Joining technique in psychotherapy with pre-oedipal patients: a model of clinical navigation between intervention forms

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Abstract

The joining technique is widely used in psychoanalytic practice when working with patients at a pre-oedipal level of personality organization. However, in clinical work, therapists regularly face the necessity of choosing between different forms of joining, primarily ego-syntonic and ego-dystonic, depending on the current psychodynamic situation. This article proposes a process-oriented model of clinical navigation between forms of joining, focusing on ego-syntonic and ego-dystonic joining based on the analysis of the patient's affective presentation, the therapist's countertransference reactions, and the phase of the psychotherapeutic process. Drawing on the theoretical foundations of modern psychoanalysis in the tradition of H. Spotnitz and the authors' clinical experience, the article analyzes the mechanisms of the technique, including ego-syntonic and ego-dystonic joining, as well as their role in reducing resistance, facilitating narcissistic transference, and safely processing intense affects. Particular attention is paid to the differences between these forms and the logic of clinical decision-making in their application. Using clinical vignettes and examples from individual and group psychotherapy, the conditions for the effective application of the technique are demonstrated.

Keywords: joining, ego-syntonic and ego-dystonic joining, clinical decision-making, modern psychoanalysis, pre-oedipal patients.

Introduction

The joining technique is a psychodynamic intervention in which the therapist tunes into the patient's dominant current affect, verbalizing and containing ego-syntonic experiences or cautiously engaging with ego-dystonic impulses, with the aim of reducing defensive resistance and enabling the safe processing of affect. The essence of the technique is that the analyst joins the patient's resistance, their subjective perception of reality, affective state, belief, or defensive position, instead of immediately subjecting them to interpretation or confrontation. This joining conveys to the patient the message: "I share, understand, and accept your position," which may facilitate the establishment of narcissistic transference and contribute to the weakening of primitive defense mechanisms. This technique is particularly effective when working with narcissistic and borderline personality structures and is one of the core psychotherapeutic tools for establishing trusting contact with the patient and reducing resistance to the work.

The history of the application of joining in psychotherapeutic practice has been examined in detail by Y. Feldman [1] and H.S. Strean [2]. This technique is sometimes described as "joining the resistance" [3] and has been discussed in relation to various psychotherapeutic traditions, including M. Erickson's hypnosis [4] and modern psychoanalysis. H. Spotnitz characterized joining as a "generalized set of clinical interventions aimed at working with preverbal forms of resistance and functioning," typically including suppressed aggressive impulses [5].

Despite the clinical significance of the joining technique, existing works leave insufficiently clarified the issue of the differential choice between its ego-syntonic and ego-dystonic forms. The use of this technique still relies largely on intuitive clinical judgment and is transmitted through practice and supervision.

The aim of this article is to explicate the logic of clinical choice between forms of joining and to propose a process-oriented model of clinical navigation that allows intuitive use of the technique to be translated into reflective professional decision-making. The model is based on the analysis of the patient's affective presentation, the therapist's

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countertransference reactions, and the phase of the psychotherapeutic process and is presented as a visual scheme supplemented by clinical decision-making criteria.

This article is theoretical-clinical in nature and is based on an analysis of the literature in the tradition of modern psychoanalysis, primarily the modern psychoanalytic tradition associated with H. Spotnitz, as well as on a synthesis of the authors' long-term clinical experience in working with patients at a pre-oedipal level of personality organization. The article employs a conceptual approach aimed at explicating the clinical logic of therapeutic decision-making and proposes a conceptual model illustrated by typical clinical vignettes. The presented model is not an algorithm or protocol but serves as a tool for reflective clinical thinking.

Theoretical premises for the effectiveness of the joining technique

The joining technique is aimed at interacting with preverbal modes of functioning from the period when the infant's psyche functioned in close emotional unity with the maternal figure. In modern psychoanalysis, such patients are considered to function at a pre-oedipal level of personality organization, characterized by fixation on early, preverbal ways of experiencing and interacting.

In this context, it is important to be sincere, to avoid monotony, and to resort to special warm, supportive intonations. With correct use of joining, the therapist's psyche temporarily functions as an external regulating system for affect, analogous to the maternal psyche in the symbiotic phase [6].

Attachment, established in early childhood, influences a child's future behavior. Attentive, sensitive, caring parents foster in the child a sense of basic trust in the world [7]. If the mother or a substitute maternal object is emotionally unavailable during the critical period of the infant's development (up to three years), the inability to contain and process the infant's raw affects leads to their encapsulation, which may later become a source of symptoms. Such a frustrated infant suppresses its rage and directs it inward to avoid destroying the maternal object.

The inability to integrate "good" and "bad" aspects of self and others is associated with powerful early aggression activated in such patients. According to M. Klein's theory, the primitive defense of splitting separates "good" and "bad" objects to protect the fragile ego from the destructive force of its own aggression [8]. The less the infant's instinctual drives are satisfied, the greater the suppressed aggression will be towards significant objects, and the higher the degree of negative influence on the forming ego. A significant portion of psychic energy, instead of being directed towards ego maturation, is expended on maintaining primitive defenses against affect. Using special techniques of modern psychoanalysis, it is possible to establish a strong emotional connection, reminiscent of the infant's attachment to the mother in the symbiotic phase. Such transferences revive in the therapeutic situation the emotional relationships of the first few years of life and thereby promote the restoration of the capacity for maturation [9].

Pre-oedipal patients, similar to infants with unsatisfied basic needs, may at the beginning of therapy demonstrate a habitual behavior pattern conducive to psychological and physical survival — exhibiting silence, idealizing the therapist. A common denominator when working with patients demonstrating primitive mental functioning is the difficulty for the therapist in containing strong countertransference feelings and impulses — the therapist may experience intense countertransference reactions, such as irritation, anger, boredom, anxiety, or helplessness [10].

The patient's narcissistic rage can be considered a phenomenon functionally similar to the infant's rage discussed above, and the therapist's ability to cope with it facilitates the patient's progress, the formation of a stable self-image, and an increase in the level of psychic functioning. The task of psychotherapy is to bring suppressed and repressed anger and rage into the therapeutic space, relieving the ego of the tension of the affect [11]. To accomplish this, it is important to be able to join, to form stable relationships, and then, based on a sufficient level of affective stability, to begin working ego-dystonically, to actualize repressed aggressive impulses.

Features of applying the technique

Joining is particularly suited for initial meetings with a patient and can be used in moments of strong affect, for example, when working with pronounced aggression, to reduce its escalation and move to exploration. This technique is especially relevant when working with borderline patients, for whom it is especially important to feel that the therapist is on their side. When working with hysterical and narcissistic patients, it is important to avoid both being captured by intense countertransference and becoming involved in the patient's acting out.

With a narcissistic patient, one can empathetically meet their grandiosity but

The joining technique may be compared to surfing, in which the psychotherapist "catches" the patient's dominant affect and, by balancing on it, moves beyond resistance.

monitor the degree of expressed admiration — if it is too strong, some patients may perceive it as manipulation. Hysterical patients may draw the therapist into their experiences. In response, for example, to the phrase from a gesticulating patient: "Can you imagine, he didn't answer my message! What an idiot, right? Tell me, tell me he's an idiot!" one can avoid dampening the drama and instead attune the intonation, try to name the feeling: "Of course, it's infuriating when messages go unanswered!" — in order to accept the patient's feelings but not become "infected" by them. It is not necessary to comply with the patient's request — in this case, it could launch a new dramatic turn and prevent reaching exploration.

Illustrative vignette

Patient S. (26 years old) comes to sessions in a strong affect, devalues therapy, wants "immediate solutions." It is important to maintain contact and avoid increasing the patient's frustration.

Patient: *Well, what's the point of all this? I come every time, I talk, and nothing changes! Why come if life is going to hell anyway?*

Therapist: *It's very tiring when you're waiting for something. You have remarkable endurance; many people would have given up long ago.*

Patient: *Yes! Exactly!*

Therapist: *You speak in such a way that I can directly feel that boiling point. Let's try to decide together what to do next.*

In this case, the therapist reflects the intensity of the patient's affective charge without lowering the temperature of their experience but also without escalating it. Here, a rapid response and explicit validation of the patient's emotional experiences are important — a clinical position in which the therapist actively and consistently confirms the subjective reality of the patient's experiences, without questioning them or offering immediate processing, interpretation, or frustration. The patient's affect gradually subsides, and contact is restored. The patient later said: "For the first time, I felt that I wasn't being calmed down or corrected, which usually infuriates me even more."

The joining technique is not limited to the expression of empathy but presupposes the therapist's ability to recognize and actively engage with the patient's dominant affective experience. This technique constitutes the foundation of the therapeutic relationship, allowing resistance to be reduced, bridges to be built between different levels of experience, and the patient to be gently guided toward inner transformation.

Ego-dystonic and ego-syntonic joining

According to the theory of the psychoanalytic school of Hyman Spotnitz, the joining technique is capable of provoking a breakthrough of aggressive impulses, which is very important when working through narcissistic defenses to form narcissistic transference. The therapist can, depending on the patient, join either *ego-syntonically* (adopting the patient's perspective and values, joining their feelings, temporarily aligning with the ego) or *ego-dystonically* — when the therapist also agrees, but in a paradoxical way (for example, hyperbolizing the introjected figure of the attacking superego or the grandiose ego). This initially leads to a strengthening of defenses, which may subsequently result in a breakthrough of restrained aggressive impulses and a resolution of resistance.

The unconscious signal from the therapist "I am just like you!" facilitates the formation of narcissistic transference, without which effective work with pre-oedipal issues is impossible. This intervention promotes a subjective experience of a reparative connection [12].

Examples of ego-syntonic joining

Patient: *I'm sure you've had at least a hundred patients like me. And for you, I'm just a simple nut. I wonder, in how many sessions will you be able to crack me?*

Therapist: *You have a unique taste in therapists and amazing intuition. I am a specialist in dealing with difficult cases and cracking hard nuts. Shall we estimate the number of sessions or let it be a pleasant surprise?*

P: *Frankly, I either don't remember or don't understand half of what you ask.*

T: *You know, sometimes I also feel like I don't understand myself. Our work will definitely be productive, because we are so similar.*

P: *I've completely lost heart, and I don't want to do anything at all.*

T: *I'm also completely drained today. Let's not do anything and just sit here until the end of the session.*

For example, when a patient says: *"I'm acting like an idiot, everything in my life is terrible, I'm always doing the wrong thing, I'm a complete idiot"*—the therapist joins ego-dystonically: *"Yes, it seems so. But don't worry, I happen to be a specialist in human foolishness."* Joining the attacking superego position creates, for some part of the patient's psyche, a sense of being understood (acknowledging that they might seem like an "idiot" to themselves), while on the other hand, it provokes anger and rage (*"I didn't expect to hear that from you, my therapist, you are cruel and unempathetic"*). Thus, the therapist steps into the transference position of the bad object, which was cruel and attacking. Ego-syntonic joining in this clinical context may be less effective.

To a patient convinced that they are *"the most disgusting person in the world,"* the therapist can amplify this statement by saying they are *"the worst person who has ever existed."* Typically, the patient acknowledges: yes, they really are as bad as they imagine, but at the same time, they feel uncomfortable hearing such words from a professional. Thus, this form of exaggerated ego-dystonic alignment (in ego-dystonic joining) has the effect of ultimately shifting the target of the attack from the ego toward the therapist [5].

Ego-syntonic joining is especially clinically justified when working with patients at a pre-oedipal level of personality organization, as well as in situations of pronounced anxiety, affective disorganization, and threat of rupture of therapeutic contact, as emphasized in a number of works on early forms of psychoanalytic therapy [13].

Examples of ego-dystonic joining

Patient: *I've completely despaired.*

Therapist: *Yes, it looks like you have nothing to hope for.*

P: *Your whole therapy is a complete farce! No benefit at all, just ripping off honest people!*

T: *I knew you were insightful, but to this extent... I really do love money.*

P: *I'm good for nothing, but at least on me you can write your dissertation!*

T: *You may be right, at least one of us will benefit in some way.*

Both formats of joining may be effective in situations of pronounced resistance to therapeutic progress in pre-oedipal patients, contributing to alliance strengthening and reinforcing narcissistic defenses, which paradoxically supports their gradual transformation over time.

Therapeutic change becomes possible when the therapist, consistently using both types of joining, functions as both a mirror and container for the patient's unbearable affects. By joining the patient's ambivalent messages and feelings, the psychotherapist introduces their own personality to the patient at a safe distance, until the ego develops.

Of course, the psychotherapist's work cannot be limited to this technique alone and represents a mixture of working interventions, among which joining is the basis and foundation for forming stable relationships and safety for the patient, therapist, and working space.

Figure 1 illustrates a process-oriented heuristic model of clinical decision-making when using the joining technique in psychotherapy. The model shows how the therapist, assessing the patient's affective and defensive presentation, chooses between ego-syntonic and ego-dystonic forms of joining depending on the patient's subjective relationship to the presented content. The cyclical nature of clinical assessment, the significance of affective dynamics and resistance, as well as the necessity for constant monitoring of countertransference, therapy phase, and containment capabilities are emphasized. The presented scheme is conceptual in nature and is intended to support clinical thinking, rather than to provide an algorithmic procedure.

It should be emphasized that ego-syntonic and ego-dystonic joining are not mutually exclusive or mechanically alternating techniques. The choice of the form of joining is made by the therapist in the process of clinical work and is based on a set of factors, including the nature of the patient's affective presentation, features of resistance, the therapist's countertransference reactions, and the phase of the psychotherapeutic process. Thus, joining implies not a fixed technical device but dynamic clinical navigation between different forms of intervention depending on the current psychodynamic situation. The model presented in Figure 1 reflects the process of navigation between ego-syntonic and ego-dystonic forms of joining in the course of real psychotherapeutic work.

Within the proposed model, the distinction between ego-syntonic and ego-dystonic joining can be clarified from the perspective of the clinical function performed. In some cases, joining is aimed primarily at containing affect and reducing internal tension, supporting the integrity of the patient's ego. In other cases, joining is used as a means to provoke previously blocked affect, primarily aggressive, for its subsequent working through in the transference. Such a functional difference does not introduce a new typology but clarifies the mechanism of action of different forms of joining in the clinical process.

Using joining with silent patients

Working with silent patients represents a particular, yet clinically illustrative, case where the necessity for a differentiated choice of the form of joining is especially evident. Silence can perform various psychodynamic functions and requires different clinical tactics depending on the patient's affective state, the nature of resistance, and the phase of therapy.

Silence as a phenomenon in classical psychoanalytic practice has long been theoretically conceptualized, but its management in the past was limited to interpretive techniques, which rarely led to its resolution. Silence serves many purposes. From a defensive or conflictual perspective, silence may

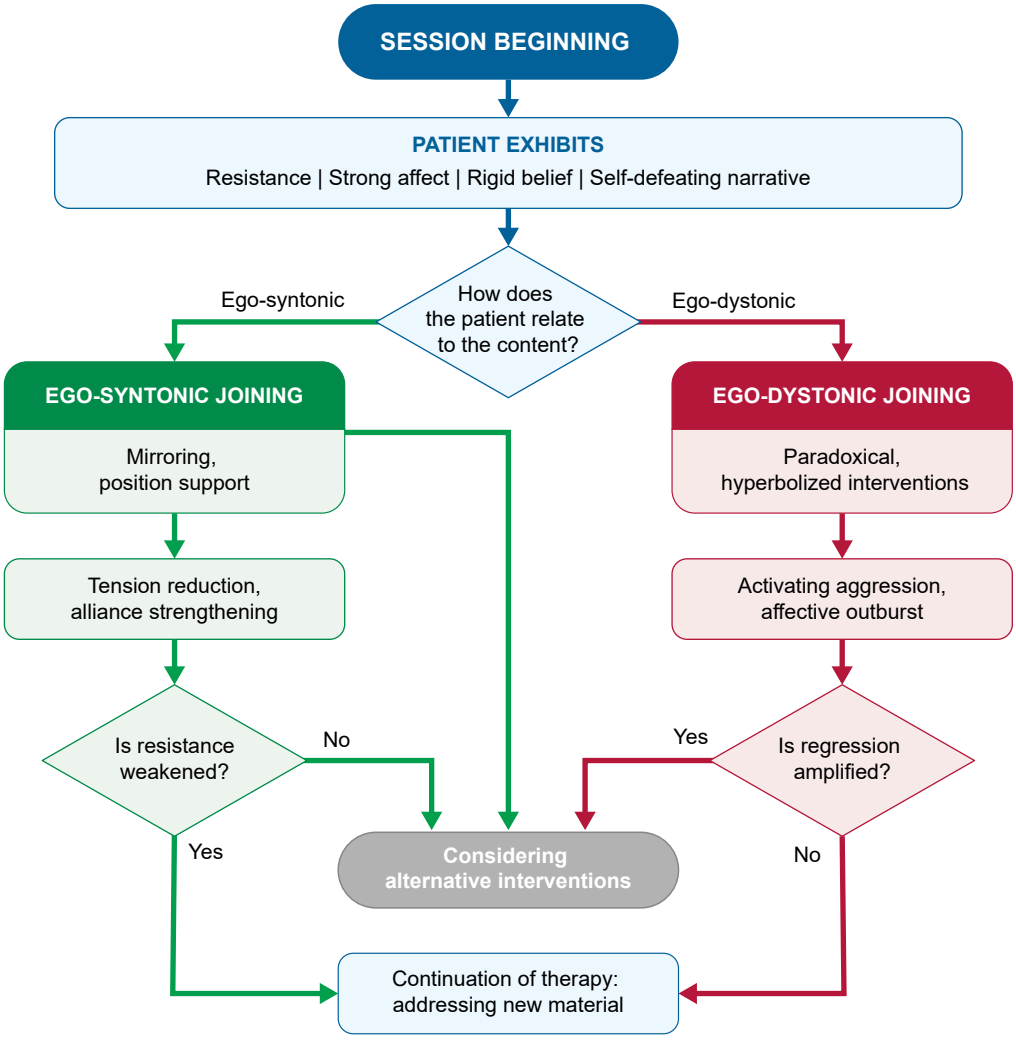

Figure 1. A process-oriented clinical decision-making model for ego-syntonic and ego-dystonic joining

signify anger, fear, despair, depression, contempt, and aggression [14]. The joining technique can be effective with such silent patients.

In individual work, one encounters silent patients whose silence is provocative or controlling, creating tension in the dyad. For example: *"I don't know what to say."* In this case, the therapist can join ego-syntonically and gently say: *"You've already said enough, we can just be silent today."* Or, when the patient expresses themselves more aggressively, for example: *"I don't want to talk with you today,"* the therapist can join ego-dystonically and say: *"We are, after all, a harmonious pair, because I have no mood to listen to you today either."*

For group therapists, it will be useful to use joining with silent groups: *"It seems this is a very caring group that has decided to be silent today so I could rest. I'm completely fine with that, I also like this group's choice."*

It is important here that the joining should be to the group as a whole, not to an individual member. This can promote group cohesion, for example, when participants do not communicate very well with each other or do not build connections well with one another.

Joining in relation to other psychoanalytic techniques

In practical work, joining is often identified with empathic mirroring, which can lead to methodological inaccuracies when choosing interventions, especially when working with patients at early levels of

personality organization. Comparison with the mirroring technique reveals differences in the logic of therapeutic action and the specificity of joining as an intervention oriented toward the active inclusion of resistance and affective dynamics into the therapeutic process. Comparing these approaches allows for a clearer delineation of the specificity of the joining technique, as well as avoiding its reduction to the general concept of empathic reflection. In this context, it is important to emphasize that this is not a comparison of psychoanalytic theories as a whole, but rather differences in clinical emphases and the logic of applying specific techniques when working with patients at early and primitive levels of personality organization.

Despite the external similarity of some clinical methods, the joining technique as understood by the modern psychoanalytic school of Spotnitz significantly differs from other psychoanalytic interventions aimed at working with early developmental disturbances. In particular, in clinical practice, the joining technique is often compared with the mirroring technique described by H. Kohut within self psychology. Both interventions rely on the therapist's empathic presence and sensitivity to the patient's subjective experience, yet they stem from different theoretical premises and are oriented toward different clinical tasks.

Table 1 presents a comparative description of the key clinical characteristics of the mirroring technique in H. Kohut's self psychology [15] and the joining technique in the modern psychoanalytic tradition of Spotnitz. The comparison is conducted along a number of parameters, including the clinical focus of the intervention, attitude toward resistance, features of working with affect, the nature of transference, the role of countertransference, as well as typical clinical risks and target patient groups. Such a comparison demonstrates that, despite a common orientation toward early levels of mental functioning, these techniques differ in the direction of therapeutic impact: mirroring is primarily oriented toward stabilizing and maintaining the ego, whereas joining focuses on actively including resistance and aggressive affect in the therapeutic process. The presented table serves as a tool for the theoretical positioning of the joining technique and allows for a more precise determination of its place among other psychoanalytic interventions.

The presented comparison emphasizes that the differences between the mirroring technique and the joining technique lie not only in theoretical premises but also in the logic of clinical choice of interventions. Unlike mirroring, where the intervention is primarily oriented toward stabilizing the ego, joining presupposes constant clinical assessment of the form of resistance and the patient's affective dynamics, making flexible switching between ego-syntonic and ego-dystonic forms of work necessary. It is precisely this necessity for clinical navigation that underlies the decision-making model proposed in this article.

Clinical limitations and risks of applying the joining technique

Despite the clinical effectiveness of the joining technique when working with patients at a pre-oedipal level of personality organization, its

Aspect	Mirroring (Kohut, self psychology)	Joining (Spotnitz, modern psychoanalysis)
Clinical focus	Support and strengthening of the ego	Work with resistance and aggression
Attitude toward resistance	Minimization of frustration in early stages	Active inclusion of resistance in the process
Type of intervention	Empathic reflection of subjective experience	Ego-syntonic and ego-dystonic joining
Work with affect	Validation and gradual differentiation of affect	Containment and activation of aggressive affect
Transference	Narcissistic – mirroring, idealizing	Narcissistic – positive (including idealizing) or negative
Role of countertransference	Used to a limited extent	Is a key diagnostic indicator
Clinical risks	Maintaining dependency	Intense countertransference reactions
Typical patients	Ego disturbances, narcissistic structures	Pre-oedipal borderline, psychotic
Direction of therapeutic change	Gradual maturation of the ego	Transformation of self-aggression and resistance, resistance resolution; ego strengthening

Table 1. **Comparative features of mirroring and joining techniques in psychoanalytic practice**

application requires careful clinical differentiation. The use of joining outside appropriate clinical conditions or in an unsuitable phase of therapy can undermine the therapeutic process and lead to the intensification of pathological forms of functioning.

In a number of clinical situations, joining is capable of supporting symbiotic fixation, especially with insufficient differentiation between the ego and the object. In such cases, constant empathic joining can hinder the formation of boundaries and increase the patient's dependence on the therapist, slowing the process of psychic separation.

Another risk is the support of narcissistic grandiosity, when ego-syntonic joining is used without subsequent working through of aggressive and frustrating affects. In such situations, the technique can contribute to the reinforcement of defensive narcissistic structures instead of their transformation.

Furthermore, excessive or untimely use of joining can block the development of symbolization, especially if interventions replace analytic work with transference and interpretation. In this case, joining loses its auxiliary function and becomes a form of avoidance of more complex therapeutic interventions.

Particular attention is required regarding the application of the technique in different phases of the psychotherapeutic process. In the early stages of therapy, premature use of ego-dystonic joining can lead to patient disorganization and the destruction of the therapeutic alliance. In later phases of therapy, maintaining exclusively supportive ego-syntonic joining can hinder the transition to working through and integrating conflictual material. Thus, the clinical effectiveness of joining is determined not only by the choice of its form but also by the accuracy of assessing the therapeutic context and the patient's readiness for the corresponding level of intervention.

Considering the nature of transference when choosing the form of joining

The choice between ego-syntonic and ego-dystonic forms of joining is also determined by the nature of the forming transference and the degree of its affective stability. In situations where symbiotic expectations, idealization of the therapist, or pronounced dependence on the object predominate in the transference, ego-syntonic joining may be clinically justified only in the early stages of therapy and under the condition of its limited and conscious application. Otherwise, it can reinforce symbiotic fixation and hinder the development of the patient's autonomy.

In cases where the transference is fragile or disorganized and accompanied by pronounced anxiety, fear of destroying the object, or loss of a basic sense of security, the use of ego-dystonic joining may be contraindicated. Premature provocation of aggressive affect in such transference patterns increases the risk of patient disorganization and disruption of the therapeutic alliance.

The use of the joining technique requires special caution when working with patients in states of pronounced disorganization, as well as with an insufficiently formed therapeutic alliance. In such cases, premature or uncritical application of joining can increase dependence on the therapist or serve as a form of avoidance of deeper analytic work, as emphasized in classic works on early developmental disturbances and the technique of psychoanalytic therapy [14].

Thus, the clinical appropriateness of one or another form of joining is determined not only by the nature of the patient's affective presentation but also by the current transference pattern, as well as the degree of its stability and the tolerability of aggressive impulses in the therapeutic field.

Conclusion

Clinical observations and accumulated practice indicate the significant therapeutic value of the joining technique, especially in work with patients at pre-oedipal borderline, and psychotic levels of functioning. Its application helps reduce self-destructive tendencies and contributes to a decrease in affective disorganization and the formation of stable narcissistic transference. The effectiveness of the technique is determined by the accuracy of psychopathological diagnosis, the flexibility of interventions, the authenticity of the therapist, and sensitivity to the patient's affective dynamics.

In group work, joining can both reduce the risks of acting out in individual pre-oedipal participants and in the group as a whole, as well as cause a directed increase in affective charge in "quiet" passive-aggressive groups. The joining technique makes it possible to translate aggression from acting out into symbolically mediated verbalization, which positively affects therapeutic relationships, enhances trust in the therapist, and promotes stabilization of the patient's mental state.

The model of clinical navigation between forms presented in the article does not claim to algorithmize the psychotherapeutic process but allows for the explication of the clinical logic of navigating between interventions when working with pre-oedipal patients.

The proposed model can be used in training novice psychotherapists as a tool for developing reflective clinical thinking. Explicating the criteria for choosing between forms of joining makes the

processes of therapeutic decision-making more transparent, processes that in clinical practice often remain implicit and are transmitted primarily through experience and supervision. In this sense, the model can serve as an auxiliary tool in an educational context, without replacing clinical experience.

A promising direction for further work is the empirical testing of the proposed model, as well as its further development and adaptation for use in the clinical training of psychotherapists. In a broader context, the model may be of interest for interdisciplinary research aimed at studying the mechanisms of affect regulation in therapeutic interaction.

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