Canadian Journal of Counselling and Psychotherapy /
Revue canadienne de counseling et de psychothérapie
ISSN 0826-3893 Vol. 53 No. 1 © 2019 Pages 1–12

Psychodynamic Therapists' Rating of the Most Important Technical Guidelines to Follow When Interpreting Defenses In-Session
Évaluation par les thérapeutes psychodynamiques des lignes directrices techniques les plus importantes à suivre pour l'interprétation des mécanismes de défense en cours de séance

Maneet Bhatia
Jonathan Petraglia
McGill University
Yves de Roten
University of Lausanne
Martin Drapeau
McGill University

ABSTRACT

In this study, we attempted to gain an understanding of the attitudes of practicing psychodynamic therapists on the importance of clinical principles regarding the interpretation of defenses in-session. We asked 140 psychodynamic psychotherapists to complete a survey to determine their level of agreement with and ranking of these clinical principles. Results of the survey indicated that therapists strongly agreed with the importance of the clinical principles. When examining therapists' ranking of the principles three groups emerged (high, middle, and low). Clinical implications of these findings and directions for future research are explored.

RÉSUMÉ

Dans le cadre de cette étude, nous tentons d'améliorer notre compréhension des attitudes des thérapeutes psychodynamiques en exercice en ce qui concerne l'importance des principes cliniques relatifs à l'interprétation des mécanismes de défense en cours de séance. Nous avons demandé à 140 psychothérapeutes utilisant l'approche psychodynamique de répondre à un sondage visant à déterminer leur degré d'assentiment et leur évaluation à l'égard de ces principes cliniques. Selon les résultats du sondage, les thérapeutes reconnaissent clairement l'importance des principes cliniques. En examinant les cotes accordées aux principes par les thérapeutes, on a pu dégager trois grands groupes (haut, moyen et faible). L'article explore les implications cliniques de ces observations et les voies qu'elles tracent pour la recherche à venir.

Defense mechanisms are considered a prominent theoretical and clinical construct within psychodynamic psychotherapy (Etchegoyen, 2005). Along with

transference interpretations, the interpretation of defenses is the key therapeutic intervention that may distinguish psychodynamic therapy from other therapies (Shedler, 2010). Despite the theoretical and empirical importance of this construct, little research has been conducted on the techniques used by therapists to interpret defenses. In the last decade, only two studies have been conducted to identify and then summarize principles that clinicians should consider when working with a patient's defenses (Olson, Perry, Janzen, Petraglia, & Presniak, 2011; Petraglia, Bhatia, & Drapeau, 2017).

Olson et al. (2011) aimed to identify recommendations related to patient defenses that psychotherapy researchers could eventually test. They reviewed 15 works and identified a total of 74 themes related to the interpretation of defenses in psychotherapy (e.g., "Interpreting too frequently diminishes the emotional impact of interpretation"; "Interpretations should raise some anxiety but not so much that the patient becomes much more defensive"; "A strong working alliance will facilitate the effect of interpretations on making ego-syntonic resistance become ego-dystonic").

The second study by Petraglia et al. (2017) focused exclusively on how therapists should interpret the patient's defenses in session. Petraglia et al. reviewed 29 textbooks, 49 empirical studies, and 19 theoretical articles. From this, they identified a total of 10 principles or guidelines (see Table 1).

Both these studies have contributed to research in this area by identifying key themes related to defenses. However, important limitations remain in that the importance of these themes in explaining psychotherapy processes and outcomes remains mostly unknown. Furthermore, within the psychodynamic community there are very few studies that have examined clinicians' views and attitudes about recommendations related to how defenses should be handled in session (for exceptions, see Bhatia, 2014; Langs, 1973; Wogan & Norcross, 1985).

This study focused on this latter topic and aimed to build on the works of Petraglia et al. (2017) by having practicing psychodynamic therapists report the extent to which they agree with each of the 10 principles identified by Petraglia et al. More specifically, this study aimed to (a) determine therapists' rating of the clinical principles regarding degree of agreement, and (b) determine therapists' ranking of the clinical principles from most important to least important.

METHOD

Recruitment

Recruitment involved asking psychotherapists to respond to an online survey. Solicitation of potential participants was conducted over the Internet via e-mails sent to the following institutions and groups, requesting them to forward the survey invitation to their respective listservs: the Society for Psychotherapy Research, the International Psychoanalytic Association, Division 39 of the American Psychological Association, the American Psychoanalytic Association, and the Canadian Psychological Association section on Psychoanalytic and Psychodynamic

Table 1
Clinical Principles on How to Address Patient Defenses In-Session

Defense Principle (Petraglia, Bhatia, & Drapeau, 2017)	Description	Principles for Interpreting Defenses (Petraglia, Bhatia, & Drapeau, 2017)
1. Consider the "depth" of an interpretation.	This principle is based on the idea that when therapists are interpreting patient material, they are working to make the unconscious conscious. Defenses aim to protect patients from deeper, more troubling feelings, thoughts, and anxieties and therapists leave the interpretation of deeper material to later on in therapy and begin by focusing on that patient material which is readily accessible (Fenichel, 1945; Greenson, 1967; Langs, 1973; Wolberg, 1977).	Therapists should systematically move from "surface-to-depth" interpretations.
2. Intervene with clients' most prominent defenses.	This principle suggests that therapists should address the patient's most prominent defenses, as they are most likely to involve repressed material. Scholars view most prominent as being patients' most characterological defenses and those that are "out of character" (Greenson, 1967; Langs, 1973).	Therapists should interpret the patients' most "typical" defenses and characterological defenses. Therapists should interpret the patients' most "atypical" and "out of character" defenses.
3. Interpretations should begin with defenses used as resistance.	This principle forms the basis of psychodynamic theory suggesting that that any action the patient exhibits that impedes the therapeutic process should be addressed before specific patient material is addressed (Gill & Hoffman, 1982; Gray, 1994; Greenson, 1967; Kaechele & Thomă, 1994; Langs, 1973; Reid, 1980; Weiner & Bornstein, 2009; Wolberg 1977).	Therapists should first interpret defenses used as resistance by the patient.
4. Attend to defenses used both inside and outside of the therapeutic hour.	This principle indicates that therapists need to focus on external stressors occurring in the patient's life outside therapy (including defensive behaviours) in-session as they will impact the course of therapy (Vaillant, 1993). Other scholars (e.g., Gray, 1994) contend that the defensive behaviour occurring within the therapeutic relationship are the only defenses that therapists should focus their interpretive activity on.	Therapists should interpret defenses used inside the therapeutic hour. Therapists should interpret defenses used outside the therapeutic hour.
5. Consider the timing of interventions.	This principle is based on the idea that therapists need always to be mindful of when during the course of the therapy session (e.g., the timing of intervention during the therapeutic hour) and in treatment overall (e.g., phase of therapy) to intervene with patient defenses (Langs, 1973; Reid, 1980).	Therapists should keep defense interpretations for the middle phase of therapy (not the beginning or end). Therapists should interpret defenses during the beginning of the therapeutic hour.

(continued on page 4)

Defense Principle (Petraglia, Bhatia, & Drapeau, 2017)	Description	Principles for Interpreting Defenses (Petraglia, Bhatia, & Drapeau, 2017)
6. Consider the Affect Associated with the Defense when Appropriate.	This principle rests on the idea that the function of all defense mechanisms is to keep painful affects out of awareness. Therefore, when working with defenses, therapists are continually working to uncover the underlying affect patients are defending against (Chessick, 1974).	Therapists should understand the affect associated with the defense when making defense interpretations.
7. Consider the Degree of Emotional "Activation" Associated with the Defense.	This principle suggests that in some cases, patients will present defenses in an emotionally charged or "hot" manner. Some scholars argue that in these moments interpretations are ineffective due to the amount of emotionality the patient is experiencing (McWilliams, 1994). On the other hand, if defenses are exhibited in an emotionally detached or "cold" manner, interpretations will also be ineffective because patients lack enough anxiety for the interpretations to be useful for change (Lowenstein, 1951).	Therapists should interpret a defense when the patient uses it in an emotionally charged or "hot" manner. Therapists should *not* interpret a defense when a patient uses it in an emotionally charged and/or "hot" manner. Therapists should interpret a defense when a patient uses it in an emotionally "cold" manner. Therapists should *not* interpret a defense when a patient uses it in an emotionally "cold" manner.
8. Avoid using Technical Language in Interpretations.	This principle suggests that therapists should not use excessively technical language and psychological jargon when articulating defense interpretations to their patients as it can have an adverse impact on the therapeutic process and outcome (Langs, 1973).	Therapists should avoid using technical language in defense interpretations.
9. Balance between Supportive and Interpretive Interventions.	This principle reminds therapists that interpreting defenses are not the only important technique therapists should use during treatment and that therapists need to provide supportive techniques that interpret feelings and situations especially when patients suffer greater psychological distress (McWilliams, 1994).	Therapists should balance between supportive and interpretive techniques when working with defenses.
10. Accurately Identify Defense Mechanisms used by Clients.	This principle indicates that therapists need to be accurate when interpreting patient defenses. Accurate interpretations are defined as therapists being able to name the defense the patient is using correctly (e.g., identifying rationalization when in fact, the patient is rationalizing), understand the purpose of the defense use and communicate this to the patient (Junod, de Roten, Martinez, Drapeau, & Despland, 2005; Petraglia, Perry, Janzen, & Olsen, 2009).	Therapists should accurately identify the defenses a patient uses in-session.

Psychology. Social media was used to solicit participation as well. For example, an invitation to the survey was posted on two Facebook pages: Affect Phobia Therapy and the Dynamic Experiential Therapy. As well, the Contemporary Psychodynamic Group on LinkedIn posted an email invitation to the survey.

The survey invitation informed potential participants of the purpose and duration of the study (approximately 10–15 minutes) and that ethical approval had been obtained for the study. No compensation was offered, and there were no inclusion criteria beyond being a practicing psychodynamic psychotherapist. Participants were then explicitly asked to provide informed consent by clicking on a link that directed them to the online survey.

Participants

In total, 162 individuals consented to participate in this study. However, 22 participants were removed from the study because of incomplete data. Therefore, data analysis was conducted on the remaining 140 participants. There were three parts to the study. While 140 participants completed Part I and Part II of the survey, 112 completed the entire survey. In the study, 53.6% of the 140 participants were male (n = 75), 45.0% were female (n = 63), and 2 participants did not specify their gender. Data regarding the participants' type of practicing license, highest degree obtained, and years of experience as a clinician can be found in Table 2.

Table 2
Demographic Information

Variable	*N*	*%*	*Variable*	*N*	*%*
Gender			**Highest Degree**		
Male	75	53.6	Ed.D.	4	2.9
Female	63	45.0	D.Ps/Psy.D.	17	12.1
Age			Masters	44	31.4
<30	10	7.1	M.D.	10	7.1
30-35	16	11.4	Ph.D.	62	44.3
36-40	9	6.4	Did Not Report	3	2.1
41-45	16	11.4	**Years Practicing**		
46-50	14	10.0	<5	15	10.7
51-55	15	10.7	5-10	29	20.7
56-60	21	15.0	11-15	19	13.6
61-65	12	8.6	16-20	18	12.9
65+	27	19.3	21-25	15	10.7
License			26-30	12	8.6
Counsellor	20	14.3	31+	31	22.1
Psychiatrist	11	7.9	Did Not Report	1	0.7
Psychologist	79	56.4			
Social Worker	8	5.7			
Non-licensed	9	6.4			
Other	13	9.3			

The Survey

The survey was designed to ask participants to report the degree to which they agreed or disagreed with the principles outlined in Table 1. The survey was piloted with 10 practicing psychodynamic therapists, and their feedback was solicited with an open-ended section for comments. Some of the 10 principles outlined by Petraglia et al. (2017) contained multiple elements and were subdivided into distinct statements to capture these different elements. For example, principle 4 indicates that therapists should "attend to defenses used both inside and outside of the therapeutic hour." In the survey, this principle was divided into two statements: therapists should interpret defenses used inside the therapeutic hour, and therapists should interpret defenses used outside the therapeutic hour (see Table 1 for a full breakdown of the principles and how they were utilized in this study).

Part I of the survey asked participants demographic questions (see Table 2). Part II of the survey asked respondents to rate 16 statements on a Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) to determine their level of agreement with the clinical principles. Part III asked participants to rank each statement from 1 (*most important*) to 16 (*least important*).

Data Analysis

Descriptive statistics (means and modes) for both the Likert scale ratings of the principles from *strongly disagree* to *strongly agree* and the rankings of the principles from *most important* to *least important* were examined.

RESULTS

Degree of Agreement and Disagreement with Clinical Principles

The survey asked participants to rate 16 statements using a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Detailed results can be found in Table 3. The data indicated that "therapists should avoid using technical language in defense interpretations" (M = 4.5, SD = 0.8) had the highest mean rating and "therapists should not interpret a defense when a patient uses it in an emotionally 'cold' manner" had the lowest mean rating (M = 2.7, SD = 0.9).

Importance Ranking of Clinical Principles

The survey also asked participants to rank the 16 statements from *most important* to *least important*. Descriptive data are summarized in Table 3. The statements were ordered from *most important* to *least important* based on their mean rank ratings. Table 3 also reports the mode ranking for each item. The modes suggest that the principles could tentatively be divided into three groups: principles ranked high (i.e., principles 1–7), principles ranked in the middle (i.e., principles 8–12), and principles with the lowest rank (i.e., principles 13–16).

Seven principles were ranked high, with the highest ranked (mean rank) principle statement being "therapists should systematically move from 'surface to depth'

Table 3
Rating and Ranking of the Clinical Principles

Principles for Interpreting Defenses	Mean Rating (SD)	Mean Rank (SD)	Mode Rank	Mode Rating
1. Therapists should systematically move from "surface-to-depth" interpretations when working with patient defenses.	4.1 (0.9)	4.1 (3.4)	1	4
2. Therapist should interpret the patients' most "typical" defenses and characterological defenses.	4.1 (0.8)	4.8 (2.9)	3	4
3. Therapists should first interpret defenses used as resistance by the patient.	3.8 (1.1)	5.0 (3.0)	4	4
4. Therapists should interpret defenses used inside the therapeutic hour.	4.3 (0.7)	5.0 (2.7)	4	5
5. Therapists should understand the affect associated with the defense when making defense interpretations.	4.0 (0.9)	5.7 (3.3)	2	4
6. Therapists should balance between supportive and interpretive techniques when working with defenses.	4.4 (0.7)	6.2 (4.0)	1	5
7. Therapists should avoid using technical language in defense interpretations.	4.5 (0.8)	6.3 (3.8)	1	5
8. Therapists should accurately identify the defenses a patient uses in-session.	4.0 (0.8)	6.9 (3.6)	12	4
9. Therapists should interpret defenses used outside the therapeutic hour.	3.9 (0.6)	8.4 (2.7)	9	4
10. Therapists should interpret the patients' most "atypical" and "out of character" defenses.	3.1 (0.9)	9.7 (3.9)	10	3
11. Therapists should keep defense interpretations for the middle phase of therapy (not the beginning or end).	2.7 (1.2)	10.8 (3.6)	11	2
12.Therapists should interpret defenses during the beginning of the therapeutic hour.	3.0 (1.0)	10.8 (3.4)	12	3
13. Therapists should interpret a defense when the patient uses it in an emotionally charged or "hot" manner.	3.2 (0.9)	11.6 (3.0)	13	3
14. Therapist should interpret a defense when a patient uses it in an emotionally "cold" manner.	2.9 (1.0)	12.4 (2.2)	13	3
15. Therapists should *not* interpret a defense when a patient uses it in an emotionally charged and/or "hot" manner.	3.3 (0.9)	13.7 (2.4)	15	3
16. Therapists should *not* interpret a defense when a patient uses it in an emotionally "cold" manner.	2.7 (0.9)	14.6 (1.8)	16	2

interpretations when working with patient defenses" (see Table 3). Five principles were ranked in the middle including the principle that "therapists should accurately identify the defenses a patient uses in-session." Four principle statements were ranked as least important, including "therapists should interpret a defense when the patient uses it in an emotionally charged or 'hot' manner," "therapists should interpret a defense when a patient uses it in an emotionally 'cold' manner," "therapists should not interpret a defense when a patient uses it in an emotionally charged and/or 'hot manner," and "therapists should not interpret a defense when a patient uses it in an emotionally 'cold' manner."

DISCUSSION

The results of this study indicate that regarding participants' degree of agreement with the clinical principles identified by Petraglia et al. (2017), there was, on average, a high level of agreement and a lack of disagreement (e.g., no mean ratings of 1 or 2). To overcome the potential lack of variation and the positive skewness of the responses concerning the level of agreement, rankings of the principles from *most important* to *least important* were collected. Examining the mode rankings of the principles led to organizing the therapist rankings of the principles into three groups (i.e., high, middle, and low).

The highest ranked principle was "therapists should systematically move from 'surface to depth' interpretations when working with patient defenses." This principle, which is known as the "surface-to-depth" rule (Fenichel, 1945), is based on the position that therapist interpretations are aimed at making the unconscious conscious. Therefore, patient material needs to be addressed with this goal, but in such a manner that more readily conscious and surface material is explored before moving towards more difficult, unconscious, and deeper patient material as therapy progresses (Fenichel, 1945; Greenson, 1967; Langs, 1973; Wolberg, 1977).

Regarding therapist technique, moving from "surface-to-depth" is a well-established technical guideline that is promoted by psychodynamic theorists and therapists (see Olson et al., 2011; Wachtel, 2011). As such, there is a clear connection between the theoretical and clinical importance of this principle based on therapist rankings in our study. Furthermore, when examining the seven high ranked principles, they are all rated as equally important or valued. This is important clinically as each of these principles is a necessary component of what constitutes a good or sound defense interpretation. Clinically, working from the perspective that any one principle alone is sufficient for a sound defense interpretation is not recommended, and clinicians recognize that all principles are needed together to communicate sound interpretations to patients effectively.

An area of research on therapist interpretation of defenses that has garnered considerable attention is therapist accuracy (e.g., Crits-Christoph, Cooper, & Luborsky, 1988; Junod, de Roten, Martinez, Drapeau, & Despland, 2005; Petraglia, Janzen, Perry, & Olson, 2009; Silberschatz, Fretter, & Curtis, 1986). Many researchers and clinicians assume that an important component of a valid

interpretation is for that interpretation to be accurate. Therefore, if a patient is using the defense of repression, the therapist should be able to accurately identify the repression, understand its purpose and function, and relay this information to the patient.

But in our study this principle was not one of the highest ranked principles in the analyses (see Table 3). One possible explanation for this seeming disconnect between the research on therapist accuracy and clinicians' rankings in our study is that clinicians may hold the viewpoint that therapist accuracy must be considered within the context of other clinical principles to be effective. This is consistent with the gaps in the current literature on the concept of therapist accuracy, as some researchers have argued that therapist accuracy alone is not a sufficient criterion when addressing patient defenses (e.g., Junod et al., 2005; Petraglia et al., 2009), and that therapist accuracy needs to be measured along with other elements of therapist interpretation including timing, language, and depth (Petraglia et al., 2017).

It is important to note that when examining the groupings for the rankings of the clinical principles, there is little variation between the middle (i.e., 8-12) and low (i.e., 13-16) groups, particularly when examining the mode rankings. However, the differentiation between the middle and low groups was created based on the finding that the lowest four statements represented components of one single principle outlined by Petraglia and colleagues (2017) (see principle 7 in Table 1). Specifically, this principle suggests that "therapists should consider the degree of emotional 'activation' associated with the defense" when making an interpretation. For this study, it was necessary to divide this principle into different components and determine what practicing therapists considered most or least important about this principle (e.g., interpreting "hot" or "cold" defense use). This principle is based on the notion that therapists need to pay attention to and explore the emotional intensity associated with patient defense use.

Different psychodynamic theorists have argued that the emotional activation, or lack thereof, that the patient exhibits can influence the therapeutic impact of an interpretation. For example, McWilliams (1994) suggested that when patients exhibit defenses when they are emotionally charged or "hot," they are less likely to integrate interpretations made by therapists. She adds that in those emotionally-charged moments, the situation could escalate, and this could have a destructive impact on patient functioning and therapeutic process. Similarly, Loewenstein (1951) indicated that interpreting defenses when they are too emotionally activated would be of little use as patients would not be responsive to interpretations in those moments. Consequently, according to these authors, therapists should wait until the patient is less emotional before addressing the defense; however, our findings suggest that clinicians have a different perspective and do not endorse that principle.

A fundamental element of psychodynamic therapy is addressing patient resistance to therapy. Theorists and clinicians have long held the view that patient resistance must be handled before any specific patient material; otherwise, the

therapeutic process could be compromised (Gray, 1994; Kaechele & Thomă, 1994; Weiner & Bornstein, 2009).

Another high ranked statement was that "therapists should interpret defenses patients use inside the therapeutic hour." This statement was a component of the principle that the therapist should "attend to defenses used both inside and outside therapy" as outlined by Gray (1994) and Vaillant (1993). In our study, therapists ranked interpreting defenses used inside therapy as more important than those outside therapy.

Gray (1994) asserted that therapists should only attend to patient material exhibited within the context of the therapist-patient relationship, and that patient material outside of therapy was not a priority for a therapist. Conversely, the statement "therapists should interpret defenses used outside the therapeutic hour" was ranked as less important (middle group), which suggests that clinicians in our study were less supportive of Vaillant's (1993) view that clinicians should address external stressors patients are facing outside therapy before tackling stressors that take place within therapy. Again, the rankings do not suggest that therapists in our study only focus on defenses inside therapy (e.g., Gray, 1994) or that they do not see importance in considering defenses used outside therapy (Vaillant, 1993), but rather that they deemed it more important to focus on patient defenses used inside the therapeutic hour.

Regarding therapeutic focus, Greenson (1967) and Langs (1973) indicated that when working with defenses, therapists need to "intervene on the patients' most prominent defenses." This principle was separated into two statements that captured the positions of Greenson and Langs, which is that therapists need to intervene with patients' characterological and typical defenses, as well as those defenses that are atypical or out of character. In our study, therapists ranked focusing on patients' most typical and characterological defenses as more important (second highest mean ranking) than those defenses that are atypical and out of character (ranked in the middle and tenth in mean ranking). It would be important to examine what constitutes patients' most typical and atypical defenses empirically and to gather a clearer understanding of which of these types of defenses therapists are tackling in-session.

This study has several limitations, the first of which is the sample size. Given the nature of the survey (i.e., online and third-party invitations), we were unable to ascertain how many practicing psychodynamic therapists received the e-mail invitation to complete the survey. As well, we could neither determine from which professional organizations nor geographical area participants who completed the survey originated from. Finally, given the size of the sample, our study did not compare responses of participants who identified themselves as practicing specific theoretical models more than others (e.g., a short-term psychodynamic therapist versus a psychoanalyst).

Future research could examine the similarities and differences between varying theoretical orientations (e.g., short-term dynamic therapy, psychoanalysis, psychodynamic). Also, it is possible that therapist factors including theoretical

orientation, therapeutic style, personality, and patient populations that they treat may have also contributed to the variability in the results. Future studies examining therapists' attitudes should explore these specific factors as a variable of comparison.

Overall, psychodynamic therapists in this study expressed strong levels of agreement and support for the clinical importance of the principles on how to interpret defenses in-session as outlined by Petraglia et al. (2017). The descriptive analyses found that clinicians highly ranked seven principles (e.g., the "surface-to-depth" principle; therapists avoiding technical language when interpreting defenses) while elements of one principle made up the lowest ranked principles (e.g., emotional activation). Future research on the importance of these principles to the therapeutic process and outcome are needed.

References

Bhatia, M. (2014). *Techniques in psychodynamic therapy: A clinical and empirical investigation of defense interpretations* (Doctoral dissertation). Available from http://digitool.library.mcgill.ca/R/?func=dbin-jump-full&object_id=126924

Chessik, R. D. (1974). *The technique and practice of intensive psychotherapy*. New York, NY: J. Aronson.

Crits-Christoph, P., Cooper, A., & Luborsky, L. (1988). The accuracy of therapists' interpretations and the outcome of dynamic psychotherapy. *Journal of Consulting and Clinical Psychology, 56*(4), 490–495. https://doi.org/10.1037/0022-006X.56.4.490

Etchegoyen, R. H. (2005). *Fundamentals of psychoanalytic technique.* London, UK: Karnac.

Fenichel, O. (1945). *The psychoanalytic theory of neurosis.* New York, NY: Norton.

Gill, M. M., & Hoffman, I. Z. (1982). Analysis of transference: II Studies of nine audio recorded psychoanalytic sessions. *Psychological Issues, 54,* 1–236. https://doi.org/10.1080/21674086.1945.11925606

Gray, P. (1994). *The ego and the analysis of defense.* Lanham, MD: Jason Aronson. https://doi.org/10.1080/07430179408405614

Greenson, R. R. (1967). *The technique and practice of psychoanalysis.* New York, NY: International Universities Press.

Junod, O., de Roten, Y., Martinez, E., Drapeau, M., & Despland, J. N. (2005). How to address patients' defenses: A pilot study of the accuracy of defence interpretation and alliance. *Psychology and Psychotherapy: Theory, Research, and Practice, 78,* 419–430. https://doi.org/10.1348/147608305X41317

Kaechele, H., & Thomă, H. (1994). *Psychoanalytic practice.* Lanham, MA : Aronson.

Langs, R. (1973). *The technique of psychoanalytic psychotherapy: Vol.1.* New York, NY: Aronson.

Loewenstein, R. M. (1951). The problem of interpretation. *Psychoanalytic Quarterly, 20,* 1–14. https://doi.org/10.1080/21674086.1951.11925827

McWilliams, N. (1994). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process.* New York, NY: Guilford Press.

Olson, T. R., Perry, J. C., Janzen, J. I., Petraglia, J., & Presniak, M. D. (2011). Addressing and interpreting defense mechanisms in psychotherapy: General considerations. *Psychiatry: Interpersonal and Biological Processes, 74*(2), 142–165. https://doi.org/10.1521/psyc.2011.74.2.142

Petraglia, J., Bhatia, M., & Drapeau, M. (2017). Ten principles to guide psychodynamic technique with defense mechanisms: An examination of theory, research, and clinical implications. *Journal of Psychology and Psychotherapy, 7*(1), https://doi.org/10.4172/2161-0487.1000288

Petraglia, J., Janzen, J. I., Perry, J. C., & Olson, T. R. (2009, June). *The relationship between therapist interpretation accuracy and in-session change in patients' defensive functioning*. Paper presented at the Canadian chapter of the Society for Psychotherapy Research (SPR), Montreal, Canada.

Reid, W. H. (1980). *Basic intensive psychotherapy.* New York, NY: Brunner Mazel.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 65,* 98–109. https://doi.org/10.1037/a0018378

Silberschatz, G., Fretter, P. B., & Curtis, J. T. (1986). How do interpretations influence the process of psychotherapy? *Journal of Consulting and Clinical Psychology, 5,* 646–652. https://doi.org/10.1037/0022-006X.54.5.646

Vaillant, G. E. (1993). *The wisdom of the ego.* Cambridge, MA: Harvard University Press.

Wachtel, P. L. (2011). *Therapeutic communication: Knowing what to say when.* New York, NY: Guilford Press.

Weiner, I. B., & Bornstein, R. F. (2009). *Principles of psychotherapy: Promoting evidence-based psychodynamic practice* (3rd ed.). Hoboken, NJ: Wiley.

Wogan, M., & Norcross, J. C. (1985). Dimensions of therapeutic skills and techniques: Empirical identification, therapist correlates, and predictive utility. *Psychotherapy: Theory, Research, Practice, Training, 22*(1), 63–74. https://doi.org/10.1037/h0088528

Wolberg, L. R. (1977). *The technique of psychotherapy* (3rd ed.). New York, NY: Grune & Stratton.

About the Authors

Maneet Bhatia is a psychologist in private practice in Toronto.

Jonathan Petraglia is a psychologist in private practice in Montreal and a lecturer at McGill University.

Yves de Roten is a senior researcher and lecturer at the University of Lausanne in Switzerland.

Martin Drapeau is an associate professor of counselling psychology and psychiatry at McGill University and clinician at Medipsy Psychological Services in Montreal.

Address correspondence to Dr. Martin Drapeau, ECP-McGill University, 3700 McTavish, Montreal, Quebec, H3A 1Y2. Email: martin.drapeau@mcgill.ca.