description of a primitive fantasy into a causally efficacious mechanism through which a person is presumed to translocate parts of himself into the psyche and soma of another [p. 15]. Stolorow and Atwood illustrate their point by referring to Kernberg's (1975) discussion of Ingmar Bergman's movie, Persona. This movie depicts

> the breakdown of an immature but basically decent young...nurse, charged with the care of a psychologically severely ill woman presenting...a typical narcissistic personality. In the face of the cold, unscrupulous exploitation to which the young nurse is subjected, she gradually breaks down....The sick woman seems to be able to live only if and when she can destroy what is valuable in other persons....In a dramatic development, the nurse develops an intense hatred for the sick woman and mistreats her cruelly at one point. [Then Kernberg interprets,] it is as if all the hatred within the sick woman had been transferred into the helping one, destroying the helping person from the inside [pp. 245-246].

Commenting on Kernberg's interpretation, Stolorow and Atwood say,

Here we see a caricature of the isolated mind unleashed. The subject is viewed as

creating not only her own experiences, but even the other's experiences as well.

A unidirectional influence system is pictured wherein everything that one

experiences from the surround is seen as being the product of one's own

omnipotent intrapsychic activity. The impact of the surround is nowhere to be

found [p. 16].

(e) Theoretical dissociation

With mounting criticism of, and an awareness of the limitations of, projective identification,

some theorists expanded its meaning. Malin and Grotstein (1966) not only view projective

identification as a defensive process but as a way of establishing object relationships to foster

integration. Langs (1976) viewed projective identification as the central element in the

interactional field through which unconscious communications are transmitted. Ogden (1979,

1982) pulled all these views together in describing projective identification as an interaction that

served three major functions: communicative, defensive, and object related.

The problem with this expanded approach to the meaning of projective identification from a

post-empiricist philosophical position, is that words and concepts gain meanings from their context

and usage (Lee and Martin, 1991). As Goldberg (1988) says, no word can stand alone outside a

dictionary. Take a word out of its context and it loses meaning; take a theoretical construct out of

the theoretical system where it was developed and into which it was embedded and its meaning

changes. Goldberg calls such efforts as extending the meaning of projective identification, "theory

stretching," and thinks that this can too easily become "theory tampering" that trivializes the original meaning.

Goldberg gives as his example the way in which the Classical view of conflict has been redefined as "ongoing new experiences" instead of conflicts between the agencies of Id, Ego and Superego.  He points out that no doubt some sort of heroic stretching of the classical theory of conflict could be equated with new experiences, but "it seems at some point to have lost its moorings in Freud's original sense" (p. 25).  Such stretched meanings means that "if everything is 'conflict,' then conflict is nothing" (p. 25).

Suttie (1935) points out that Freud succumbed to theory stretching. Freud (1931), reluctant to "retract the universality of the thesis that the Oedipus complex is the nucleus of the neuroses" (p. 226), said "we can extend the content of the Oedipus complex to include all the child's relations to both parents" or "we can give due recognition to our new findings by saying that women reach a normal positive Oedipus situation only after surmounting a first phase dominated by the negative complex" (p. 226).  Suttie then comments, "why...should we be 'reluctant to correct an admitted error; why should we obscure it by making our original propositions all but meaningless (through an indefinite extension of the Oedipus Concept)" (1935, p. 223).

Mitchell (1988) sees theory stretching as similar to "loose constructionism" in law.   He says that

> Loose constructionists regard the Constitution as a document with no fixed
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> meaning; the Founding Fathers could not have foreseen the enormous social and
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> economic changes that have occurred over the course of American history, and

the Constitution is therefore best used as a text whose interpretation is contingent

upon changing circumstances [p. 55].

He also points out that in psychoanalysis Loewald makes "imaginative" interpretations and creative

use of Freud's text to generate new meanings and is essentially uninterested in how Freud actually

understood things.  Loewald is concerned with assigning new meanings to Freud's text as a vehicle

for developing his own thought (p. 56).

To Mitchell (1988) what is troublesome, however, is when the looseness of the

constructionism is unacknowledged, and Freud is made to read as if he actually meant to say what

the current author now proclaims.  This creates great confusion; basic differences in premises and

conceptions are blurred, and an accurate exploration of the implications of these differences

becomes impossible.  Such a constructionistic strategy depends ultimately on the illusion that using

the original words does retain something of the original meanings (p. 56).

Modern adherents of the drive model frequently claim to be updating the concept of "drive,"

while changing it fundamentally, in an attempt to claim the authority and interpretive power of the

original formulation.  Brenner, for example, disconnects 'drive' from any organic substrate or

energic flow, treating it as self-evident, purely psychological concept, yet he feels no need to derive

the power of the drive from other sources.  On the one hand, the original concept is radically

redefined; on the other, all the connotations and attributes of the original concepts are still claimed

(p. 56).

In a similar fashion, Malin and Grotstein, Langs, and Ogden are open to the criticism of

theory stretching and loose constructionism when it comes to the concept of "projective

identification."  Tansey and Burke (1989) think so.  They say, "to subsume all these separate

processes under the name projective identification diminishes the precision of the term" (p. 44). So, when Malin and Grotstein, langs and Ogden expand the meaning of projective identification, they are describing a frequently encountered clinical experience, but are not describing projective identification and associated theoretical meanings any more. They are forming a new interpretation that needs a new label and critical scrutiny as to its theoretical value.

Conclusion.

According to Kernberg (1975), there is a hostile, sadistic clinical pattern that, if it emerges in patients, is impossible to handle without hospitalization because the patient's pattern of projection and reintrojection becomes destructive to the psychotherapy, the patient and the therapist. Although the projective identification construct offers one explanation of this situation, it may make the condition worse because of its perceived automatic and mechanical quality. The possibility that projective identification is iatrogenic raises the question of more useful theoretical ways to understand this clinical phenomenon. One alternative is the concept of an archaic twinship experience to describe the clinical experience referred to as projective identification.

Archaic twinship experiences can be considered as a special form of preverbal communication. Its theoretical connections, however, are not with communication theory, but with the central construct of self-psychology, the selfobject experience. Understanding that the so called sadistic pounding of the therapist may be an expression of a need for twinship, links it into self-psychology theory and, therefore, views such behavior as a person's attempt to become more cohesive.

Self-psychology also suggests that the uncontrolled projective and introjective circling, referred to by Heimann, may result from the wounding that accompanies the therapist's failure to respond empathetically to a patient's need for twinship.  This further suggests that if sadistic behavior is interpreted as a patient's hunger for the therapist to experience what the patient experienced growing up, the behavior has a chance of abating if this explanation is made early in the process.

If the therapist responds to the twinship pattern that emerges with helpless passivity - rationalized as "empathic immersion" - such passivity may become destructive and necessitate the hospital treatment Kernberg recommends.  Could it be, however, that the bleak theory of projective identification contributes to a therapeutic phobia about the borderline and a sense of helplessness that makes the psychotherapist less likely to respond with empathy to the archaic expressions of a hunger for a twin?  I have supervised cases where this has been so.  As difficult as the therapeutic exploration with severe self disorders may be, a theory of archaic twinship gives us a new clinical way to proceed and a new avenue to explore the understanding of these patients and, hence, sustains the precious therapeutic ingredient of hope.

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