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Joining, Mirroring, Psychological Reflection: Terminology, Definitions, Theoretical Considerations

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Joining is a powerful technique for resolving narcissistic resistance in psychoanalytic therapy. Its very power, however, calls for prudence in determining when and how to apply it. In the hands of the uninitiated, and used without reference to the larger maturational purpose which it aims to advance, joining, especially in its dystonic form, may subserve analytic aggrandizement against the patient; at worst, it may destroy the analysis. In this spirit, **Spotnitz (1976)** warns against using the joining technique as "a gimmick, a device that can be flicked on mechanically" (p. 42), and **Nelson and Nelson (1957)** similarly advise against "shotgun" application (p. 12).

The nucleus of therapy with the preoedipal patient is in the transference-countertransference relationship, reflected in the patient's evolving feelings toward the analyst and the latter's perception of the process through the medium of his own induced feelings. Generally speaking, technical skills such as joining come into perspective only as they further the objectives of a comprehensive therapeutic design associated with the patient-analyst relationship. The joining technique, powerful as it is, has no *intrinsic* significance. It is means to an end. Its value derives wholly from its role as handmaiden of a clinical method. If, therefore, we elect to study its many uses in treatment and to trace the sources of its effectiveness, we do so only in order to clarify how modern analysis goes about its pursuit of larger analytic goals.

Terminology

Modern psychoanalysis has often been called the joining method. This is surely a limited view of what happens in the treatment of the preoedipal patient. Joining is after all merely one treatment technique. It takes its place among other modalities, such as mirroring, object-oriented and ego-oriented questions, confrontation, commands, explanations and finally interpretations. It is true, nevertheless, that joining is one of the most powerful instruments devised for dealing with resistance in the therapy of narcissism.

It will repay us first to clarify the terminology that has developed over the years around the joining concept. Confronted with the stonewall resistance of the narcissistic patient in treatment, Spotnitz and his co-workers early on hit upon the notion of proceeding in accordance with the old adage, "If you can't lick 'em, join' em." We shall soon see how they went about putting this strategy into effect. The new procedures, in any event, demanded a supplementary vocabulary. The papers describing the modern approach and its results that subsequently appeared in the professional journals sprouted a new idiom. Joining, mirroring, psychological reflection, siding with the resistance, supporting, reinforcing—these and other expressions made their appearance in order to convey what was taking place in the therapists' offices. The so-called "paradigmatic" approach **(Nelson, Nelson, Sherman & Strean, 1968)**, a parallel clinical method which took its cue from a similar view of the narcissistic patient and his resistances, added to the above its own quota of terms, such as, active mirroring and role playing. The terms employed most frequently in both approaches were joining, mirroring and psychological reflection.

A certain confusion has by now developed over the exact meaning of these terms and how they differ. The literature of modern psychoanalysis, in its mushrooming growth, offers ambiguous aid in clarifying these concepts. Thus, psychological reflection and mirroring are synonymous (Marshall, **1982**, p. 14; Spotnitz, **1976**, p. 37; Spotnitz & Nagelberg, **1960**, p. 195); psychological reflection and joining are synonymous (Clevans, **1976**, p. **144**; Meadow, **1974**, p. **81**; Spotnitz, **1976**, p. 37; **1985**, p. 183; Spotnitz & Meadow, **1976**, p. 181); joining and mirroring are synonymous (Davis, **1965-66**, pp. 93, 100-101; Nelson, **1962**, p. 121); joining is a form of psychological reflection (Kirman, **1977**, p. 172; Spotnitz, **1976**, p. 37); joining is accomplished by means of mirroring (Strean, **1964**, p. 35); joining

is accomplished by means of psychological reflection (Spotnitz, **1976**, p. 27); psychological reflection is accomplished by means of

joining (Spotnitz, **1976**, p. 134). Some attempt at differentiation would appear to be in order. A careful reading of texts yields the following tentative conclusions regarding the interrelationships of these terms.

As the concepts have developed and are now most frequently used, it is reasonable to say that mirroring and psychological reflection are one and the same. Joining and mirroring (psychological reflection) represent two forms of modern analytic technique for dealing with preoedipal resistance. Each in its way affirms a similarity between the egos of analyst and patient, and they may therefore be viewed as variant applications of the same approach. Having pursued these distinctions this far, we must now acknowledge that "joining" and "psychological reflection" have each by common usage come separately to serve as umbrella terms for the combined joining and mirroring techniques. This is for purposes of general reference. Caution is indicated, however, when discussing specific treatment procedures, to distinguish between joining and mirroring (psychological reflection) *qua* techniques.

The writings of Hyman Spotnitz, originator of these procedures, provide the most authoritative formulations of the techniques and offer striking examples of their use in psychoanalytic therapy. (See especially Spotnitz, **1976**, **1985**.)

Definitions

In simplest terms, joining and mirroring refer to a communication from the analyst which conveys to the patient that the analyst agrees with him. Several levels of agreement are involved, matching the patient's conscious feeling state behind it.* If the analyst is in resonance with the patient, his joining and mirroring remarks, while addressed to the literal resistance message, will simultaneously engage the unconscious emotional contents sheltering behind it. These concealed contents constitute the patient's true affective disposition, which is usually at variance with the one displayed in the manifest resistance. And just as the patient's overt resistance communication is linked to subterranean emotional tendencies, so does

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For a discussion of conscious and unconscious resistance patterns and motives, see **Margolis (1984)**.

the analyst gain access to these tendencies by allying himself with the overt resistance pattern. In other words, in joining the manifest resistance, the analyst is also speaking to the unconscious forces warded off behind it. He thus informs the patient that it is acceptable to entertain both his resistance attitudes and the unneutralized aggressive and libidinal feelings which they defend against.

In the case of joining, agreement may take a variety of forms. The analyst may simply say "Yes" or "That's right," he may echo the patient's statement by repeating it in the same or different form, he may accept the patient's views and encourage him to maintain them, he may "pursue the patient's perception" (Spotnitz & Meadow, **1976**, p. 204) by helping the patient elaborate on it. These procedures, each in its way, indicate the analyst's agreement with the patient. They constitute different means of "going along with the resistance" (Spotnitz, **1976**, p. 178), "siding with the resistance" (Sherman, **1961-62**, p. 44; **Strean, 1964**, p. 35), "supporting and reinforcing it" (Spotnitz & Nagelberg, **1960**, p. 193; Davis, **1965-66**, p. 84), in short, *joining* it.

The agreement may be with a specific comment of the patient about himself or others.*

P: I slept poorly last night and feel tired today.

A: You look tired.

P: I feel miserable.

A: You're entitled to feel miserable.

Or the analyst may join the patient's total set of values or attitude toward life.

P: (after a harrowing review of his life history) I haven't had much in the way of pleasure.

A: Life has been one misery after another.

In the case of mirroring (psychological reflection), agreement takes the form of communications in which the analyst presents his own condition or attitude as matching that of the patient. Thus, the analyst may respond in kind to a statement by the patient. For example, if the patient devalues the ego (himself), the analyst devalues the

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These illustrations, as well as most of those that follow, are limited, for brevity's sake, to two-line exchanges. This by no means typifies the joining technique, which often generates extended dialogues between analyst and patient, and may also take non-verbal forms.

object (himself). If the patient directs a question to the analyst, the latter directs a similar question to the patient. If the patient expresses certain thoughts about the analyst, the latter expresses similar thoughts about the patient.

P: I want to think about it before deciding to enter treatment with you.

A: And I want to think about it before taking you on as a patient.

P: I'm thinking of stopping analysis.

A: I'm considering discharging you.

In a more elaborate scenario, the mirroring is not of a single thought or attitude of the patient, but of his total approach. For example, a self-centered patient spends session after session complaining about his aches and pains or his distressing feelings or experiences, without making contact with the analyst. The latter then begins to ask questions about himself, directing the patient's attention to the analyst. “Is there something you want of me in connection with these feelings (experiences)?” Or, “How do I feel about the things you're describing?” The analyst is doing exactly what the patient is doing, reflecting the patient's self-centered attitude. Depending on the maturational context, the analyst may also mirror the patient's silence with silence of his own, respond in an aloof manner to the patient's intellectualizations, or counter the patient's vacillation with a parallel indecisiveness.

Joining and mirroring may be ego-syntonic, i.e., fall pleasurably upon the patient's ears, or ego-dystonic, i.e., abrasive and unpleasant. It is difficult to convey on the printed page the special quality that renders an intervention syntonic or dystonic. The verbal content is, of course, important. Crucial, however, is the emotional charge attached to the verbal content. This is what defines its pleasant or unpleasant character and in either case exercises a maturational effect upon the patient. A harsh or friendly tone of voice, adding a hint of asperity or a touch of gentleness, will confirm or modify the sense of the spoken word. Emotional communication in the form of joining and mirroring interventions is thus capable of registering endless nuances of interplay between content and feeling, and of providing the patient with emotional experiences of infinite syntonic and dystonic variety (**Margolis, 1978**; **Sherman, 1983**). Very little of this interplay, particularly from the emotional side, is amenable to reproduction in print. In the examples that follow, the reader may supply,

if he desires, imagined emotional resonances to go with the interventions and heighten or temper their effect.

Ego-syntonic joining:

P: I had to plow through a lot of snow to get here.

A: You showed a lot of determination.

P: My mother was more interested in having fun than in taking care of me.

A: She neglected you.

Ego-dystonic joining:

P: I feel worthless.

A: You are worthless.

P: I feel hopeless.

A: There's no hope for you.

Ego-syntonic mirroring:

P: I feel depressed.

A: So do I.

P: I'm not doing so well in the analysis.

A: Perhaps I'm the one who's not doing so well.

Ego-dystonic mirroring:

P: I didn't feel like coming here and seeing you today.

A: I can't say I was looking forward with great eagerness to seeing you today.

P: What's the use of my saying this over and over again?

A: What's the use of my listening to this over and over again?

In general, ego-syntonic joining is employed when the patient's ego is judged to be in a fragile state and he stands in need of careful reinforcement of his current defensive patterns. This is often the case at the beginning of treatment. Ego-dystonic joining, while also supportive of the patient's resistance patterns, is employed when the patient is judged to be capable of withstanding his own impulsivity and of confining himself to verbal expression of feelings.

Joining as Related to Stages of Resistance

The techniques of joining and mirroring are employed for one purpose only, to resolve the narcissistic patient's resistance to putting his thoughts and feelings into words. The resistances vary with the individual, but they tend to fall into certain general

categories. These have been discussed by Spotnitz (**1985**, pp. 175-183) under the headings: treatment destructive resistance, status quo resistance, resistance to analytic progress, resistance to cooperation, and resistance to termination. The categories represent stages in the upward mat-urational mobility of the patient in a successful analysis. In terms of treatment goals, the categories stand for the steps in the patient's progressive emotional evolution from isolationist self-absorption through narcissistic transference to object transference, in other words, from early preoedipal, to later preoedipal to oedipal.

Keeping in mind that joining is employed primarily in order to resolve the resistances of the preoedipal patient, the technique is introduced with the utmost caution in the early phases of treatment, when the patient's ego is most fragile. Its use increases in frequency and in intensity of impact as the narcissistic transference develops and the patient forges new ties to reality in the person of the analyst. Joining interventions then begin to decline in number, as the patient gradually withdraws from the complete symbiotic stage attained in the narcissistic transference and begins to achieve the self-other sep-arateness manifested in object transference (Margolis, **1979**, **1981**). Thus, joining procedures are used sparingly in dealing with treatment destructive resistance, which tends to occur at the beginning of treatment. They appear with mounting frequency and intensity as status quo resistance is activated. They achieve maximum use in dealing with resistance to analytic progress. They fade into intermittent application and stand-by status when confronted with resistance to cooperation. And their use is revived again on a temporary basis, often in a harshly dystonic form, with the appearance of resistance to termination.

The rich variability of individual development produces endless permutations and combinations among the elements of the foregoing sequence. Some constants stand out, however, and they invite structuring of the process. Short of reproducing the verbatim protocols of a chain of sessions, it is impossible adequately to convey the complexities of analyst-patient interchanges that sustain the treatment process. The following examples of joining and mirroring interventions

must therefore be viewed as mere “trail markers” that identify the stages of resistance and provide some notion of the use of joining communications in the resolution of different resistance types.

Treatment Destructive Resistance. As the name implies, this form of resistance, usually in the early phases of treatment, imperils the analysis. It must be dealt with at once, preferably by questioning and investigating the patient's attitudes, occasionally by joining.

P: I feel as though I'm falling apart.

A: Am I falling apart too?

P: I'm thinking of stopping treatment.

A: Why am I doing such a poor job that you want to get away from me?

In both cases, the analyst is trying by means of mirroring to draw the patient's attention to himself. This leads the patient to stop scrutinizing his own shortcomings and impulses and to focus on the object (analyst) and his possible defects. The aim is to involve the patient's feelings with the analyst and lessen the danger of disruption of therapy.

Status Quo Resistance. The patient, having resolved his initial resistances and made visible progress in the analysis, has now arrived at a stage where he is quite satisfied with himself and with his relationship with the analyst, and prefers to stay exactly where he is. In the transference, he attributes this attitude to the analyst.

P: You don't mind my silences. You just like my company.

A: What's my problem that I like you to be silent?

The analyst, joining the patient's view of him, proceeds to investigate why he, the analyst, is that way.

Resistance to Analytic Progress. Having resolved his status quo resistance, the patient is now confronted with the prospect of advancing into unknown territory where hitherto successfully repressed memories, thoughts and feelings lurk. He resists venturing forth, and the analyst deals with this resistance when the patient expresses it as a transference feeling.

P: I think you'd rather I relaxed and didn't bring up any troublesome new problems and ideas.

A: Why would I have an attitude like that?

Again the analyst joins the patient's view of him and pursues it.

Resistance to Cooperation. The patient has by now resolved his resistance to communication, has gradually begun to establish object transference, and is able to speak more freely of his thoughts and feelings. He does, however, balk from time to time and, in revival of his former narcissistic attitudes, hesitates to continue progressive productions and dialogue. Joining is now one of several options, since the patient's ego has become strong enough to accept explanations and interpretations as well.

Resistance to Termination. The patient will often greet the prospect of termination with a revival of his old problems and with complaints that nothing has changed. He will also report that new problems have appeared. He seems to be saying: I don't want to be

adult and independent. His renewed narcissistic resistances are once again joined and mirrored—often sharply dystonically in order to test his resilience—until he arrives at a full acceptance of his new role as an adult.

Special Situations

There are many special situations in the therapy of the narcissistic patient that call for joining procedures. Each pathological syndrome rooted in the preoedipal period requires particular joining techniques that will help resolve the resistances specific to it. Perhaps the special situation that arises most frequently, along the entire spectrum of preoedipal disorders, is represented in the resistance to voicing aggressive feelings. This is so because at the root of all narcissistic disorders is found the narcissistic defense, a repudiation primarily (though not exclusively) of the aggressive impulse. The therapist working with the preoedipal patient in whatever context is destined to deal with the varied consequences of the narcissistic defense. The patient avoids experiencing and expressing negative feelings with a doggedness born of a fear of annihilation. Depending upon his character structure and the etiology of his disorder, he will resort to paranoid attitudes, depressive or delusional states, silences, self-disparagement, psychosomatic equivalents of his affective processes and other forms of self-attack. When these manifestations begin to infiltrate the transference relationship, joining becomes a necessary strategy for engaging the resistances they present. The ultimate purpose, in every instance, is to help the patient mobilize and liberate the negative (as well as the positive) feelings he has long kept submerged.

The analyst accomplishes this by first joining the patient's resistance and supporting and reinforcing his uncooperative attitudes. He helps the patient maintain the narcissistic defense until the latter feels secure enough to give it up of his own volition.

The following excerpt provides an example of the uses of joining and psychological reflection in the treatment of depression in one particular context. The patient was a young woman who had entered treatment because depressive episodes interfered with her functioning.

P: If you really look at things the way things are, I am unimportant. It's the truth. Everybody is unimportant. It's just that some people like to believe that they're important.

A: Does that include me?

P: Yes. It includes everybody. I mean, what good are you, or me? What good is anybody if they have to die? What's the sense at all of being born? Let's say, what good are you?

A: Yes. What good am I?

P: I don't know. I don't see that there's any good in anything or anybody at all.

A: I certainly can't keep you from dying, or even myself.

P: Right. That's just what I was thinking. I don't understand why anybody is doing anything they're doing in the world. The people who might be considered the psychiatric people in a way are living the best lives. Because they're into spells. Criminals also. There's absolutely no reason not to steal, cheat, lie, murder, anything. It doesn't matter. People are doing all these stupid things like making money, having jobs, going to school, working. There's just no point at all in these things of civilization. We should live like animals. It should be survival of the fittest, where we just kill off whoever gets in our way. There's no point in trying to live eighty years. There's absolutely no point to my life. I don't understand what I'm doing. And that's the part that makes me feel sick ... hearing those crazy people out there telling me there is a point to my life. There's no point to my life. What do you have to say? Say something.

A: It's very impressive.

P: What's very impressive about that?

A: Your whole point of view, yes.

P: You're just saying that so I'll talk more, probably. What do you find impressive about it?

A: There's a great deal of truth in it.

P: Then why do you still go on doing things anyway?

A: What should I do? I'm like a wound-up clock. Destiny has wound me up and I'm just ticking away.

P: Oh, I hope that's not true. Is that really true?

A: What else is there? You go through your daily rounds, over and over again. Then along will come a day when somebody will press the wrong button and that will be the end of us all.

P: Who's that?

A: I don't know. Some crazy man either here or in Russia or someplace will just press the wrong button and that will take

care of all of us. Or maybe there'll be a slow death, maybe the atmosphere will give out, there'll be pollution and everybody will die of something or other. The planet will become uninhabitable. How many people can escape to the moon?

P: Why do you want to live, if you expect that? What difference does it make if you die today or five years or ten years from now?

A: Not much difference.

P: And wouldn't it be so much more satisfying if you could kill yourself, like if you knew that's only the real worthwhile thing doing in life because you have control over it then. It's much more satisfying than if you left it to nature or whatever you want to call it, if you had a physical illness or a heart attack or something like that or if you left it to chance and you had an accident and can be run over by a car or were in a train wreck.

A: You can get killed in your bathtub.

P: Or in your bathtub, right.

A: Or open a polluted can and get, what do you call that stuff that you get?

P: Botulism?

A: Botulism, yes.

P: Right. Or one of the things that you said before, like somebody will push the wrong button or it might be a slow death. Isn't it really the only satisfying thing to be able to kill yourself and say, okay, today's the day, this is what I'm going to do with my life, and let them put something like that on my tombstone, and let all the dumb people who are still living come and stand there and cry for me. But I really did it. I killed myself. I did the one worthwhile thing in life—was to kill myself.

A: Well, it's something to think about, as long as you keep coming here and telling me what you're thinking.

P: Absolutely. It really is something to think about. And it makes

me feel better in a way talking to you about it. It makes me feel that I'm in control of my life after all—and I don't have to kill myself to prove it. (After a pause, the patient launched cheerfully into another matter.)

Note the circumspection with which the joining and mirroring are employed. The patient is fragile, and the analyst is intent upon creating a secure setting in which the patient can feel free to express her feelings to their fullest. The joining interventions are therefore all syntonic. They help the patient voice her suicidal thoughts and they open the way to expression of the sweeping homicidal attitudes that lie behind them. The narcissistic defense finally gives way to a sense of control over her life which is associated with the experience of telling all to the analyst, and which can now be expressed through living rather than through dying. How the joining procedures have wrought this change in the patient's frame of mind is of no small interest. We may now proceed with a discussion of the theory of joining.

The Theory of Joining

Observing the effectiveness of the joining technique in resolving the different forms of narcissistic resistance, the reader may have wondered how this was accounted for in theory. Why is joining effective? What characteristics of the narcissistic patient not merely exclude rational interpretive measures but actually dictate procedures such as joining and mirroring?

As we know, the preoedipal patient interrupted his own emotional growth and established the narcissistic defense at a very early stage of development out of anxiety over his unacceptable impulsivity, aggressive and hbidinal. It stands to reason that he will present may obstacles to a therapist bent upon helping him achieve awareness and release of feeling. For all their diversity and ingenuity, however, his multiple resistances are nothing but derivatives of the overriding neg-ativistic defense pattern so typical of the narcissistic patient. “Such negativism,” **Nelson (1967)** declares, “[is] representative of a preverbal insulation barrier activated to protect the organism against overstimulation” (p. **9**). But what was once normal negation has been transformed, under the impact of unwholesome interactions with the mother, into a posture of “malignant No,” in Lichtenstein's **(1977)** phrase. The preoedipal patient, arrested at the narcissistic phase, says

No to the world. He defends his fragile emotional economy by turning a deaf ear not only to the stimuli that press upon him from without, but also to his own psychic processes. In these circumstances, any attempt to address his problems with rational interpretations and insights meet a stone wall, at best of incomprehension, at worst of negation. The narcissistic patient's No connotes more than denial; it is an action equivalent, an assertion of antithesis. That is what is meant when we say that the narcissistic patient is negatively suggestible. In the service of the narcissistic defense, he will assume an attitude, take a position, perform an act, in exact

contravention of the conventional or suggested one.

How to deal with such an unyielding resistance pattern? From much work with schizophrenic and other narcissistic patients, Spotnitz (**1976**, **1985**) gradually evolved the notion that the way to exert an influence for change on these patients was for the therapist to ally himself with the patient's position against change. This required that the therapist align himself in favor of the resistance. He was to forego all efforts at inducing the patient to give up his defensive pattern. Instead, he would support and reinforce it and help the patient maintain it. He named this procedure the "joining" method, and devised numerous variations to meet the many forms of narcissistic resistance.

The effectiveness of the joining method in reversing narcissistic pathology has generated widespread clinical and theoretical comment. We are indebted to **Robert Marshall (1982)** for his thoroughgoing review of the background literature bearing on the subject, notably with regard to mirroring. According to **Davis (1965-1966)**, four different theories have been advanced to explain the dynamics of the joining approach. (1) **Sherman (1961-1962)** proposes that the phenomenon of ambivalence underlies the process. The patient is in an unsettled mental state and is open to fluid changes from one attitude to another. When the analyst overtly adopts the patient's position, the latter, out of his customary negativism, switches to an antagonistic one. This switch moves the patient to a position opposed to his previous negative one; he finds himself taking a positive view. (2) **Nelson (1956)** bases her explanation on the assumption that, during the preoedipal period, the patient reacted to a frustrating object (mother) by internalizing a representation of the object. The internalized frustrating object, the toxic introject, is now an integral part of the ego and resists efforts at effecting maturation in the analysis. Nelson suggests that the analyst, in joining the patient, takes on the role of the introject, which the patient can now reexperience

as an external object. This enables him to express externally the forbidden feelings that have been tormenting him internally, and thus to separate himself out from the unhealthy introject. (3) Davis himself hypothesizes that the joining intervention evokes a surprise reaction in the patient. This releases other feelings, including anger. "With respect to the discharge of the latter affects, it is as though a powerful ally has intervened in the life of the patient, taking over some of the more onerous tasks (his defenses), thus freeing him to experiment with new attitudes or hitherto repressed feelings" (pp. 101-102). Davis then proceeds with an imaginative effort at bridging the theoretical gap between classical and modern analysis. He reminds us that the element of surprise which accompanies genuine insight is common both to joining and to classical interpretation. This leads him to conclude that the joining intervention too may be classified as an interpretation, differing from the classical version only in that the one is verbal and the other preverbal. (4) Spotnitz (**1976**, **1985**) attributes the success of the joining process to its intimate associations with the narcissistic transference. The patient perceives joining as support of his innermost impulses and needs. He is thereby induced to let down his guard and enter a narcissistic relationship with the analyst, ultimately leading to the forthright expression of feelings.

We may elaborate Spotnitz's views as follows. The patient has entered treatment with reluctance, suspicious of the analyst, in whom he is prepared to find a personification of societal demands and pressures and ultimately of the omnipotent and frustrating mother figure of early life. Instead, he finds a mirror image of himself, a therapist who supports his negative attitudes and encourages him to maintain and even elaborate his resistance patterns. The patient reacts hesitantly, testing the analyst's good faith with ploys and maneuvers. In the course of developing the narcissistic transference, he gradually comes to accept the analyst as his true double, a figure whose ego matches his own. This unexpected bounty confers a twofold benefit upon him. Since there is nothing to oppose, he can dispense with his negativism or use it for purposes of maturational growth **(Kesten, 1955)**. Furthermore, the twin image of his ego presented by the analyst serves as palpable evidence that he is not alone, that a kindred spirit shares his view of life and its encounters. This awareness of fellowship signifies an identification with the analyst's ego and a consequent enhancement of the patient's ego. When the process has gone far enough to enable him to feel secure and ready to cooperate with the analyst, the latter helps the patient

resolve his resistance to accepting positive goals of growth and maturity.

Another theory, originating outside modern analytic circles, associates the joining technique with the process of projective identification, a concept first propounded by **Melanie Klein (1946)**. Briefly, projective identification is projection with a string attached to it, as it were. The individual who projects rids himself of an unacceptable idea or feeling by attributing it to another. He spits it out for good. In projective identification, on the other hand, the unacceptable idea or feeling is projected onto another with the intention that the recipient will process the induced feeling through his own personality and make it available in a revised form for reinternalization by the projector. **Ogden (1982)**, describing this process with exquisite clarity, suggests that joining plays out a projective identificatory drama in the following way: (1) The patient externalizes his toxic introject onto the analyst. (2) The analyst joins the patient. (3) This enables the patient to observe and understand himself in the person of the analyst and to reinternalize a detoxified introject now imbued with qualities partaking of the analyst's healthy personality. In Ogden's words, joining is "a way of returning to the patient a modified version of an unconscious defensive aspect of the patient that has been externalized by means of

projective identification" (p. 87).

The last word has obviously not been spoken on the meaning of the joining technique. For the time being, we must content ourselves with a variety of often overlapping explanations, while we go about our absorbing therapeutic encounters with narcissism. Sooner or later, theory is bound to overtake us and fully divulge the reasons for our clinical successes.

References

Clevans, E. (1976), The depressive reaction. *Mod. Psychoanal.*, 1: 139-147. [→]
Davis, H.L. (1965-1966), Short-term psychoanalytic therapy with hospitalized schizophrenics. *Psychoanal. Rev.*, 52: 81-108. [→]
Kesten, J. (1955), Learning for spite. *Psychoanalysis*, 4: 63-67.
Kirman, W. J. (1977), Modern Psychoanalysis in the Schools. Dubuque, IO: Kendall/Hunt. [→]
Klein, M. (1946), Notes on some schizoid mechanisms. In Envy and Gratitude and Other Works, 1946-1963. New York: Delacorte Press/Seymour Laurence, 1975. [→]
Lichtenstein, H. (1977), The Dilemma of Human Identity. New York: Jason Aronson.

Margolis, B.D. (1978), Narcissistic countertransference: emotional availability and case management. *Mod. Psychoanal.*, 3: 133-151. [→]
Margolis, B.D. (1979), Narcissistic transference: the product of overlapping self and object fields. *Mod. Psychoanal.*, 4: 131-140. [→]
Margolis, B.D. (1981), Narcissistic transference: further considerations. *Mod. Psychoanal.*, 6: 171-182. [→]
Margolis, B.D. (1984), Notes on narcissistic resistance. *Mod. Psychoanal.*, 9: 149-156. [→]
Marshall, R.J. (1982), Resistant Interactions: Child, Family, and Psychotherapist. New York: Human Sciences Press.
Meadow, P. W. (1974), A research method for investigating the effectiveness of psychoanalytic techniques. *Psychoanal. Rev.*, 61: 79-94. [→]
Nelson, M. C. (1956), Externalization of the toxic introject. *Psychoanal. Rev.*, 43: 235-242. [→]
Nelson, M. C. (1962), The effect of paradigmatic techniques on the psychic economy of borderline patients. *Psychiatry*, 25: 119-134.
Nelson, M. C. (1967), On the therapeutic redirection of energy and affects. *Int. J. Psycho-Anal.*, 48: 1-15. [→]
Nelson, M. C. & B. Nelson (1957), Paradigmatic encounters in life and treatment. In Paradigmatic Approaches to Psychoanalysis: Four Papers. Ed. M. C. Nelson, New York: Stuyvesant Polyclinic, 1962.
Nelson, M.C., M.H. Sherman, & H.S. Strean, (1968), Roles and Paradigms in Psychotherapy. New York: Grune and Stratton.
Ogden, T. H. (1982), Projective Identification and Psychotherapeutic Technique. New York: Jason Aronson.
Sherman, M. H. (1961-1962), Siding with the resistance in paradigmatic psychotherapy. *Psychoanal. Rev.*, 48: 43-59. [→]
Sherman, M. H. (1983), Emotional communication in modern psychoanalysis: some Freudian origins and comparisons. *Mod. Psychoanal.*, 8: 173-189. [→]
Spotnitz, H. (1976), Psychotherapy of Preoedipal Conditions. New York: Jason Aronson.
Spotnitz, H. (1985), Modem Psychoanalysis of the Schizophrenic Patient: Theory of the Technique, Second Edition. New York: Human Sciences Press. [→]
Spotnitz, H. & P. W. Meadow (1976), Treatment of the Narcissistic Neuroses. New York: Manhattan Center for Advanced Psychoanalytic Studies.
Spotnitz, H. & L. Nagelberg (1960), A preanalytic technique for resolving the narcissistic defense. *Psychiatry*, 23: 193-197.
Strean, H. S. (1964), The contribution of paradigmatic psychotherapy to psychoanalysis. *Psychoanal. Rev.*, 51: 29-45. [→]

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