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Comparison of Vignette-based Ratings of Satisfaction with Treatment by Training Analysts and Non-Training Analysts

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Abstract

This study provides data about vignettes of individual interviews from 13 American Psychoanalytic Association (APsaA) psychoanalyst-patients who had both a training analysis and an analysis by a non-training analyst (non-T.A.). A prior questionnaire study (Schachter et al.) as well as an interview study (Tessman, 2003) both found no difference in reports of satisfaction with training analysis compared to analysis by a non-T.A. by the same analyst-patients.

Both questionnaire ratings and vignette-based ratings of satisfaction individually by two senior psychoanalysts indicated that when the training analysis preceded the analysis by a non-T.A. *less* satisfaction was reported with training analysis than with analysis by a non-T.A.. The Board on Professional Standards of the American Psychoanalytic Association (APsaA) which requires that candidates be treated only by T.A.'s, presumes that analysis by a qualified T.A. will be *more* satisfactory than analysis by a non-T.A.. To date, the empirical data in two studies fail to support that presumption. Clearly, the burden of proof falls on the Board on Professional Standards to provide empirical evidence that analysis by a T.A. actually is *more* satisfactory than analysis by a non-T.A..

Failure to produce such empirical evidence makes it plausible to conclude that the concept of a qualified T.A. has become a ritual designed to create and foster an omniscient analytic elite with authority and power, who, it may have been believed, will provide an

image of consensus, magical help and protection during the increasingly serious strains confronting APsaA (241)

Training Analyst, Non-Training Analyst, Training Analysis, Interview, American Psychoanalytic Association

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Vignette-based Ratings of Satisfaction with Psychoanalytic Treatment by Training Analysts and by Non-Training Analysts

At the Nurnberg Congress in 1910, Freud said “It seems that the pre-requisite for a successful application of psychoanalytical technique is that the physician should begin his analytical training by being analyzed himself.” (Quoted by Kovacs, 1936, from the Report of the Nurnberg Congress by Otto Rank). At the Budapest Congress of the International Psychoanalytic Association in 1918, Nunberg remarked similarly in a private conversation, “no one should henceforth be allowed to analyze who himself has not been analyzed previously” (Szasz, 1958, p.599; Sandler, 1982). The Berlin institute was founded in 1920, and many of its members felt the need for a personal analysis. During the winter of 1923-1924, Hanns Sachs was invited to move from Vienna to Berlin to specialize in the analysis of psychoanalysts; he thus became the first training analyst (Bernfeld, 1962).

In contrast, at the same time, in 1922 Bernfeld (1962) discussed with Freud his intention to establish himself as a practicing analyst and asked Freud if it was desirable for him to have a didactic analysis. Freud responded “Nonsense. Go right ahead. You certainly will have difficulties. When you get into trouble, we will see what we can do about it.” (p.463). Apparently Freud was not in favor of dictating a training analysis, at least not for everyone aspiring to become an analyst.

However, that same year the Berlin Congress it was agreed that authorization to practice psychoanalysis would be limited to those taking theoretical courses, and submitted to a training analysis by an approved analyst (Kovacs, 1936). Three years later, at the Ninth International Congress in *Bad Homburg* in 1925, Eitington suggested the establishment in each country of institutes to take full responsibility for the training of prospective analysts, including supervision as well as training analysis (Sandler, 1982). Thus, Freud and Nunberg's original suggestion proceeded within seven years to complete institutionalization of psychoanalysis without leaving any record indicating any discussion of possible issues in this major transformation. Balint (1954) recognized this absence and commented during a symposium about training analysis, "This symposium will then stand to our credit, that at least we were conscious that there were problems to be faced" (p.157). "In psychoanalysis, as elsewhere," Bernfeld noted, "institutionalization does not encourage thinking" (p.468), and "the laying down of laws is a hobby of psychoanalysts everywhere" (p. 479). As if to fulfill this insight, at the Innsbruck Congress in 1927 the International Training Commission adopted an additional standard, namely, that analysts should be more fully analyzed than their patients (Kovacs, 1936).

"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] Kernberg (2000), a repeated, preeminent critic, identified

[1] (Balint, 1954, Bibring, 1954; Nacht, 1954, Weigert, 1955, Thompson, 1958, Lewin & Ross, 1960; Szasz, 1960, Nacht et al., 1961, Greenacre, P. 1966, Bernfeld, S. 1962, Kairys, 1964,

"a tendency to infantilize psychoanalytic candidates, a persisting trend towards 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).

The collected and extensive criticisms of training analysis imply that a training analysis will be *less* satisfactory than analysis by a non-T.A..

One specific problem regarding therapeutic benefit was that of 'syncretism' (Lewin and Ross, 1960), which assumed a conflict between the therapeutic and educational goals of training analysis which inevitably would interfere with the therapeutic benefit and the satisfaction with training analysis. The collected and extensive criticisms of training analysis imply that a training analysis will be *less* satisfactory than analysis by a non-T.A. We consider that the APsaA requirement that candidates may be treated only by a T.A. , presumes, au fond, that qualified T.A.'s will conduct analyses that are *more* satisfactory than analyses by non-T.A.'s. Failure to document empirically this assumption will challenge the rationale of APsa"s

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McLaughlin, F. 1967, Arlow, 1972, McLaughlin, J.T., 1973, Friedman, L., 1974, Pfeffer, A.Z. 1974, Van der Sterren & Seidenberg, 1975; Schecter, 1979; Bruzzone et al., 1985; Hinshelwood, 1985; Kernberg, 1986, Stelzer, 1986; Lipton, 1988; Cremerius, 1990, Orgel, 1990; Thomä, 1993; Thomä & Kächele 1999; Masur, 1998; Thomä & Kächele, 2000; Kernberg, 2000; Desmond, 2004; Reeder, 2004; Casement, 2005; Lothane, 2007; Meyer, 2007; Kirsner, 2009; Kernberg, 2010; Wallerstein, 1993; Wallerstein, 2010; Wilson, 2010).

Board on Professional Standards for continuing its conception of a T.A.

In a previous report (Schachter et al.) of our study of analysts who had *both* a training analysis and a personal analysis by a non-T.A. we had hypothesized that analyst/candidates would be *less* satisfied with their training analysis than they would with analysis by a non-T.A. The data failed to support our hypothesis; there was *no difference* in satisfaction with training analysis compared to analysis by a non-T.A., thus replicating the same finding in Tessman's (2003) interview study. She reported, for example, that the category of "highly dissatisfied" accounted for 22% of all 64 analyses and 23% of training analyses. We consider that the APsaA, requirement that candidates may be treated only by a T.A., presumes, au fond, that qualified T.A.'s will conduct analyses that are *more* satisfactory than analyses by non-T.A's. The finding of *no difference* in satisfaction in Tessman's study and in our prior study provides *no support* for APsaA's presumption that analysis by T.A.'s will be more satisfactory than analysis by non-T.A.'s.

Schachter et al., also reported that ratings of satisfaction from interview vignettes of training analyses were significantly, positively associated with the respondents' questionnaire ratings, thereby supporting the validity of the respondents questionnaire ratings of satisfaction with training analysis. The present report will attempt to validate the questionnaire ratings of satisfaction both with analysis by a T.A. and by a non-T.A. by comparing vignette-based ratings with questionnaire ratings. In addition, satisfaction with a T.A. will be

compared with satisfaction with analysis by non-T.A.'s on the basis of vignette-based ratings.

Method

In the prior paper (Schachter et al.) questionnaire ratings of satisfaction with training analysis were compared to satisfaction with analysis by non-T.A's for 31 graduate analyst respondents who had experienced both. From these 31 respondents, 13 were had participated in the individual interview about their analyses with J.S.; the remaining 18 respondents had not volunteered to be interviewed, so there were no vignettes for them. The same analysts, Rater A and Rater B, who had rated the vignettes in the prior paper, again blindly with regard to the questionnaire ratings, individually rated for satisfaction the vignettes about training analyses and those about analyses by non-T.A.'s of these 13 interviewees. We determined that it was not feasible to disguise the vignettes about training analyses so that it would not be possible to identify them as training analyses. Therefore, we separated and scrambled the 13 training analyses and the 13 analyses by non-T.A.'s, so that Rater A and Rater B would not be able to recognize that a T.A. vignette and a non T.A.vignette both came from the same interviewee. Each rater dealt with a population of 13 T.A. vignettes, and, separately, 13 vignettes of analyses by non-T.A.'s. Then these 13 respondents' questionnaire ratings of satisfaction and interview vignette-based ratings of satisfaction were compared separately for training analysis and for analysis by a non-T.A. . Vignette-based ratings employed the same Likert-scale format used for questionnaire ratings*: (1) Very satisfied; (2) Moderately*

satisfied;(3) Partially satisfied/partially dissatisfied; (4) Moderately dissatisfied; and (5) Very dissatisfied. In order to further anchor the ratings of the participants, J.S. had provided brief prompts about each of the five points on the scale of satisfaction for rating vignettes.

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. A limited number of themes were consistently explored in the interviews: interviewees were regularly asked how they'd selected their analyst, how they felt about the "fit" with their analyst, and about post-termination contact issues. The full transcribed interviews by J.S. have been reviewed and approved by the interviewee, and permission granted to publish vignettes.
The vignettes were selected by J.S. to separate material about the T.A. from that about the non-T.A..

Results

Qualitative Analysis of Interview Vignettes

The first analysis of ratings of vignettes will examine whether there is a close association between the two analysts' blind vignette ratings of satisfaction and the questionnaire ratings of the analyst-patients satisfaction, separately for training analyses and for analyses by non-T.A.'s. Each rater assessed each vignette. The two raters agreed substantially in evaluating the 26 vignettes ($r=.75$, $p<.001$). This agreement was consistently high for the two groups of 13

considered separately as well. We next assessed the closeness in agreement between the average of the two raters and the analyst-patients' questionnaire scores: the correlation was ($r=.65$, $p<.001$), confirming a central hypothesis of this study. A further check on the reliability of these ratings was made by comparing the vignette scores of each of the two raters to the questionnaire rating by the analyst-patients: Cronbach's alpha =.83 for all 26 sets of ratings.

Table 1

Table of Satisfaction Ratings*

Non-T.A. *Before* T.A.

Subject Code	Questionnaire Rating		Average Vignette Rating	
	Non-T.A.	T.A.	Non-T.A.	T.A.
6014	2	1	3	3
3064	1	2	2.5	2
1023	1	3	2	5
1500	3	3	2	3
1741	3	2	3	1.5
3005	3	1	4	1
1761	1	1	1.5	1
2097	3	1	2	3.5
5007	1	1	2	1.5
8002	2	4	3	3
Mean	2.0	1.9	2.5	2.5

T.A. *Before* Non-T.A.

3061	1	2	1.5	4
1310	1	5	2	4.5
8024	1	3	2	4
Mean	1.0	3.3	1.8	4.2
Overall Mean (n=13)	1.8	2.3	2.2	2.8

*The larger the number the *less* the satisfaction.

Only two of the total of 26 questionnaire ratings for these 13 respondents indicated levels of dissatisfaction (ratings of 4 or 5) and both were for training analysis.

Questionnaire Ratings

The questionnaire satisfaction data for 13 S's in Table 1 was subjected to a two-factor analysis of variance, consisting of a between subject factor, Group (non-training analysis *before* training analysis vs. training analysis *before* non-training analysis) and a within subjects factor, Treatment type (non-training analysis vs. training analysis). There was no statistically significant main effect for group membership ($F(1, 11) = 0.20$, $p = .66$, eta-squared= .02); indicating that overall levels of satisfaction for both types of analysis combined did not differ by the sequence in which participants had experienced their analyses. However, there was a statistically significant main effect for the Treatment type factor ($F(1, 11) = 5.75$, $p<04$, eta-squared= .33); indicating that training analysis generally was rated as *less* satisfactory than non-training analysis. Further, a statistically significant interaction effect between Treatment type and Group membership was found ($F(1, 11) = 6.38$, $p<.03$, eta-squared = .38). The interaction plot, displayed in Figure 1 and a series of simple main effects contrasts indicated that satisfaction levels for training analysis were significantly lower than ratings of analysis by non-T.A.'s for those participants who had training analyses before their analyses by non-T.A.'s.

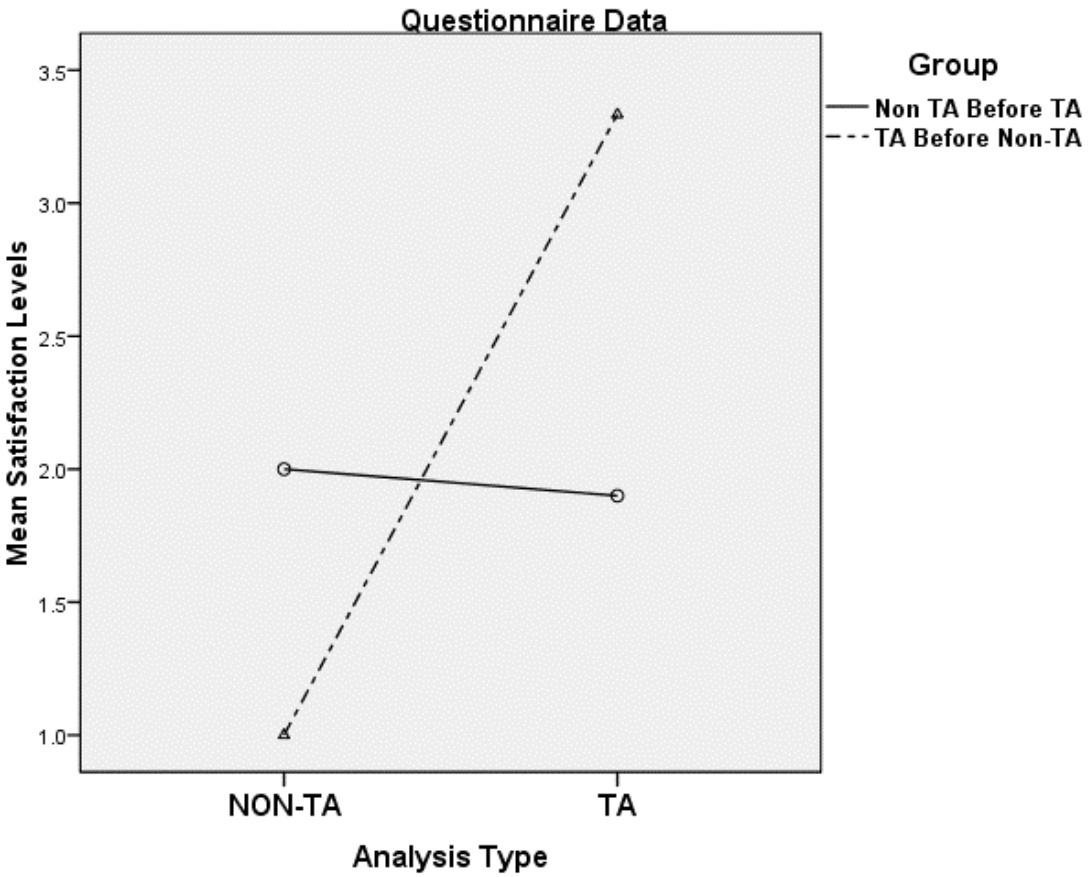

Figure 1. Mean questionnaire ratings of satisfaction levels by type of analysis and the order in which analysts experienced their personal and training analyses.

The vignette ratings of satisfaction data in Table 1 was subjected to the same two-factor analysis of variance procedure as the questionnaire data. There was no statistically significant main effect for Group membership (F (1, 11) =1.78, p= .21, eta-squared= .14); indicating that overall levels of satisfaction for both types of analysis combined did not differ by the sequence by in which participants had experienced their analyses. However, as in the questionnaire data, there was a statistically significant main effect for the Therapy type factor (F (1, 11) = 6.02, p <.04, eta-squared= .33); indicating that training analysis was generally rated as *less*

satisfactory than analysis by non-T.A.'s. Here too, a statistically significant interaction effect between Therapy type and Group membership was found (F (1, 11) =6.55, p<.03, eta-squared = .35). The interaction plot is displayed in Figure 2 and a series of simple main effects contrasts indicated that satisfaction levels for training analysis were significantly *lower* than ratings of analysis by non-T.A.'s for those participants who had training analyses before their analyses by non-T.A.'s and that ratings of training analysis were significantly less satisfactory for the group that had training analysis prior to analysis by non-T.A.'s.

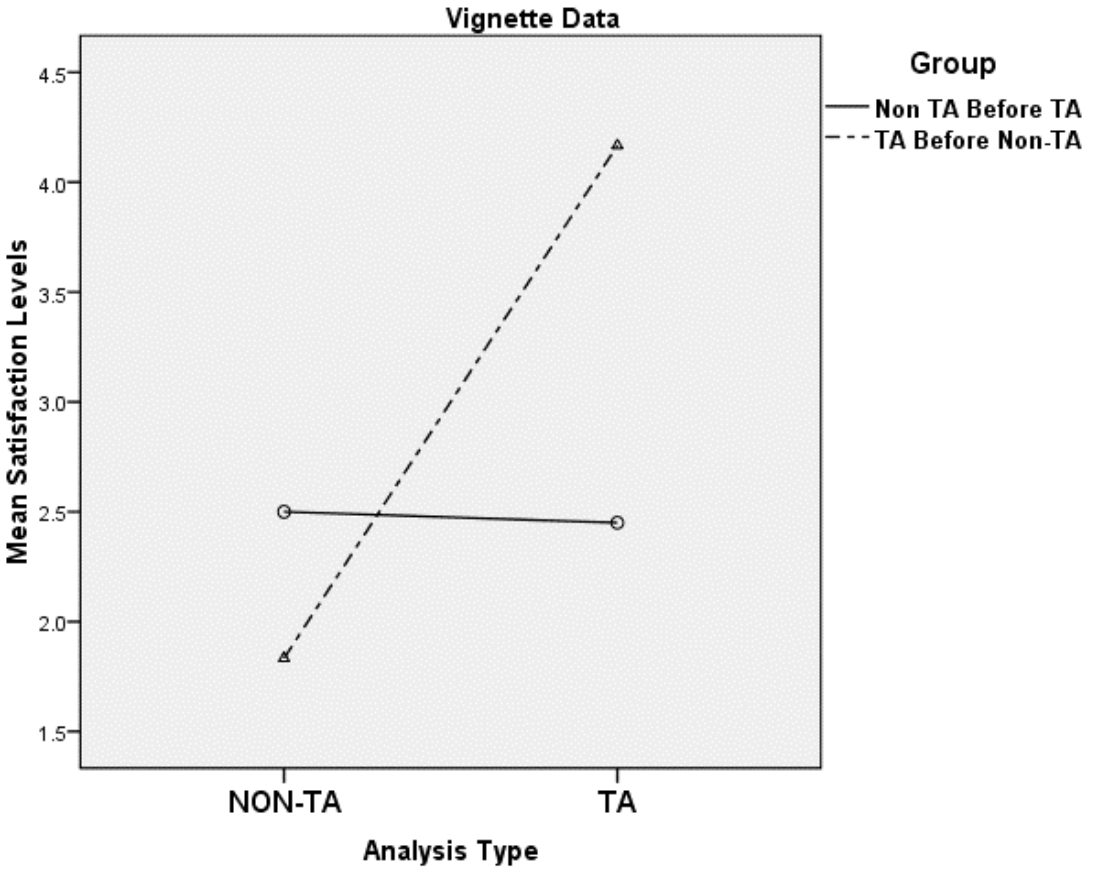

Figure 2. Mean vignette ratings of satisfaction levels by type of analysis and the order in which analysts experienced their personal and training analyses.

Transcribed vignettes of the 13 interviewed S's will be presented next**.** We begin with interview vignettes of the 10 S's who had analysis by a non-T.A. before the training analysis will be presented first. Honoring chronology, for each of these respondents, the first vignette will refer to the analysis by a non-T.A., and the second vignette will refer to the training analysis. After each vignette, the questionnaire's satisfaction rating will be presented, followed by the ratings by Rater A and Rater B for comparison.

Analysis by non-T.A.'s *Before* Training Analysis

Analysis by non-T.A.: Questionnaire # 6014

Dr. Jepson likes to participate in any analytic research she can because she doesn't actually do any research, and feels the least she can do is participate in some research. Additionally, she is particularly interested in the training analyst system. In her twenties Dr. Jepson had had some psychotherapy in Europe, and then in the 70's, when she was having marital problems, she began analytic treatment in the United States. Her analyst, Dr. Phillips, focused on her narcissism and the guilt that lay behind it, resulting in her working on childhood issues. He challenged her presenting herself as dumb, and encouraged her to go to graduate school and move on with her life. Dr. Jepson, however, felt that the way he worked remained mysterious to her.

Analysis by non-T.A. Questionnaire #6014, Moderately satisfied =2; Rater A =3; Rater B =3. .

Training Analysis: (Questionnaire #6014)

Years later she again struggled with difficulties in her relationship with a man who was an analyst and who urged her to seek further analytic treatment. When choosing an analyst she reviewed several who were bright, but felt they had character problems, and then selected a male analyst, Dr. Carter, who was very smart, and was analyzing a good friend of hers. He also offered a fee she felt she could afford. Her analysis with Dr. Carter, who was a training analyst, led her to decide to become an analyst. During this treatment, however, she was so consumed by her personal problems that she didn't directly make use of this analysis as a "training analysis"; she didn't talk about her treatment of patients or supervision. From him she learned the value of abstinence, and of regression in working with early experiences and memories.

She sees herself as fairly compliant and was unable to express anger towards him. An example she provided focused on her not coming to a session on a May 31. She had assumed he did not work on the holiday; since she had never missed a session she was angry that he charged for that session. She paid for the session but was unable to express her anger. Another time, when he was leaving for a trip, she asked where he was going. He didn't answer, and, again, she was angry but couldn't express her anger. She accepted his "rule" and never again asked him a similar question

Dr. Jepson had written several papers critical of the training analyst system, but Dr. Carter never explored whether her writing these

papers involved her transference feelings, and neither did she. Dr. Carter was always supportive of her progression at the institute **Training analysis** Questionnaire #6014: Very satisfied: = 1; Rater A = 3; Rater B = 3.

Analysis by non-T.A.: Questionnaire #3064

Asked why he was interested in being interviewed, Dr. Peterson replied that he wanted to be of some help, and the study sounded interesting and valuable. Dr. Peterson reported that when he was in college he was unhappy and disillusioned. A teacher/friend who was in analysis realized he needed treatment, and asked his analyst for a referral. Dr. Peterson began analysis with Dr. Paul and soon went five sessions per week and used the couch. His teacher/friend was gay and tried to seduce him, which disturbed him but he didn't even think of telling his analyst about it, until it sort-of erupted. Dr. Paul was British trained and allowed him to get connected to his own feelings. Dr. Paul didn't say much; Dr. Peterson sort-of did it himself, which was important to his self-esteem. Dr. Paul did do a lot of dream interpreting which Dr. Peterson loved. It was a fairly regressive experience; Dr. Peterson dropped out of college for a couple years. His whole life was devoted to analysis. He thinks his transference was displaced onto his teacher/friend, and Dr. Paul just let that happen. Near the end of treatment Dr. Paul suggested that Dr. Peterson should read Winnicott, of whom he had never heard. Dr. Peterson emerged from analysis with his own identity, graduated college, was accepted in medical school and got married.

When Dr. Peterson left for medical school Dr. Paul gave him the name of an analyst in the city in which he would be going to medical school, which Dr. Peterson felt was the first time he had broken the frame. Dr. Peterson wrote to him a few times, and Dr. Paul wrote back, and mentioned that he had published an article about Dr. Peterson's treatment which disturbed Dr. Peterson because it referred to a specific possibly identifiable attribute of Dr. Peterson.
Analysis by non-T.A.: Questionnaire #3064: Very satisfied =1; Rater A =2; Rater B = 3.

Training analysis Questionnaire #3064

When Dr. Peterson began his residency he felt he still had work he needed to do analytically, and wanted to process his residency experience. He asked one of his supervisors for analysts' names and started analysis with a Dr. Flemming, a self psychologist, with whom he felt comfortable. When he began analytic training Dr. Flemming became his training analyst.
Like Dr. Paul, Dr. Flemming never imposed anything on him; sometimes he wished they would have imposed more. He feels he was able to distance himself from his family in a healthy way, though he is still pretty involved with them. Although he had been his father's least favored child, his relationship with his father improved enormously. This analysis, too, helped him to carve out his own identity. His two analyses were not that different from each other, which may say more about him than about the analyses.
Then Dr. Flemming and several other analysts left to form a new analytic group, and asked him to join them. Dr. Peterson felt

abandoned and hurt by that, and did not join them. This precipitated his terminating his analysis with Dr. Flemming.

J.S. asked if he could have Dr. Peterson's permission to contact his analysts. Dr. Peterson responded that he thinks Dr. Paul is not alive any more, but it would be fine to contact Dr. Flemming. Dr. Peterson added that he had read J.S.'s book on transference and really loved it. Perhaps that had influenced him to want to be interviewed.

Training analysis Questionnaire # 3064; Moderately satisfied = 2; Rater A =2; Rater B =2.

Analysis by non-T.A.: Questionnaire # 1023

Dr. Dolphin had gone into personal analysis when she was a psychiatric resident with an analyst she had previously seen for a short period of psychotherapy as an undergraduate. She had been very suspicious about lying on the couch; she had been watching the analyst's reactions the way she used to watch her mother to see if the latter was O.K. However, the treatment was very helpful, and she became more and more interested in doing analysis. The institute told her she could apply for analytic training after she finished her personal analysis which lasted four years.

Analysis by non-T.A. Questionnaire = 1023: Very satisfied = 1; Rater A =2; Rater B =2.

Training Analysis: Questionnaire #1023)

Dr. Dolphin had had a choice of only two training analysts. One seemed a very cold kind of person, so she chose the other who was

at least kind of warm. The training analysis was terrible; it was a little due to herself, but a lot due to him. She didn't feel he understood her, didn't feel that he was empathic. He asked if she had ever had an abortion, which made her feel very misunderstood, though the truth was she had had an abortion. She never had an alliance with him as she had had with her first analyst; she felt he was unfair. He thought she idealized her first analyst, which was true. He was "a kind of a crazy guy" who ended up having a psychotic break and being hospitalized. She consulted a liaison analyst about ending her training analysis, and did terminate it. She objected to rules about how long a training analysis had to be.

After her training analysis ended, she went back to her first analyst for a short time. She then moved into an office across the hall from him, and began having lunch with him and developed a personal relationship with him. Dr. Dolphin said that talking about this began to feel uncomfortable, so perhaps she will come back to it. Her concern about that relationship led her to join J.S.'s Clinical Discussion Group on Post-termination Patient-analyst Contact which she said was the best discussion group in which she had participated. She ended up marrying one of her analyst's patients, which was a big mistake. She then saw a woman analyst, a self-psychologist, who was really very nice and very supportive. The analyst indicated she thought it would be O.K. if she left the marriage, and she did so. She remains in contact with this analyst by email. She commented that she's good at talking to people and intuitive, but has difficulty describing in a conceptual framework what she was doing. J.S. asked Dr. Dolphin if

she would give him permission to contact this last analyst, and she replied that that would be fine.

Training Analysis Questionnaire 1023: Partially satisfied/partially dissatisfied = 3; Rater A =5; Rater B =5.

Analysis by non-T.A. : Questionnaire # 3061)

Dr. Prentice started participating in a psychoanalytic training group and went for a personal analysis with one of the instructors there. She had wanted to work with a woman who proved to be incredibly perceptive. She has continued to work with her, and is now seeing her twice each week. The analysts in this group feel there is a psychoanalytic reason for everything; the focus is on a one-person psychology and the unconscious, with much less interest in the relational-interpersonal. She's very happy there. The group is part of a study of psychotic patients.

Non-training analysis Questionnaire # 3061 Very satisfied =1; Rater A =1; Rater B =2.

Training analysis: Questionnaire #3061

Dr. Prentice agreed to be interviewed because she was curious to see what might come out about her analytic experiences, and because she was interested in the subject of the training analysis. As a graduate student she had had a professional and personal breakdown, and obtained analytic treatment for a limited time period, which was quite helpful. She knew immediately she wanted to go into analysis. She ended treatment when she obtained a position and left.

She was accepted for analytic training, and selected Dr. Forrest who offered the lowest fee. It wasn't, she noted, "a match made in heaven," but it seemed to work. She did miss the first analyst she had seen. Her financial state became quite dire. Dr. Forrest became defensive, and suggested since she was trying to get pregnant, that she sell one of her own eggs. Dr. Prentice felt that that specific suggestion at that time of her life was problematic, and she became enraged. Although Dr. Forrest didn't agree, she terminated her analysis anyway. After a break she went back and tried to work with him, but was unable to do so. Another training analyst was willing to see her so she could reach a mutually-agreed termination of the training analysis. After she left Dr. Forrest, they did have a friendly relationship, and she purchased his collected works of Freud. In response to J.S.'s question, Dr. Prentice said she didn't think her training analyst had intervened in her progression in the institute. **Training analysis**: Questionnaire #3061 Moderately satisfied =2; Rater A =3; Rater B =5.

Analysis by a non-T.A.: Questionnaire # 1500

Dr. Peters agreed to participate in the interview because psychoanalytic research was a fundamental part of the psychoanalytic world; the more information the better. He first had a personal analysis. He had previously seen the analyst he selected as a consultant, and liked him. He had very impressive credentials, and seemed empathic and down to earth. His basic understanding was extremely helpful; it enabled him to resolve a divorce and find an appropriate partner. Dr. Peters thought the analyst liked him. Certain

issues, however, were not worked out – but that's O.K. Subsequently, though, he became disappointed in him as a human being.

Analysis by a non-T.A. Questionnaire # 1500 Partially satisfied/Partially dissatisfied = 3; Rater A =2; Dr. Rater B =2.

Training Analysis: Questionnaire #1500

Later, he considered going into analytic training, and went to see a training analyst, initially once/twice per week. He had the most gravitas. Although he was formal in a lot of ways, his ideas were more radical than his demeanor. I asked Dr. Peters if he thought his analyst intervened in his progression in the institute. He thought in that local psychoanalytic community that it could be done subtly, indirectly; it operates insidiously from a negative point of view.

An internal conflict developed at the institute. He and his analyst had different views. His analyst simply wasn't interested in what he had to say. His analyst interpreted Dr. Porter's disagreement as his own psychological problem. That made him decide to end his training analysis, though he wasn't honest that that was the reason he was terminating. He didn't consider switching to another analyst because of how that would upset his analyst. He was a fine man, a deep thinking man, and he had been quite helpful. Later, he died.

J.S. asked if before termination he and his analyst had discussed the possibility of post-termination contact. They had not; he commented that they conformed to pretty traditional ways. He did have professional contacts with him, especially after he, himself, became a training analyst. He came to recognize the disparity between his idealization and a realistic view of his analyst. Similarly,

he doesn't encourage post-termination contact with his own patients. He doesn't see there being an analyst-patient relationship after treatment has ended.

Training analysis Questionnaire # 1500: Partially satisfied/Partially dissatisfied = 3; Rater A =3; Rater B =3,

Analysis by non-T.A.: Questionnaire # 1741

Dr. Crawford was interested in participating in the interview because she thought it might improve her perspective, help her to reflect on her experiences. She selected her first analyst for a personal analysis because her boyfriend was in analysis with him and spoke very highly of him. She didn't begin analysis so much because she had specific symptoms or problems, but because in the 1970's many people wanted analysis to reflect on themselves. She was part of a group of leftist activists, and this analyst treated members in that group. She described positive and negative aspects to the "fit" between them. She felt very supported in her intellectual development by him; she went on to a PhD. On the other hand, he was demanding and moralistic – pushing all the time. It had the effect of enhancing her perfectionistic qualities.

Analysis by non-T.A. Questionnaire #1741 Moderately satisfied =2; Rater A =3; Rater B =3.

Training analysis: Questionnaire #1741

She married, went into practice, and a supervisor urged her to consider analytic training. She did decide to go back into treatment and selected a training analyst recommended by her supervisor so

she would be eligible for training. She felt this analyst was a good "fit"; he was deeply compassionate, a real "mensch". He helped her fix her judgmentalism. Having that good experience fostered her decision to go into analytic training, despite the onerous waiver process as a psychologist. She didn't know many psychologists who were applying for training. Her positive transference and support from her training analyst probably influenced her decision to persevere. She terminated her analysis well before she graduated from analytic training.

J.S. asked if she had had any post-termination contact with her training analyst. They had not discussed this possibility during the analysis. They met when she graduated; he was not an analyst with rigid boundaries. Later he became ill; she wrote him a note about how much he had meant to her. She wasn't comfortable visiting him; felt it was too intimate. She has boundary concerns about that. Felt she wouldn't have known what to say if she had visited him. Later, he died.

She has not become a training analyst. Her career has taken a different path. She obtained a part-time job working with volunteers who had been working overseas and became troubled. This work became a large part of her practice. She became interested in working with PTSD patients, and learned that she had to work with them in a very different way than she had with analytic patients. She became interested in somatic approaches. She used a technique called EMDR and was quite successful with PTSD patients. Basically, she became a trauma therapist, seeing patients once per week and

doing a lot of teaching about the technique. She doesn't practice psychoanalysis any more.

Training analysis Questionnaire # 1741 Moderately satisfied = 2; Rater A =2; Rater B =1.

Analysis by a non-T.A. Questionnaire # 3005:

Dr. Fletcher said that she agreed to an interview because she was responding to J.S.'s request. Prior to her training analysis she had had a twice-weekly, face-to-face therapeutic experience with an analyst, Dr. Green. Although she free associated, she did not consider it psychoanalysis, and felt it was a problematic, conflicted experience, that was more painful than it needed to be. She now feels they were not a good match, and considers that he had narcissistic and counter-transference difficulties. She feels she was subjected to unnecessary information which was provocative and not helpful to her. She did not need to be repeatedly confronted with him "avoiding" eye contact, especially when he ended up, after her, in the adjacent check-out line in a grocery with many checkers from which to choose. When his wife died during her treatment, although he reduced his practice, he did continue to treat her; she didn't need to know he had reduced his practice. During her analytic training, in a class he taught, a classmate of hers specifically commented on Dr. Green's behavior toward her.

Analysis by a non-T.A. Questionnaire # 3005: Partially satisfied/Partially dissatisfied = 3; Rater A =4; Rater B =4.

Training analysis: Questionnaire # 3005

When picking her training analyst, Dr. Fletcher talked to several people and interviewed three analysts. She chose Dr. Roberts, a calm, relaxed person who didn't seem to need to prove anything. He had a maternal quality with which he seemed comfortable. Although she would have preferred a woman analyst, none seemed appealing. Although she knew he and one of the analytic teachers with whom she was having difficulty in a class were friends, she wondered, perhaps he was more rigid, arrogant and insensitive than she had imagined him to be. Dr. Roberts carefully lived up to his responsibility about confidentiality, and that was very important to her.

One weekend she became unexpectedly, intensely depressed, and had no idea what the cause was. In the Monday session, Dr. Roberts speculated that in the Friday session he had been sicker than he realized, and had been relatively absent emotionally; he thought the loss of his presence had provoked her depression. That intervention was a relief for Dr. Fletcher, who had been disturbed by her reaction. She was pleased that Dr. Roberts could look at himself and "self-reveal" in ways that were helpful to her. She became tearful, even now, as she recalled that.

J.S. asked Dr. Fletcher if she had discussed post-termination contact with Dr. Roberts, and she had not; she had assumed she would be seeing him from time-to-time at institute-related activities. She noted, apparently with some self-awareness that she had grown up in a family with no boundaries. Although she and Dr. Roberts were at the same institute, they actually didn't see that much of each other. She commented that he's retired, and she should call him and take him to lunch. Lastly, J.S. asked Dr. Fletcher if she would give him

permission to contact Dr. Roberts to get his view of her treatment, and she responded, “sure”.

Training analysis Questionnaire # 3005: Very satisfied = 1; Rater A =1; Rater B =1.

Analysis by non-T.A. Questionnaire #1761

Dr. Haven’s first analytic treatment was by a candidate. She had no choice in regard to selecting this analyst, but she felt he was a good “fit”. He was actually quite experienced and said things that were particularly relevant to her. He encouraged her to talk about (and develop a sense of validity about) her feelings and to experience them at greater depth. After more than five years she brought up the question of termination. He didn't explore her motivation for doing so, perhaps because he needed a completed case to graduate training. She felt a particularly encrusted layer of problems had been lifted and she was able to get married. She and her analyst had not discussed the possibility of post termination contact. When they occasionally met, he was very friendly.

Analysis by non-T.A. Questionnaire #1761; Very satisfied =1; Rater A =1; Rater B =2.

Training Analysis Questionnaire #1761

Some years later she developed a life-threatening illness which required intensive treatments; chronic treatments have been required. She worked briefly with an analyst twice a week to deal with this trauma and during that time she felt her mother, about whom she had been conflicted, ‘float’ away; it had been an amazing experience.

Later, when she entered analytic training she asked friends for recommendations for a training analyst. She met with two of them. The woman thought she should wait a year before beginning training, which she did not want to do. She chose to work with the man. Looking back, she feels that was definitely the right decision. She had periods of intense anger at him that were very uncomfortable and lasted for days. With time they were able to work through that. When she disagreed with him, or criticized him he “put up with” her; he could “deal with” her. During the treatment something fundamental about her had taken a new shape. She had always felt she had views that were in the minority, and while she expressed them she was quite aware of how anxious this made her feel. When she understood in the analysis what that was about she felt much more comfortable saying what she thought. She felt she had given her analyst a very hard time, but that her attitude and behavior had changed. She came to accept him the way he was and to understand that they were different.

After termination she had considerable contact with him in professional settings, and he was always friendly and social. He congratulated her when she graduated. She kept in touch with him, and whenever there was a change in her medical condition, she would let him know. Finally, J. S. asked for permission to contact her training analyst. She jokingly asked if she could know what he said and then said, “Sure, you can”. J. S. closed by saying he had enjoyed talking to her, and she said she had enjoyed it as well.

Training analysis Questionnaire #1761: Very satisfied = 1; Dr. Rater A =1;

Rater B =1.

Analysis by a non-T.A. Questionnaire # 2097

Dr. Roberts had had a personal analysis with a male analyst of self- psychological persuasion that had been very helpful. He became involved in her life and made suggestions which at times may have been problematic. She became less suicidal working with him, and had loved him very much. Her experience with him made her decide to become an analyst. J. S. commented that her description in the interview of her first treatment sounds more positive than her questionnaire rating of “Partially satisfied/Partially dissatisfied”.

Questionnaire Analysis by a non-T.A. # 2097 Partially satisfied/Partially dissatisfied = 3; Rater A =2; Rater B =2.

Training Analysis: Questionnaire #2097

For her training analysis Dr. Roberts wanted a good classical analyst, and selected a woman analyst who “did it by the book” and this analysis of 18 years is still ongoing. When Dr. Roberts reminisced about her mother's death in the interview, which had occurred before her first analysis, she came to the verge of tears, as she said she wished she had done more to help her mother before she died. Dr. Roberts said that her second analysis by a woman took place at a greater emotional distance, and she added that she thought the second, traditional analysis probably wouldn't have “worked” at the time she sought help the first time; she probably would have left her. J. S. commented that she had had two very different analyses, and both had been helpful.

Training analysis Questionnaire #2097: Very satisfied = 1; Rater A =2; Rater B =5.

Analysis by a non-T.A.: Questionnaire # 5007

Dr. Thorpe initially had two periods of twice-weekly psychotherapy, one in her early twenties, and a second in her latter twenties. She began a personal analysis 2-3 sessions/week with a non-training analyst when she was in her thirties which lasted seven years. There were only two senior analysts to pick from; she selected the one who was recommended by a friend, and went to the other for supervision. He was knowledgeable about people who had experienced trauma, and her own early life had been very traumatic. She trusted him, felt safe with him, and made a good connection with him. He was able to look into very gory things: seemed to be able to bear anything. He commented that her early life sounded like one of the most horrible he had heard about. He didn't work much in the transference; never invited her to talk about him. After working with him for seven years, she was accepted for analytic training; it was very difficult to leave her analyst. From May to September, when she had to make the switch, she cried every day. She and her analyst did not discuss the possibility of post-termination contact, though, as they were in a small town, they met occasionally. She thought it was odd that they hadn't discussed it. It was clear she could return to him for more treatment if she needed to. He later died suddenly, and she regretted not having gone back to meet with him. She herself, now, does planned follow-up sessions with her patients who terminate. She doesn't want them to suffer unduly about the separation. Having

had a very traumatic childhood of her own, she feels she has a talent for working with those who had a terrible trauma. Eventually, though, she does terminate with her patients. She does lean toward staying available as a future therapist for former patients; she is comfortable with that. She feels patients have a legitimate need to idealize their analyst and to have someone in the wings after termination who can perform the very unique self-object function that an analyst performs. She did see her first therapist occasionally for lunch years after termination. She's only seen a few patients with whom she worked that she thought might become a friend. If she began a friendship with a former patient, that might include socializing and confiding personal issues, she feels that would interfere with the possibility of the patient returning to see her for further treatment.

Analysis by a non-T.A. Questionnaire # 5007: Very satisfied = 1; Rater A =2; Rater B =2.

Training analysis: Questionnaire #5007

J.S. asked how Dr. Thorpe had selected her training analyst. One friend reported that she had had a good experience with him; she had met him once or twice and really like him. He was one of seven available training analysts. She did, however, have to drive half-an-hour to get to his office. Although he was not the kind of person she would look twice at on the street, she immediately developed a major crush on him. He was an old-fashioned analyst, very proper, who didn't say much. He never put a finger on her. He smiled when she came into his office, and she always felt he liked her, and was enjoying working with her. He tended to be playful,

though he only interpreted the transference. Next, J.S. asked if her analyst had ever intervened in her progression at the institute. He had not, though he felt they should discuss whether she was ready to start her first analytic case. She never had any issues with her progression at the institute. Had Dr. Thorpe ever gotten angry with her analyst? When she learned another candidate was living in an apartment in his home, she had an incredible rage attack; she was furious!

Training analysis Questionnaire # 5007 Very satisfied = 1; Rater A =1; Rater B =2.

Analysis by non-T.A.: Questionnaire # 8002

Dr. Griffin had become depressed during his first year in college and started personal psychoanalytic treatment. They were a poor "fit". The analyst was much older and was from another country. Dr. Griffin thought he couldn't understand a lot of what he, Dr. Griffin, talked about. Dr. Griffin went five sessions per week for three years. J.S. asked how it helped with his depression. His depression lifted. The analyst did get Dr. Griffin to appreciate introspection. J.S. asked if Dr. Griffin thought he identified with his analyst; he thought he did, though he didn't practice the way his analyst practiced – quite taciturn. He realized he wouldn't survive as a therapist if he tried to be somebody he was not.

Analysis by a non-T.A.: Questionnaire # 8002: Moderately satisfied = 2; Rater A =3; Rater B =3.

Training analysis: Questionnaire # 8002

Much later he chose a training analyst. He interviewed two analysts whose names had been suggested. He selected the analyst whose office was closer to his. He had had too much anxiety to be able to master quiet listening; he learned that from his analyst. But they were not a good “fit”. He was very quiet; some sessions not saying anything; he practiced elective mutism. That was hugely frustrating to him and he complained about it bitterly. Dr. Griffin was unhappy about how unresponsive he was to Dr. Griffin’s need for more engagement. It was like his father having hit him when he was a small boy. He couldn’t say, “Fathers don’t do that to boys”. Dr. Griffin was concerned that if he switched to another training analyst that his analyst would use his power against him.

One day Dr. Griffin asked him why he wasn’t listening – he was so quiet. His analyst replied, “Why do you think I’m not listening; I am listening”. Dr. Griffin said that changed the whole way he listens to patients. Dr. Griffin had felt abandoned as a child, and his analyst helped him to understand that quiet listening wasn’t abandoning him. Dr. Griffin then felt less pressure to respond to patients. Dr. Griffin’s wife commented that he had benefited a good deal from his analysis.

Did he think his analyst had intervened in his progression at the institute? There was no talk about it; he doesn’t pay attention to it. He has not become a training analyst; the option never presented itself. He would have had to offer low fees and recommend analysis; he stopped doing both since graduation. His work-a-day patients can’t afford either the time or the money for analysis. He has too many expenses to offer lower fees. Also, he doesn’t believe analysis is

what patients need most; he does very good psychodynamic psychotherapy. His practice is so unlike his analyst's.

He's been very happy to do a lot of teaching in a psychotherapy program for residents. He's also very active on local committees. He does have identification with the institute which is his intellectual home. He has written a couple of papers. He said he's not a member of APsaA any longer; he's not that rich. J.S. asked if he had any post-termination contact with his analyst. They lived in the same section, and during analysis would see each other walking around the nearby lake. It had given him so much anxiety that he turned the other way.

After analysis ended they developed a friendly relationship. His analyst was dying of prostate cancer, and they talked about it. He reacted to his analyst's death the way he reacted to his father's death – great sadness and great sense of triumph. He does think about him, especially when he walks around the lake. He has to remind himself that his analyst is dead.

Training analysis Questionnaire # 8002: Moderately dissatisfied =4; Rater A =3; Rater B =3.

Training Analysis *Before* Personal Analysis

Training analysis: Questionnaire # 1310

Dr. Balter asked around who would see her for a reduced fee and selected Dr. Richmond. She was anxious about beginning treatment; when she saw him she thought it would be a good fit. He seemed to be interested and followed what she said. Subsequently he started making positive comments about her appearance, and

after he returned from a separation, he said he had not wanted to separate from her. He became a training analyst, and his comments about her became more egregious, talking about his positive feelings and sexual attraction toward her. They never develop a physical relationship. She felt this was no longer an analysis and became worried about an impact on her own analytic work. He warned her not to disclose what was going on, saying that if she did she would be perceived as a borderline personality disorder and no one would refer patients to her; she was too scared to disclose this. Perhaps she wouldn't be believed and would be discharged from training. She had wondered if she had been so sick or needy that she had caused this. **Training Analysis** Questionnaire #1310; Very dissatisfied =5; Rater A =4; Rater B = 5.

Analysis by non-T.A. Questionnaire # 1310

Dr. Balter ended her very problematic training analysis and sought additional help. She selected a therapist recommended by her supervisor, and found him to be a decent person and a good clinician. He conveyed empathy, and was less reserved than her previous analyst. She was too anxious to lie on the couch, but her analyst was patient and flexible. She was so anxious about this current treatment that she asked a woman supervisor if she could consult with her about her ongoing treatment, and the supervisor agreed to do so. Dr. Balter never needed to consult the supervisor. Subsequently, she ended treatment with her second analyst, and soon thereafter he left for another city. They had not discussed the possibility of post-

termination contact. She had started writing him a letter, but hadn't finished it. Currently, she plays a very active role in her institute.
Analysis by a non-TA Questionnaire #1310; Very satisfied =1; Rater A =2; Rater B =2.

Training Analysis Questionnaire # 8024

Dr. Turner had agreed to participate in this interview because he wanted to help support research and develop psychoanalytic understanding. Dr. Turner had begun his first analysis as a personal analysis and later switched to a training analysis. Dr. Turner's analyst-parent suggested who he should see for treatment. His analyst, Dr. Fisher, exhibited patience, empathy, and a good appreciation of Dr. Turner's narcissistic vulnerabilities. Dr. Fisher was also very encouraging. After several years, Dr. Turner, partly from a feeling of obligation to become an analyst, was accepted for analytic training, so his treatment with Dr. Fisher became a training analysis. The switch was not reflected in any way in which they worked. Dr. Fisher remained, as before, a judicious analyst.

J.S. asked if he thought Dr. Fisher had intervened to facilitate his progression in the institute. Dr. Turner recalled that he had started his first control case before getting permission from the Progression Committee. Dr. Fisher was outraged by his grandiosity in doing so. Dr. Turner was fearful of Dr. Fisher's anger, and concerned that Dr. Fisher would have him dropped from training. Dr. Turner felt that instead of Dr. Fisher adopting a superego role, he should have helped Dr. Turner get in touch with his feelings. Although Dr. Fisher had not intervened in his own progression, Dr. Turner recalled that he

had heard once the Chair of the Progression Committee decided to accept a candidate's case to enable her to graduate. Dr. Turner also learned that Dr. Fisher had blocked the graduation of a candidate, though not one he was treating.

On one occasion, Dr. Fisher yelled at Dr. Turner who he felt was being unreasonably narcissistic. Dr. Turner consulted another analyst about this, who advised Dr. Turner that he was entitled to an apology from Dr. Fisher. In fact, Dr. Fisher did apologize, but Dr. Turner started to have a change of thinking. He began to explore the possibility of changing to another training analyst. Dr. Turner continued to try to make the treatment work, but couldn't reestablish the relationship they had had before the anger incident. They never explored why Dr. Fisher had become so angry, or, why Dr. Turner had been so hurt. Dr. Turner decided to change to another analyst who was more interested in early pre-oedipal trauma. When his treatment with Dr. Fisher ended he was so happy to get out of there, that he had no interest in the possibility of post-termination contact.

Training analysis Questionnaire # 8024 Partially satisfied/partially dissatisfied = 3; Rater A =3; Rater B =5.

Analysis by non-T.A. Questionnaire #8024

Dr. Turner selected as his new analyst a woman, Dr. Previn, who had training and interest in infantile issues. Dr. Turner felt that he and Dr. Previn were a good fit. She was empathic and they were able to deal with his maternal transference. They focused on more infantile conflicts. Dr. Turner still sees Dr. Previn, though he feels they are in

the final phase of his analysis. He has had a few contacts with Dr. Previn both at conferences and at non-professional activities, which were collegial and respectful. J.S. asked if Dr. Turner would give him permission to contact Dr. Previn, and he replied that would be fine with him.

Analysis by non-T.A. Questionnaire # 8024 Very satisfied = 1; Rater A =2; Rater B =2.

Discussion

The reviewed extensive literature critical of training analysis led us to hypothesize that graduate analysts would report *less* satisfaction with training analysis compared to satisfaction with analysis by a non-T.A. The most cogent test for comparing satisfaction is to examine analysts who had experienced both, and in their first paper (Schachter et al.) 31 graduate analysts who had been treated both by T.A.'s and non-T.A.'s reported no difference in questionnaire ratings of satisfaction. In addition, blind ratings of satisfaction based upon vignettes of individual interviews were significantly associated with the questionnaire ratings of satisfaction with training analysis thus supporting the validity of questionnaire ratings.

Thirteen of the 31 analyst-patients had been selected for the present study because they had been interviewed. Blind ratings of satisfaction from vignettes both about training analysis and about analysis by a non-T.A. were significantly associated with questionnaire ratings of satisfaction, thereby supporting the validity of

questionnaire ratings both of training analysis and of analysis by a non-T.A.

Among these 13 interviewees, 61% reported questionnaire ratings of satisfaction with training analysis, a rate which is close to and similar to results reported in five prior published questionnaire studies and one interview study: 86% (Shapiro, 1976); 90% (Goldensohn, 1977); 72% (Craige, 2002); 77% (Tessman, 2003). Tessman's (2003) intensive interview study of 14 analysts who had both a training analysis and an analysis by a non-T.A. concluded that "nothing suggests that non-TA analyses were less satisfactory per se" (Personal communication). Additionally, Martinez and Hoppe (1998) reported that 78% of T.A.'s reported that their own analyses were of "very much" or "tremendous benefit", while Bush and Meehan (2011) reported that the mean satisfaction score of 3.8 of graduate analysts' ratings of training analysis falls between "Moderately satisfied" and "Very satisfied". Thus, empirical reports (both questionnaire- and interview-based studies) substantiate that a majority of analysts report satisfaction with their training analysis, countering those clinical papers asserting that training analyses are intrinsically problematic to the analyst-patient. It is noteworthy that these six significant empirical studies that document satisfaction with training analysis *are not referenced* in the numerous clinical papers that are critical of training analysis. Further, the finding that 15 % of these 13 S's were dissatisfied with their training analysis is also similar to prior questionnaire studies in which reported dissatisfaction with training analysis ranging from 10% to 28% (Schachter et al.). Consequently,

these 13 interviewees appear to represent a sample similar to the analysts evaluated in six other prior empirical studies.

Our reported vignettes illustrate, and further support, the finding in prior questionnaire studies, that the majority of analysts are satisfied with their training analysis. In this study vignette-based ratings of the degree of satisfaction showed satisfactory reliability between the two raters, and they correlated positively and significantly with questionnaire ratings both of training analysis and of analyses by non-T.A.'s, thus further supporting the validity of the questionnaire ratings of analyses by T.A.'s and by non-T.A.'s.

Our previous report of this study (Schachter et al.) concluded that among 31 analyst-patients who had experienced both an analysis by a T.A. and an analysis by a non-T.A. there was no significant difference in satisfaction levels for the two treatments, thus replicating the earlier finding by Tessman (2003). A subset of 13 of these 31 analyst-patients were selected for further examination in this paper because they had participated in individual interviews; the remaining subset of 18 had not participated in interviews. Statistical analyses of questionnaire ratings of satisfaction and vignette-based ratings of satisfaction independently of each other indicated that for these 13, satisfaction with analysis by a T.A. was *less* satisfactory than analysis by a non-T.A., thereby *supporting our original hypothesis.* This suggests that in some samples of analyst-patients there will be no difference in satisfaction with treatment by a T.A. compared to treatment by a non-T.A, but other samples of analyst-patients will report *less* satisfaction with analytic treatment by a T.A. compared to treatment by a non-T.A..

It may appear paradoxical that a majority of analyst-patients are satisfied with training analysis, but some samples of analysts report being *less* satisfied with analysis by a T.A. compared to analysis by a non-T.A.. A plausible explanation is that a majority of analyst-patients are also satisfied with analytic treatment by non-T.A.'s. However, on a comparative basis, some samples of analyst-patients are *less* satisfied with analysis by a T.A., especially if the analysis by a T.A. precedes the analysis by a non-T.A., since our prior report demonstrated that second analyses were more satisfactory than first analyses.

Sixty-six per cent of questionnaire respondents requested individual interviews, and many of them commented that they were motivated to do so in order to support analytic research. Evidence suggests that a majority of APsaA members are disinterested in and even hostile toward analytic research. Thus, those who requested interviews and are supportive of analytic research probably represent a minority of APsaA members. We can only speculate that the positive attitude toward research expressed by the 13 interviewed analyst-patients in this study, their positive attitude toward analytic research might be connected to their more searching and critical attitude toward training analysis.

In summary, our earlier report, the present study and Tessman's study all failed to find evidence that treatment by a T.A. produced *greater* satisfaction than treatment by a non-T.A. This does not mean that it may not be possible to find evidence of the superiority of treatment by a T.A.; it means only that these three

studies as well as the existent literature have failed to find such evidence.

Limitations of this Study

Thirteen subjects constitute a small sample and although a similar finding was reported in Tessman's prior study of 14 analysts, further replication and broadening of the demographics will be needed. Evidence that satisfaction with analysis is positively associated with therapeutic benefit is limited (Bush and Meehan, 2011), and therefore further studies are warranted to examine this connection. The present study obtained data only from the analyst-patients and not from their treating analysts. The variable, *satisfaction*, itself may be limited in its ability to encompass the many complexities of psychoanalytic treatment, but we've chosen it as a measure because of its use in prior studies.

Conclusion

Two reports (Schachter et al.'s and Tessman's) found that overall there was no difference in satisfaction with analytic treatment reported by the same analyst/patient for analysis by a T.A. compared to satisfaction with analysis by a non-T.A. For those 13 analyst-patients who are the subjects of this study because they had been interviewed, satisfaction with analysis by a T.A. was *less* satisfactory than analysis by a non-T.A. No reported study has found *greater* satisfaction with analysis by a T.A. than with analysis by a non-T.A..

Following the ‘golden’ years of the 1940’s and 1950’s, APsaA has exhibited a slow decline and become a more precarious professional. Recent decades of increasing stress, both externally and internally, are reflected in long-term reductions in the numbers of analytic patients per graduate and new candidates. The diverse array of psychoanalytic theories, along with the absence of consensually-agreed definitions either of psychoanalysis or of psychoanalytic process means that although its principal tenets are potentially falsifiable, (Grünbaum, 2008) they remain un-validated. Thomä and Kächele wrote that there is “a fundamental crisis of the entire theoretical structure of psychoanalysis” (1994, p. 33). Evidence of the effectiveness of psychoanalytic treatment is limited (Sandell et al., 2000; Blomberg et al., 2001) although there is growing empirical support for psychoanalytic psychotherapy (Falkenström et al., 2007; De Matt et al., 2009; Grande et al., 2009; Shedler, 2010; Leichsenring and Rabung, 2011).

APsaA’s responses to these threatening circumstances can be contextualized and viewed historically by considering that other groups, faced with a perilous world, have turned to the magical help and protection of ritual (Taylor, 2004). Some members of APsaA may have unconsciously elaborated, from there cloistered belief system, an increasingly delineated ritual involving the qualification of T.A. status. The transmission of orthodox psychoanalytic theories served to transform the authority and power of a minority of APsaA members (Bernfeld, 1962; Cremerius, 1990; Reeder, 2004; Kirsner, 2009) into an omniscient, priestly elite to help deal with a threatening world. .

APsA's Board on Professional Standards, which requires candidates to be treated only by T.A.'s, presumes that these more "qualified" T.A.'s produce an undefined *more* satisfactory analytic treatment of analyst-patients than do treatments of analyst-patients by non-T.A.'s. The failure of our initial study (Schachter et al.), the current report and Tessman's (2003) interview study to find any evidence that analytic treatment of an analyst-patient by a T.A. is *more* satisfactory than analytic treatment of an analyst-patient by a non-T.A., clearly places the burden of proof upon APsaA's Board on Professional Standards to present empirical evidence that treatment by a T.A. *actually is more satisfactory* to the analyst-patient than treatment by a non-T.A..

Failure to produce such empirical evidence makes it plausible to conclude that the concept of a qualified T.A. constitutes a ritual constructed primarily in order to create and maintain the authority and power of a priestly, omniscient, elite minority in APsaA, as an aid in dealing with the threatening stresses confronting APsaA.

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