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A QUESTIONNAIRE/INTERVIEW COMPARISON OF SATISFACTION WITH TRAINING ANALYSIS TO SATISFACTION WITH ANALYSIS BY A NONTRAINING ANALYST: *Implications for Training Analysis*

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The training analysis concept assumes that training analysts (TAs) can more effectively treat analyst-patients than non-TAs can. This study tests this assumption empirically by comparing satisfaction with analytic treatment by a TA with that by a non-TA in the *same* analyst-patients. Extensive literature critical of training analysis led us to hypothesize that analysis of analyst-patients by TAs would actually be *less* satisfactory than personal analysis by a non-TA. The validity of the analyst's questionnaire ratings of satisfaction was supported by independent ratings

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by 2 senior analysts of transcribed individual interviews of participants. It correlated significantly with participants' questionnaire ratings of satisfaction. Theoretically, treatment by TAs should be *more* satisfactory than treatment by non-TAs. This study, however, found no significant difference between satisfaction with analytic treatment by a TA compared with treatment by a non-TA. This same lack of difference in satisfaction had been reported in a previous unrelated clinical interview study. In addition, there was no difference between TAs and non-TAs in the proportion of analysts who reached a mutually agreed termination and no difference in treatment duration. Because *no* study has reported that treatment by a TA is *more* satisfactory than treatment by a non-TA, the burden of proof falls on those psychoanalytic organizations who utilize a TA conception to demonstrate that treatment by a TA is more satisfactory.

Keywords: training analysis, nontraining analysis, satisfaction, questionnaire

"The training analysis," writes Wallerstein (2010), "has been the central problematic of our entire institutionalized educational structure" (p. 903). A variety of difficulties and problems have been identified.[1]

Lewin and Ross (1960) termed a basic problem with training analysis as "syncretism": "the two models, 'psychoanalytic patient' and 'student' complement, alternate with and oppose each other. . . . The institutes are unavoidably trying to exert two effects on the student: to 'educate' him and to 'cure' or 'change him'" (pp. 46–47). Another critic, Cremerius (1990), noted that "when the negative transference has not been satisfactorily worked through, analysands will introject an unrealistic image of the training analyst which will serve as the kernel both of a new super ego formation and for the organization of a pathological-narcissistic identification" (p.1074). Kernberg (2000), a repeated, preeminent critic, identified "a tendency to infantilize psychoanalytic candidates, a persisting trend toward isolation from the scientific community, a lack of consistent concern for the total educational experience of candidates, authoritarian management and a denial of the effects of external, social reality." (p. 97). Kernberg added, "The inhibition of the creativity of psychoanalytic candidates . . . is one of the major problems of present-day psychoanalytic education" (p. 116). None of these critics compared the difficulties with training analysis with the problematic aspects of analysis by non-training analysts (non-TAs).

One clinical interview study (Tessman, 2003) did report such a comparison. This study explored "how their own analyst became memorable in ways that have made themselves felt over postanalytic time" (p. 2). There were 34 analyst participants, most from the Boston Psychoanalytic Society and Institute; eight declined to participate. Of the 34 participants, 28 had two or more analyses; they presented narratives about 64 analyses. The taped interviews lasted between 2 and 8 hr per participant, and included both spontaneous narrative and

[1] Arlow, 1972; Balint, 1954; Bernfeld, 1962; Bezahler, 2008; Bibring, 1954; Bruzzone, Casaula, Jimenez, & Jordan, 1985; Casement, 2005; Cremerius, 1990; Desmond, 2004; Friedman, 1974; Greenacre, 1966; Hinshelwood, 1985; Kächele & Thomä, 2000; Kairys, 1964; Kernberg, 1986, 2000, 2010; Kirsner, 2009; Lewin & Ross, 1960; Lipton, 1988; Lothane, 2007; Masur, 1998; F. McLaughlin, 1967; J. T. McLaughlin, 1973; Meyer, 2007; Nacht, 1954; Nacht, Lebovichi, & Diatkine, 1961; Orgel, 1990; Pfeffer, 1974; Reeder, 2004; Schecter, 1979; Stelzer, 1986; Szasz, 1960; Thomä, 1993; Thomä & Kächele, 1999; Thompson, 1958; Van der Sterren, & Seidenberg, 1975; Wallerstein, 1993, 2010; Weigert, 1955; Wilson, 2010.

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responses to 13 lines of open-ended questions. Seventy percent were deeply or moderately satisfied; 23% were dissatisfied. The category of highly dissatisfied accounts for 22% of all analyses and 23% of training analyses, suggesting no difference in satisfaction with training analysis compared with analysis by a non-TA. Tessman concluded that "nothing suggests that non-TA analyses were less satisfactory per se" (L. Tessman, personal communication, September 12, 2011).

The imposing list of critics agree that training analysis suffers from a wide variety of problems and flaws, which led to our first hypothesis—that training analyses will be *less* satisfactory than nontraining analyses not burdened by these difficulties: Analysts who had *both* a TA and a personal analysis by a non-TA would be *less* satisfied with their TA than they were with analysis by a non-TA. Although empirical studies stated that analysts report having been generally satisfied with TAs, we know of no empirical study that compared satisfaction with TA to satisfaction with non-TA. This comparison has important implications for the rationale for training analysis.

Method

This is a mixed-method quantitative and qualitative study utilizing both an anonymous questionnaire and an unstructured individual clinical interview. The variable "satisfaction" was selected for study because of its use as the central variable of prior empirical questionnaire studies of TA. In addition, Tessman's (2003) comprehensive interview study of training analysis also utilized "satisfaction." For his own questionnaire study, Bush concluded that "satisfaction is probably the most valid [measure]" (M. Bush, personal communication, November 10, 2011).

The questionnaire, presented in the Appendix, was limited to two pages to enhance the usual low response rate reported in prior surveys of analysts; we expected that a longer questionnaire would reduce the response rate further. The questionnaire focused on the graduate analyst's report of satisfaction with both training analysis and analysis by a non-TA, if relevant. Satisfaction was rated on a 5-point scale: 5 = *very satisfied*; 4 = *moderately satisfied*; 3 = *partially satisfied/partially dissatisfied*; 2 = *moderately dissatisfied*; and 1 = *very dissatisfied*.

The target population of American Psychoanalytic Association (APsaA) graduate analysts selected for study were those who had graduated between 1993 and 2003. This range was selected so that they all would be relatively recent graduates, but it allowed for a 5-year postgraduation period to engage in additional analytic treatment. It was not possible to mail directly to members because the year of graduation could not be determined from the membership roster. At the author's (J. S.) request, APsaA institutes were asked to send lists of names of graduates from 1993 and 2003 to our research assistant, pledged to confidentiality, who e-mailed the questionnaire to the graduates. Respondents e-mailed the questionnaire back to the research assistant, who removed the respondent's name and e-mail address from the questionnaire, assigned a code number, and forwarded the anonymized questionnaire to the author for scoring. Only respondents who requested an individual interview were identified by name to the author.

This article illustrates the process of assessment of the validity of the questionnaire ratings of satisfaction by comparison of questionnaire ratings with ratings of satisfaction based on transcriptions of individual interviews of those volunteer respondents. The interviews were not as focused on the respondent's satisfaction with analysis as the questionnaire, but on a broad range of feelings and experiences in relation to the analysis.

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Because the interview material is different from, and not simply redundant to, the questionnaire rating, it seems appropriate to use the interview material to validate the questionnaire rating of satisfaction. Interviews were designed to obtain information about the emotional aspects of respondents' analyses, which were not explored in the brief questionnaire. Interviews were voluntary, exploratory, and relatively unstructured; they prioritized developing emotional contact with the interviewee to provide more illumination of emotionally charged views of their training analysis rather than the cataloguing possible in a structured interview. Interviewees were regularly asked how they had selected their analyst, how they felt about the "fit" with their analyst, and about post-termination contact issues. All transcribed interviews by the author have been reviewed and approved by the interviewees, who also had access to this entire article.

The order of transcribed interviews was scrambled and sent separately to two senior psychoanalyst raters (HK and FP), who rated them individually and blindly for satisfaction using the scale of questionnaire ratings of 5 to 1, based on brief descriptive anchor points from the author about each questionnaire level.

Results

The current article presents the results of analyses of the *overall data* for the *total population* of respondents in this study. (A second article, already published, Schachter, Gorman, Pfäfflin, & Kächele, 2013, presented analyses based on a *subset* of 13 subjects who had treatment by a TA and a non-TA and also participated in individual interviews.)

Pilot Study

A pilot study was conducted at a non-International Psychoanalytic Association institute. Questionnaires were mailed to those who had graduated between 1992 and 2002 who were asked to complete the questionnaire and mail it, unsigned and with no return address, to the author. In this group, 32 out of 65 analysts responded, providing a 48% response rate. Seventy-two percent reported being either very satisfied or moderately satisfied with their training analysis.

Main Study

Questionnaires were distributed to 409 analysts at 17 participating APsaA institutes who had graduated during between 1993 and 2003. Ninety questionnaires were returned, resulting in a 22% response rate, and 59 of the 90 respondents requested an interview. To date, 48 have been interviewed. For all 82 training analysis respondents who supplied complete data, the mean satisfaction rating was 4.02; 73% were "very" or "moderately" satisfied. The initial hypothesis was *not* supported for the 31 analysts who had *both* a training analysis and a personal analysis *by a non-TA*. Ratings of satisfaction averaged 3.89 for training analyses and 3.75 for non-TA analyses; the difference was not significant, $t(27) = 0.53$, $p = .73$, point-biserial $r = .10$, $d = .20$. A rating of either "very" or "moderately" satisfied was made for 68% of the training analyses, and for 61% of the non-TA analyses.

Additional analyses indicated that there was no difference between TAs and non-TAs in the proportion that reached a mutually agreed termination or in the duration of analysis.

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Additional Findings

The following additional findings were found.

1. Patient perceived patient–analyst "fit" (Question #7: "How satisfied were you with the working relationship, the fit with your training analyst?") correlated highly positively with satisfaction for training analysis, $r = .81$, $p < .0001$, and for personal analysis, $r = .83$, $p < .0001$.
2. Fifty-two of the 82 respondents with complete TA data (63%) had two analyses. Second analyses, whether training or personal, were rated as more satisfactory than prior analyses, $t(39) = -2.541$, $p < .015$, point-biserial $r = .37$, $d = .80$.
3. Degree of satisfaction with treatment was positively associated with the degree with which the graduate analyst now works similarly to the way his or her analyst had worked with him/her both for training analysis, $r = .60$ $p < .0001$, and personal analysis, $r = .59$ $p < .00015$.
4. Length of treatment was positively correlated with satisfaction for personal analysis, $r = .35$ $p < .021$, but not for training analysis.
5. Ratings of either "very dissatisfied" or "moderately dissatisfied" were recoded as unsatisfactory; this designation applied to 15% of training analyses and 12% of personal analyses.

The Relationship of Questionnaire Ratings to Transcribed Recordings

Forty-eight 1-hr individual interviews were recorded and transcribed. Each of two senior analysts separately and blindly rated each transcribed interview for degree of interviewee's satisfaction with their training analysis using the same 5-point scale used in the questionnaire. (Thirteen interviews were of analysts who had both had analyses by TAs and non-TAs and were analyzed in the previously published article; interview ratings correlated significantly with questionnaire ratings of satisfaction.) The remaining 35 interviews comprised 18 (51%) who gave the highest positive questionnaire rating of their training analysis, that is, "very satisfied (#5)"; 10 (29%) who rated their training analysis "moderately satisfied (#4)"; five (14%) who rated their training analysis "partially satisfied/partially dissatisfied (#3)"; one reported "moderately dissatisfied (#2)," and one reported "very dissatisfied (#1)." Thus, 27 of these 35 interviewed subjects (77%) reported being either very or moderately satisfied with their training analysis, similar to the results for the questionnaire group as a whole. To provide the flavor of these interviews, six brief interview transcriptions were randomly selected by protocol from the 18 subjects whose questionnaire ratings were "very satisfied"; similarly, six of the nine subjects whose ratings were "moderately satisfied" were randomly selected; and all five interviewees whose ratings were "partially satisfied/partially dissatisfied" were selected. However, to limit the length of this article, only the first two transcriptions of each of these three groups are presented here. The sole "moderately dissatisfied" analyst, as well as the one "very dissatisfied" analyst, are also presented. Thus, a total of 19 interviews were selected from the subtotal of 35 for clinical assessment of satisfaction by the two analysts; of these, eight are presented in this article. Recorded interviews about training analysis are presented using fictitious names.

Two Transcribed Recordings With "Very Satisfied (#5)" Interviewee Questionnaire Ratings

Subject #1021. Dr. Porter selected his training analyst by surveying those friends already seeing TAs about available analysts and read some of their publications. He selected Dr. Felix because he thought he was knowledgeable, liked his writing, and a

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friend believed Dr. Felix would be especially good for him.

Dr. Porter has a PhD and was accepted as a research candidate. The letter of acceptance that came from a Dr. Paul, the analyst in charge of the psychoanalytic training program, told him he was to begin his analysis with Dr. Paul and specified that he call to set up an appointment. He had not liked Dr. Paul one bit, and was shocked and astounded by this turn of events. He consulted an institute leader, who assured him that he could select his own analyst and should go ahead and do so. Thereafter, Dr. Porter believed that Dr. Paul really disliked him, and subsequently prevented him from starting classes. His training analyst, Dr. Felix, told him that he thought the grounds for postponing his starting classes were ridiculous, but that Dr. Porter should just hang in there and eventually he would get where he wanted to go.

He had a very good experience with Dr. Felix, a self psychologist, and a caring, fine, thoughtful, smart person who was very much "present" and remembered whatever he had talked about. That was especially important to Dr. Porter because his father had not been "present" but was rather a silent, uncommunicative person. Dr. Porter got a great deal out of the analysis.

Dr. Felix did not speak a lot but made clarifying comments and some interpretations. He tended to be quiet, not chatty or interactive. Dr. Felix's noncritical approach was conducive to increasing his understanding of his narcissistic issues and his grandiosity. However, Dr. Porter indicated he had one complaint: He wished Dr. Felix had been more interactive and had put himself out more. Dr. Porter had been troubled when the analysis was interrupted for 3 months due to his analyst's medical problems. He found this interruption to be a very painful period of time and he felt Dr. Felix should have kept in touch with him more during the hiatus, perhaps by offering some phone sessions. Dr. Porter also criticized Dr. Felix for not directly giving advice about how to handle a difficult situation. His analyst responded that it would not be very psychoanalytic to do so, and when Dr. Porter had gotten angry at that and said, "Who gives a damn about what is psychoanalytic? The purpose of these sessions is for you to help me," Dr. Felix thought about it, decided Dr. Porter was right, and then did give him specific help. When Dr. Porter got turned down for progression the first time, Dr. Felix commented that sometimes the institute gives candidates a hard time, and again reassured him that if he hung in there he would be fine in the long run.

Ratings for this vignette are as follows:
Interviewee's questionnaire rating, #5; Kächele, #5; Pfäfflin, #5.

Subject #1053. Dr. Perry had experienced initial therapy, felt it was not going well, and terminated it. One of her colleagues suggested a consultant who might be expected to refer her to another analyst. She met with Dr. Franklin, a TA, was comfortable with him, and started treatment with him. He made a point of telling her that his wife and daughter were both therapists, and they had taught him quite a lot about women; she felt it was a good sign that he could learn from others. Dr. Franklin helped her to get in touch with her own emotional life, and was skilled at capturing the essence of someone else's difficulties. Sometimes he would sit quietly and listen to her, though he was usually a talker. He encouraged her to confront people directly, sometimes in a playful way. She felt valued by him and did not really become angry with him. At termination, Dr. Franklin commented that he realized she needed to idealize him, so he had left it alone. Before graduation, she ended regular sessions with him, and then met with him occasionally, especially if she was beginning or ending a relationship. Later, she was invited to and

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attended a birthday party for him. Subsequently, a supervisor highlighted a personal issue of hers that her analyst had not raised. She then felt less need to idealize him; she could accept his having missed certain matters with her own emotional life.

Ratings for this vignette are as follows:
Interviewee's questionnaire rating, #5; Kächele, #5; Pfäfflin, #3.

Two Vignettes of "Moderately Satisfied (#4)" Interviewee Questionnaire Rating

Subject #1000. Dr. Warren had been depressed and was treated twice weekly for 2 years. Six months after stopping that treatment, she started a personal analysis with Dr. Clark, knowing that she planned to enter analytic training in about one year, and recognizing that this analysis would become a training analysis. She had little choice of training analysts in her city, and the alternative, to commute to another city, did not seem desirable. She had taken a seminar with Dr. Clark, felt he was a bright, nice enough guy; there was nothing she disliked about him. She recalled one dream from her analysis in which her analyst would not let her enter a college. This dream was interpreted as probably related to her own conflict about being a woman in a man's field. She recollected that she once left the last session before a summer vacation angry, and was pleased at the thought that the analyst would be concerned about her for a whole month!

Dr. Clark was a fairly classical analyst; although not exactly rigid, he was not as flexible as she. There were times when she was extremely angry with him. He once stopped the session 15 min early, but she was halfway across town before she realized it. Another time she was obsessing about what a word meant, and he said, "Does it really matter?" And she said if it mattered to her, it should matter to him.

Later, after a year of saying that she was ready to terminate the analysis, one day he agreed with her. She was astonished and immediately did not want to terminate. Six months later, she did terminate the analysis, and spent those last 6 months grieving about the loss of the analysis. The analysis had helped her become more open and comfortable with herself personally and sexually. Dr. Warren thought of her analyst fondly and found herself remembering some of the things he said. Even now, she said, it was hard for her to say that she loved him, and she began to cry. She mentioned that she had given him her check in the next to last session, so giving him a check would not be the last thing she did with him.

She thought some of this work was accomplished after the analysis ended. Several years after termination, she returned to him for once-a-week treatment for 6 months; when her father died, she used that as an excuse not to pursue further treatment. Although she wanted to go back and have someone analyze her again, she did not think she could afford it.

Ratings for this vignette are as follows:
Interviewee questionnaire rating, #4; Kächele, #4; Pfäfflin, #3.

Subject #1714. When Dr. Black moved from university and medical settings to independent practice, she felt her prior training was not adequate. She wanted to learn how to be more helpful to patients and to do more personal work for herself. She wanted to start personal psychotherapy first, and eventually transition to analysis; she was not ready for psychoanalysis at that time. She saw a male psychoanalyst who had been recommended to her and was fairly prominent in the local analytic group, but she felt that the fit was not right; he wanted her to start four-session-per-week psychoanalysis immediately. She had young children, was unable to afford either the time or the money, and was not yet ready

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emotionally for psychoanalysis. He said he would agree to a reduced schedule if they would use their time to examine her resistance to analysis. She had been very clear about what she wanted, but he did not hear what she was saying. Although, at that point, she was not very assertive, she did not continue to see him.

She obtained other recommendations and saw a woman analyst in once-per-week psychotherapy. It would not have mattered if the analyst was male or female. The analyst's competence was not the issue; both analysts were competent. She needed a therapist who she believed heard her, took her subjective experience into account, and whose responses she could feel, so she would feel connected to the analyst. The woman analyst did not sit with a blank-screen kind of face. It seems as though she made the right decision. Somewhere in her analysis she realized she did want to become an analyst.

Ratings for this interview vignette are as follows:
Interviewee questionnaire rating, #4; Kächele, #4; Pfäfflin, #4.

Two Vignettes of "Partially Satisfied/Partially/Dissatisfied (#3)" Interviewee Questionnaire Rating

Subject #1800. When Dr. Marshall was selecting a training analyst, there were only three training analysts available. One turned her down, so she went to see one of the other training analysts whose office was not far from hers. He was hesitant about seeing her because he had previously treated a family member, but they proceeded and she felt he was emotionally available. They had a good working relationship; he was "good enough." Her analysis was very helpful, but she felt his talk about his own parents' difficulties was intrusive. She imagined switching to another training analyst, and discussed it with her analyst, but never seriously considered doing so. She concluded she would have been better off working things out with him.

Ratings for this interview vignette are as follows:
Interviewee questionnaire rating, #3; Kächele, #4; Pfäfflin, #3.

Subject #1205. Dr. Stuart started once-a-week therapy, but she and the therapist did not have a good fit, so she left after 6 months. Subsequently, she decided she wanted to be analyzed, though at that time she was not interested in becoming a psychoanalyst. She obtained the names of several analysts from an analyst she knew. One did not return her call, but another analyst she felt was kind and emotionally available accepted her after a six-session evaluation. Later, she decided to enter analytic training. Her analyst was a training analyst, so she continued working with him, even though she knew that he felt that individuals with her professional background should not become analysts.

She rated her evaluation of her training analysis as "partially satisfied/partially dissatisfied"; a lot of things were missing. Although it was a good relationship, it was not a good analysis. Although he was real, as a person, and she needed that, he made very few interpretations, perhaps six in the entire analysis. Because she knew Dr. Forrest was not in favor of individuals from her professional background becoming analysts, she stayed away from difficult subjects. Now that she has become a training analyst, she feels that her criticism of her analysis, in retrospect, is valid. Although she had been dissatisfied, she did not consider transferring to another training analyst because it was a small institute and

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she knew all the other training analysts. As Dr. Forrest aged, he appeared to suffer from the dementia that eventually caused his death.

Ratings for this interview vignette are as follows:
Interviewee questionnaire rating, #3; Kächele, #2; Pfäfflin, #3.

One Vignette With "Very Dissatisfied (#1)" Interviewee Questionnaire Rating

Subject # 3025. Dr. Prentice reported such a lousy experience with her first training analyst that, after termination, she had to correct the work with someone else. She had been in training analysis for 8 years, did not know what she was doing with her own patients, did not have an analytic identity, and was not going anywhere. It was an uncomfortable relationship. However, her analyst's Kohutian approach of being supportive and kind made it easier for her to feel comfortable. Initially, she had idealized her as a training analyst, as she felt she herself would never be able to become a training analyst. Dr. Prentice never dealt with her own transference and the analyst never brought anything into the transference. There was practically no transference interpretation in 8 years. Her analyst was so anti-Freud that Oedipal issues were never addressed. Her analyst wanted her to read about "unformulated experience." Dr. Prentice could not get her analyst to be "with her." Her own masochistic tendencies were not analyzed. It was inconvenient for her analyst to acknowledge that they were not getting anywhere in treatment. Her analyst's devotion to theory was much greater than to understanding the patient. How could her hostile comments about her analyst go on being unrecognized?

After about four years of treatment she began to question problematic aspects of her relationship with her husband. If she called him on anything, he became abusive and either threatened divorce or having a fourth child. It was clear it was crazy for him to try to blackmail his wife. She colluded with the analyst in denying the significance of the passage of time and in her not switching to another analyst. Dr. Prentice finally became aware that she had been in treatment for 8 years and was devastated. At that point, she knew nothing could stop her from terminating. She became assertive, set the date, and terminated. Initially, she felt jubilation that the "imprisonment" was over, but then she became depressed.

Subsequently, she decided to end the supervision she was engaged in and began twice-weekly psychotherapy with that former supervisor. She had huge Oedipal conflicts that she had to work through, which she did by an enactment with him. They worked together for approximately 3 years and she identified with him as a person. He was matter-of-fact and brutally honest. Occasionally he was rigid, but she could call him on it. At times he was explicitly helpful; he said, for example, it was okay to give a woman patient a hug. She really loved him and that shaped her whole identity as an analyst. One time she did yell at him for not letting her talk, and he interpreted her anger and traced it to a significant trauma of her past. She ultimately divorced her husband, and now regards her former supervisor/analyst as a dear friend.

The following ratings refer to her second training analysis:
Interviewee questionnaire rating, #1; Kächele, #1; Pfäfflin, #1.

Statistical Assessment of Ratings

The reliability of Kächele's and Pfäfflin's ratings of recorded interviews is satisfactory, the Cronbach's alpha coefficient of reliability among the two psychoanalysts' raters and the interviewees' questionnaire ratings was .92 ($df = 16$, $p < .001$), and

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correlations with the respondents' questionnaire ratings are significant, $r = .76$ ($df = 16$, $p < .001$) for Kächele, and $r = .77$ ($df = 16$, $p < .001$) for Pfäfflin. The correlations between the two psychoanalyst raters was 0.83 ($df = 16$, $p < .001$). To date, these are the only reported data assessing the validity of questionnaire ratings of satisfaction (in addition to those in our previously published study).

Discussion

Although modest, a 22% response rate in the main study is similar to response rates in other questionnaire studies: 27% (Blaya Perez, 1985), 36% (Martinez & Hoppe, 1998), 25% (Curtis, Field, Knaan-Kostman, & Mannix, 2004), and 39% (Ward, Gibson, & Mique-Baz, 2010). Craige (2002) reported a 9% response rate from all candidates in APsaA.

Satisfaction has been used in six other empirical studies of training analysis, in a study of psychoanalysis (Beutel & Rasting, 2002), and is significantly and positively associated both with therapeutic benefit (Bush & Meehan, 2011), and with patient–analyst "fit" in the present study.

Why did our data fail to substantiate the hypothesis derived from an extensive literature that there would be decreased satisfaction with training analysis? It is unlikely to be due to sample bias because Tessman's (2003) earlier multiple interview study, with the same finding, had an 81% participation rate, and six prior empirical studies, plus our pilot study with a non-APsaA institute, all showed that a majority of analysts were satisfied with their training analysis. Sample bias for all is unlikely.

The decision of some APsaA institutes not to participate in the study means that our sample is derived from a subset of training institutes; the basis for that possible skewing is not clear. Although our 22% sample may be biased toward analysts who support analytic research, we know of no compelling reason why such an influence would affect the *comparison* of satisfaction with analysis by a TA to satisfaction with analysis by a non-TA.

We now hypothesize that our failure to find reduced satisfaction with training analysis, as we had expected, is due to the fact that published criticisms of training analysis, like those of Lewin and Ross (1960), were primarily based upon clinical and anecdotal material. Comparable critical assessment of non-TA analysis was not considered. Moreover, these repeated and innumerable criticisms do not proffer evidence that the difficulties with training analysis are specific or unique; rather, there may be a similar set of difficulties applicable to *all* analyses. In addition, information within an institute and its education committee may be tilted toward assessing problems with a training analysis rather than problems with a personal analysis, thus biasing conclusions about the prevalence of problems with training analysis.

Every empirical study, in addition to our pilot study and main study, has reported that a large majority of candidates are satisfied with their training analysis. Satisfaction rates for training analyses were: 86% (Shapiro, 1976), 90% (Goldensohn, 1977), 72% (Craige, 2002), and 77% (Tessman, 2003). Additionally, Martinez and Hoppe (1998) reported that 78% of TAs reported their own analyses were of "very much" or "tremendous benefit." Bush and Meehan (2011) reported a mean satisfaction score of 3.8 for graduate analysts' rating of training analysis, which falls between "moderately satisfied" and "very satisfied." Empirical reports thus substantiate that a majority of analysts report being satisfied with training analysis, and thus counter those clinical articles asserting that training analyses

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are intrinsically problematic. It is noteworthy that these six empirical studies that document satisfaction with training analysis *are not referenced* in the numerous clinical articles that are critical of training analysis.

The literature also includes arguments that our training analyses are "good enough" (Bernardi & Nieto, 1992; Limentani, 1992; Sachs, 1992; Torras de Bea, 1992). Shapiro (1976) went further and, contrary to the critics, emphasized the positive value of training analysis and considered the criticisms without basis. Target (2001), too, concluded that the critical literature "really only captures one side of the picture. It leaves out the imparting of profound understanding and skill, both through training analyses and teaching" (p. 12). Hardt (2000) also concluded "much of the criticism directed at training analysis merely indicates that some training analyses are bad analyses" (p. 23).

Now that *two* studies have failed to find any evidence that treatment by a TA is *more* satisfactory, and no other study provides evidence that training analysis *is* more satisfactory, it clearly shifts the burden of proof for generating evidence of superior satisfaction of training analysis on any psychoanalytic organization that utilizes a conception of training analysis.

The lack of a difference between TAs and non-TAs in the proportion of mutually agreed terminations may be a result of such high proportions of reported mutually agreed terminations for *both* TAs and non-TAs that it is not possible to find a difference between them. In sharp contrast, *nonpsychoanalyst* patients reach a mutually agreed termination of analytic treatment in only approximately 50% of cases (Erle, 1979; Erle & Goldberg, 1979; Glover, 1955; Hamburg et al., 1967; Hendrick, 1967; Kantrowitz, 1993; Sashin, Eldred, & Van Amerongen, 1975; Weber, Bachrach, & Solomon, 1985a, 1985b). This low proportion of mutually agreed terminations for nonpsychoanalyst patients is a function, in part, of including those who dropped out of treatment, whereas our data for psychoanalyst-patients is drawn from graduate analysts and therefore does not include those who dropped out of analytic training. We concur with Marmor's (1986) suggestion that this large reported difference in mutually agreed termination rates of 80% for analyst patients, compared with 50% for nonanalyst patients, may be due to psychoanalyst-patients' greater positive professional stake in all psychoanalytic treatment because of personal identification as psychoanalysts. This identification with psychoanalysis may also have influenced the high frequency of positive reports about the benefits of analytic treatment both by TAs and non-TAs.

We turn next to our finding of a strong positive association between patient–analyst "fit" and satisfaction in both training analysis and treatment by a non-TA. Although it is possible that, in our study, the satisfaction with treatment influenced retrospectively the assessment of patient–analyst "fit," our finding does replicate the association between patient–analyst "fit" and satisfaction previously reported by Bush and Meehan (2011), Carr (2006), Kantrowitz (1993), Kantrowitz et al., 1989, Kantrowitz, Katz, and Paolitto, 1990, Leuzinger-Bohleber (2002), Shapiro (1976), and Tessman (2003). Kantrowitz et al. (1989) described "fit" as "the analyst's character or style provide a beneficial effect for the patient" (p. 906), though "only in 13 of the 21 cases did match stand out as centrally relevant to outcome" (p. 915). Kantrowitz et al. (1989) added that

> matches of patients and analysts that appear to have facilitated the analytic process . . . are those in which the analyst's character style provided some quality that was inhibited, deficient or in some other way lacking for the patient. We suspect that the patient's acquisition of a formerly missing attribute may be based on the patient having internalized an identification with the analyst." (p. 918)

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Kantrowitz et al. (1990) concluded later that "for 12 of the 17 patients interviewed five to 10 years after termination of psychoanalysis, the researchers found that the patient-analyst match played a role in the outcome of the analysis" (p. 655). Tessman (2003)similarly noted that "the particularity of the dynamics within each analytic dyad was pivotal, because some analysts could be highly effective with one participant and damaging with another" (p. 308). Sampson (1994), referring to the theory of Weiss and Sampson (1982), described that when the analyst behaves differently than the patient anticipates, it helps the patient to disconfirm pathogenic beliefs. He added that "important changes also take place when the analyst is attuned effortlessly—because of his own sensitivity" (p. 361). Presumably, patient–analyst "fit" facilitates this attunement. Dolinsky, Vaughan, Luber, Mellmann, and Roose (1998), however, assert that this association between "fit" and positive outcome does not itself prove cause and effect.

There is a substantial literature about second analyses or reanalyses that we will not attempt to review; rather, we limit our discussion to trying to understand our finding that second analyses, whether training analyses or analysis by a non-TA, are more satisfactory than first analyses. Of the 82 TA respondents who provided complete data, eight had the TA before the non-TA. Because 68% of training analyses and 61% of analyses by non-TAs in our study were satisfactory, it seems likely that dissatisfaction with the first analysis was *not* the motivation for the second analysis. Meyer and Debbink (2003) note, "Given all the variables influencing results, the definition of reanalysis does not require consideration of prior analytic adequacy" (p. 62), and Tessman (2003) agrees that reanalysis implies "an affinity for analytic process and its yield, rather than dissatisfaction with a first experience" (p. 5). Lyon (2008), too, considers that "later life experience and challenges may make further treatment necessary or possible; there need be no implication of a problematic lack in the initial treatment" (p. 959). Numerous analysts agree that a second analysis is likely to reflect the fact of subsequent developments in the patient's life, including improvements and achievements not present in the first analysis, that may have made a second analysis possible and necessary (Lyon, 2008; McLaughlin & Johan, 1985; Meyer, 2007). Jacobs (in Lyon, 2008) acknowledged that a second analyst stands on the shoulders of the first, learning from the missed opportunities and inevitable shortcomings of the first analysis, and learning, with the patient, what remains to be done.

There is agreement that reanalysis is characterized by a greater regression (Meyer, 2007) perhaps because, for some, resistance to the training analysis involved shielding pathology from the training analyst for the sake of career (Caligor, 1985; Greenacre, 1966; Szalita, 1968). Szalita (1968) also frequently found, in her reanalytic work, that losses of any kind, whether the death of grandparents, parents, siblings, friends, and pets, or even loss of dolls, had previously been neglected. Later (Szalita, 1982), she added that there was similar omission of an early relationship, usually with a sibling.

Concerning the limitations of this study, the number of subjects is modest, and we cannot be assured they are a representative sample of APsaA's institute graduates or that this was a representative time period. We cannot assess the effects on the sampling of respondents due to the absence of graduates from those institutes unwilling to participate in the study. In addition, our sample was limited to graduate analysts, and, as noted, we do not know the possible effect on the data of candidates who dropped out of training. We have only the views of the graduate analysts, not of their analysts. The failure to find significant differences in satisfaction between training analysis and nontraining analysis may be a function of unknown factors.

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We acknowledge that satisfaction with analysis is a much more complex phenomenon than can adequately be evaluated with the questionnaire/interview methods we used. Research sometimes involves measuring relatively delineated and specific parts of complex wholes. The scientific enterprise assumes that many efforts to make such measurements by independent investigators will add to knowledge.

Conclusion

This empirical questionnaire/interview study failed to find any evidence for the assumption that treatment by a TA is *more* satisfactory than treatment by a non-TA; no other extant study provides such evidence. Therefore, the burden of generating data to support the presumption of superior satisfaction of treatment by a TA compared with treatment by a non-TA now rests on any psychoanalytic organization that utilizes this conception of training analysis.

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(*Appendix follows*)

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Appendix

Training Analysis and Personal Analysis Questionnaire

1. Your gender? Male ___; Female ___.
2. Year of graduation from psychoanalytic training _____.

Training Analysis

3. Gender of your training analyst? Male ___; Female ___.
4. Frequency of sessions per week? ____
5. Did you lie on a couch? Not at all ____; Occasionally ___; Frequently ____; All the time ___.
6. What was the length of your training analysis in years? ___.
7. How satisfied were you with the working relationship, the fit with your training analyst? Very ___; Moderately ___; Partially satisfied/ Partially dissatisfied ___; Moderately dissatisfied ___; Very dissatisfied ___.
8. Did your analyst exert influence on your progression in analytic training at the institute either overtly or covertly? Yes ___; No ___; Don't know ___.
9. Did you terminate your analysis unilaterally without your analyst's agreement? Yes ___; No ___;

Reasons You Terminated

10. If your training analysis was terminated by mutual agreement was it because treatment had been satisfactory? Yes ___; No ___.
11. Did you switch to another training analyst during analytic training for reasons other than the analyst's retirement, death or change of residence? No ___; Yes ___.
12. How do you feel about the results of your training analysis? Very satisfied ___; Moderately satisfied ___; Partially satisfied/partially dissatisfied ___; Somewhat dissatisfied ___; Very dissatisfied ___.
13. Do you believe that you work with analytic patients in the same way your analyst worked with you? Almost identically ___; Very similarly ___; Moderately similarly ___; Substantially differently ___; Almost completely differently ___.
14. After termination of your training analysis and after graduation, did you engage in additional treatment, either psychotherapy or analysis, either with your prior analyst or with a different therapist? Yes ___; No ___.

(*Appendix continues*)

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If You Had a Personal Analysis, Please Answer the Following. If You Had Several Personal Analyses, Please Respond About the Last Analysis

15. Was your personal analysis Before ____ or After ____ your training analysis?
16. Reasons you engaged in a personal analysis?
17. Gender of your personal analyst? Male ____; Female ___.
18. Frequency of sessions per week? ____.
19. Did you lie on a couch? Not at all ____; Occasionally ___; Frequently ____; All the time ____.
20. What was the length of your personal analysis in years? ____.
21. How satisfied were you with the working relationship, the "fit" with your personal analyst? Very ___; Moderately ___; Partially satisfied/partially dissatisfied ___; Moderately dissatisfied ___; Very dissatisfied ___.
22. Did you terminate your analysis unilaterally without your analyst's agreement? Yes ____; No ____.

Reasons You Terminated

23. If your personal analysis was terminated by mutual agreement, was it because treatment had been satisfactory? Yes ____; No ___.
24. How do you feel about the results of your personal analysis? Very satisfied ____; Moderately satisfied ____; Partially satisfied/partially dissatisfied ____; Somewhat dissatisfied ____; Very dissatisfied____.
25. Do you believe that you work with analytic patients in the same way your analysts worked with you? Almost identically ___; Very similarly ___; Moderately similarly ___; Substantially differently ____ Almost completely differently___
26. Would you be interested in adding a further contribution to this project by participating in a one-to-one, confidential interview with Principal Investigator Joe Schachter about your responses? That would add a depth to this study that a questionnaire is unable to provide. Yes ___ No ___.

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