The Responses of Dissociative Patients on the Thematic Apperception Test

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This study compared the responses of dissociative inpatients and general inpatient psychiatric controls on the Thematic Apperception Test (TAT; Murray, 1943). We found the stories of dissociative participants to be characterized by a greater interpersonal distance and more trauma and dissociation responses than those of the controls. No significant differences were found regarding total number of emotional references, although references to positive emotions were almost nonexistent for the dissociative group. A post hoc analysis of the data found the testing behaviors of dissociative participants to be characterized by switching, trance states, intrainterview amnesias, and affectively loaded card rejections. Questions were raised regarding the relevancy of the findings to clinical practice and how they might explain some of the controversies surrounding the diagnosis of dissociative identity disorder (DID). © 2001 John Wiley & Sons, Inc. J Clin Psychol 57: 847–864, 2001.

Keywords: dissociation; emotionality index; trauma index; dissociation index; object-relations index

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Although the study of dissociation in relation to psychological trauma and the formation of alter personality states can be traced to the late nineteenth century work of Pierre Janet (Ellenberger, 1970), it was not until the early 1980s that multiple personality disorder (currently referred to as dissociative identity disorder; DID) and other dissociative conditions became recognized as diagnosable psychiatric disorders. Research by Ross, Anderson, Fleisher, and Norton (1991) suggests dissociative patients comprise approximately 3% of the patients housed in adult inpatient psychiatric wards. Other clinical research found that patients with bulimia, depression, posttraumatic stress disorder (PTSD), and borderline personality disorder exhibit significant levels of dissociative symptoms (Groth-Marnat & Michel, 2000; Schumaker, Warren, Carr, & Schreiber, 1995). Despite outcry from researchers, theorists, and clinicians (Fahy, 1988; McHugh, 1995; Merskey, 1992; Piper, 1994) who question the legitimacy of dissociative disorders, the last decade has witnessed an explosion (Ross, 1991) in the number of cases reported in the literature and the development of an international society and journal devoted specifically to the study of dissociative phenomena.

Several aspects of dissociative experience have been touched upon by theorists, researchers, and clinicians including social, developmental, and physiological perspectives as well as diagnostic and treatment issues. Although there are too many articles to cite for purposes of this research, some of the more prominent works include Kluft’s (1993) discussion of DID presentation and treatment, Putnam’s (1995) review of developmental issues, Carlson and Armstrong’s (1994) review of assessment research, and books by Braun (1986), Putnam (1989), and Ross (1989) which cover many, if not all, the domains of DID. This study probes further into the assessment literature by examining how dissociative patients respond on the Thematic Apperception Test (TAT; Murray, 1943), building on pilot research (Pica, 1997; Pica, Beere, & Repasky, 1996) which found the TAT stories of dissociative inpatients and college students to be marked by an interpersonal distance, a lack of affect, and trauma and dissociation responses.
and dissociation responses while Scroppo, Weinberger, Drobb, and Eagle (1998) reported a significant number of blood and morbid responses and fabulized combinations in the Rorschachs of DID patients compared to a psychiatric control group. MMPI investigations found dissociative patients to respond in a consistent manner characterized by marked elevations on Scale F and Scale 8 and at least five clinical elevations (Bliss, 1984; Coons & Fine, 1990; Griffin, 1996; Solomon, 1983). One problem with applying the MMPI findings to the clinical setting is that such profiles are common among nondissociative patients experiencing severe emotional turmoil and crisis.

Far less attention has been given to the TAT than the Rorschach and the MMPI. Pilot research by Pica, Beere, and Repasky (1996) found that the stories of dissociative college students read like descriptions, contained limited references to emotion, and possessed lonely, isolated characters who did not interact with each other except to do harm. Dissociative college students were identified as participants who scored greater than 22.5 on the DES. Their stories were compared to stories from low dissociators, or participants who scored less than 5.0 on the DES. Similar results were found with three dissociative inpatients (Pica, 1997), in addition to “dissociation responses;” that is, responses in which alterlike phenomena were mentioned in the card, or characters were said to look or feel unreal or were experiencing a flashback, entering trance, or in the process of “dissociating.”

Hypotheses

We proposed four hypotheses thought to distinguish dissociative patients and psychiatric controls on the TAT. First, the TAT stories of dissociative participants should have fewer references to emotion compared to the stories of control participants as measured by the Emotionality Index, a score developed in this study to assess the frequency of emotional references made by the participant. For clarity’s sake, we defined emotional references as statements of feeling, including but not limited to feeling happy, angry, sad, frightened, surprised, ecstatic, and so on. Second, the TAT stories of dissociative participants should be marked by a greater number of trauma responses compared to the stories of control participants as measured by the Trauma Index, a score we developed to assess the frequency of trauma responses made by the participant. Trauma responses were defined as responses depicting muggings, shootings, rapes, murder, torture, domestic violence, molestation of a child, neglect, confinement abuse, verbal abuse, and so on. Third, the TAT stories of dissociative participants should be marked by a greater number of dissociation responses compared to the stories of control participants as measured by the Dissociation Index, a score developed to assess the frequency of dissociation responses made by the participant. We defined dissociation responses as responses in which a character or characters were said to be dissociating, leaving the body, entering trance, experiencing flashbacks, feeling unreal, looking unreal, and alters or other “parts” taking over for the characters. Fourth, the TAT stories of dissociative participants should be characterized by a greater interpersonal distance among the characters compared to the stories of the control participants as measured by the Object-Relations index, a score developed to assess the presence or absence of object-relations in the story. The Object-Relations index was comprised of two types of responses, responses depicting interaction between the characters (talking, hugging, fighting, working together, telling a joke, and so on) and responses tapping the characters general sense of intimacy with others mentioned in the story (feeling close to, connected, attached, intimate, or in love with another, or out of place, disconnected, isolated, distant, or disinterested in others). For scoring purposes, stories depicting interaction or a sense of intimacy were given a “1” to indicate the presence of object-relations while stories that depicted no interaction, no intimacy, or an attempt to
sever attempts at interaction were assigned a “0” to indicate no object-relations. Although intended for research purposes only, a copy of the scoring criteria is included in the Appendix.

Methods

Participants

Two groups of participants, 19 dissociative inpatients (19 females, \( M \) age = 36.4 years, \( M \) years of education = 13.7) and 19 general psychiatric inpatients (1 male, 18 females, \( M \) age = 35.1 years, \( M \) years of education = 13.5) participated in this study. The number of participants was derived based on a power analysis formula which estimated power by what it would be in the Multivariate Analysis of Variance (MANOVA) case using two groups, an estimated effect size (\( E \)) of 2.25, and a power of .80 (see Stevens, 1986). The \( E \) was determined by calculating the effect sizes for dissociative screening instruments reported in the literature (Phillips, 1994; Ross, Norton, & Anderson, 1988).

Participants were recruited from inpatient units in McLean Hospital’s Trauma and Dissociation Program and Women’s Treatment Program and from their partial hospitalization program. Treatment teams working on the inpatient units identified 33 patients (17 dissociatives and 16 controls) considered appropriate for the study. Participants were considered appropriate if they had no history of psychosis, developmental disabilities, or neuropsychological impairment. Of this group, one dissociative patient refused to participate. Six additional patients (three dissociatives and three controls) were identified by the partial hospitalization program.

All psychiatric diagnoses were determined by three resident psychiatrists in consultation with their respective treatment teams who have experience in the diagnosis of dissociative psychopathology. One of the psychiatrists, who also is the head of the Trauma and Dissociative Disorder Program, is an internationally known expert in the field of dissociation. Thirteen participants in the dissociative group were diagnosed with DID, the remaining six with dissociative disorder not otherwise specified (DDNOS). For the psychiatric control group, seven participants were diagnosed with major depression, four with borderline personality disorder, four with PTSD, two with bipolar disorder, one with bulimia, and one with anorexia nervosa.

Procedure

All participants who participated in the study signed a general consent form that gave a brief explanation of the project, described benefits and risks of participation, and explained their rights to confidentiality. Participants were tested (one-on-one) by the first author in areas designated on each of the appropriate units, with the examiner blind to the patient’s diagnosis going into each testing session. Participants were administered a standard set of ten TAT cards with the following instructions:

I am going to show you some pictures and I’d like you to make up stories about each picture. Tell me what is happening or going on—what led up to how this event came about, and then how the story will end. Make up how the characters or people in the picture are feeling and what they are thinking. Use your imagination. Just let yourself go.

Following administration of the TAT, participants were administered the DES (Bernstein & Putnam, 1986) and went through a debriefing period before exiting the session.
Measures

The TAT is a projective psychological assessment measure consisting of black and white cards which depict individuals and groups of individuals in “classical human situations” (Murray, 1943, p. 2). The stories are believed to elicit clinical information about the individual’s conscious and unconscious impulses, wishes, defenses, motives, drives, fantasies, conflicts, interpersonal attitudes, and perceptions (Alvarado, 1994; Bell, 1948; Karon, 1982). Although met with initial enthusiasm, the TAT has been the subject of heated debate with critics pointing to its lack of a universal scoring system and failure to achieve adequate validity and reliability estimates as reasons for discontinuing its use in clinical practice. Karon (1982) rebuffed such claims by noting that the literature on the validity and reliability of the TAT shows a wide range of variability. He argued that one can find studies supporting the validity of the TAT just as easily as one can find studies in which the TAT has not been shown to be valid. Explaining these discrepant findings, he pointed to one frequently overlooked variable, the experience of the examiner doing the testing.

Notes Karon:

In those studies where the individuals had training or experience using the TAT and are predicting a criterion about which something they know, the TAT turns out to be valid. In those studies where the interpretation is made by people without any training or experience, who are trained by people without training, or who are predicting a criterion about which they know nothing, the TAT turns out not to work very well. Clinical processes require relevant training or experience. (p. 107)

More recently, Cramer (1999) suggested that the TAT might best be conceptualized as an observational method which does not lend itself so well to traditional ways of assessing reliability and validity. In terms of internal consistency, she noted that the different TAT cards pull on different themes, making it difficult to expect that scores assessed on one picture will be consistent with scores based on another picture. Regarding test-retest reliability, she noted that second administrations of the TAT often lose their novelty and surprise and may prompt the individual, responding to covert self-instructions, to give a different set of stories to the same cards. As well, there is the possibility that the personality characteristic being measured may change over time so that a different set of responses are elicited. She concluded that with any observational instrument, the best way to assess reliability is through interrater agreement on a card-by-card basis.

Ten cards (1, 2, 3GF, 4, 6GF, 7GF, 8BM, 12M, 13B, 14) were selected for the test battery. Card selection was determined based on feedback from two of the coauthors (D.B. & S.L.), who each have over 20 years of experience working with dissociative patients. We attended to include a mix of “benign” cards and cards thought to pull on more powerful affects so as not to completely overwhelm the dissociative patient. Some consideration was given to cards that could be perceived as depicting alterlike characters (9GF, 12F, 18M). However, we decided to be more subtle in eliciting dissociation responses and did not include them in the test set. Readers interested in a description of the selected cards and the dynamics on which they are thought to pull should see Murray (1943) and Henry (1956).

The DES was administered to provide further validation of the dissociative diagnoses assigned to the experimental and control groups. This measure is a 28-item self-report questionnaire that asks participants to circle the percentage of time they experience various dissociative experiences in their daily lives. Several investigations found that the
DES possesses excellent validity and reliability as a measure for assessing dissociativity with reported split-half reliabilities ranging from .83 to .93 with Cronbach’s alpha equal to .95 (Bernstein & Putnam, 1986; Carlson, 1994; Frischholz et al., 1990; Ross et al., 1988; Steinberg et al., 1991). Research by Steinberg et al. (1991) found it to be effective in screening for patients with DID.

Calculation of the TAT Index Scores

Raw data for each of the four dependent variables were converted to four index scores—an Emotionality Index Score, a Trauma Index Score, a Dissociation Index Score, and an Object-Relations Index Score. Index scores were calculated for each participant by adding the raw scores for each dependent variable and dividing by ten. Thus, to calculate the Emotionality Index score, the rater would add each emotional reference in a participant’s set of stories and divide that overall score by ten. Likewise, the rater would calculate each instance of object-relations and divide by ten. Corrections were made to account for 14 card rejections (11 dissociative stories and 3 control stories) which might have biased the results. Because most cards were rejected by dissociative patients, a conservative approach was used in which corrections were made in the direction indicating no difference in emotional references, trauma responses, dissociation responses, and depiction of object-relations. This was accomplished by excluding card rejections in the computation of Emotionality and Object-Relations Indices, as dissociatives were hypothesized to give less emotional responses and contain less object-relations in their stories, and including card rejections in the calculation of the Trauma and Dissociation Indices because these indices were hypothesized to be greater for dissociative participants. To illustrate, a dissociative participant might give three emotional responses in his or her battery and reject one card. Using the correction formula, this would result in an Emotionality Index score of .33 rather than .30. Remember, we hypothesized that dissociative stories would be marked by fewer emotional references. A score of .33 would make it more difficult to find a significant difference in the hypothesized direction. Likewise, three trauma responses and one card rejection would yield an index score of .30 rather than .33. As we hypothesized that dissociatives should give more trauma responses, adding a .30 score in the analysis would make it harder to find a significant difference in the hypothesized direction. Multivariate analyses were conducted on a final set of index scores averaged from Raters 1 and 2. These scores were run using an SPSS/PC+ 2.0 software program (Norusis, 1988).

Interrater Reliabilities

All stories were scored by two psychology students who were blind to the nature of the study. For training purposes, raters completed a practice set of stories from a previous pilot study. In some stories, the first author added trauma and dissociation responses. The first author reviewed the practice ratings with both raters, clarifying questions about the scoring system and revising each of the indices. Stories were rated by card number, with ratings made on separate pieces of paper to prevent any response bias. Pearson correlations were calculated for each of the index scores. These results (Table 1) suggest that index scores were fairly consistent between the two raters. Meyer (1999) notes that analyzing the reliability of summary scores is appropriate for research or applied clinical practice. However, to ensure that the scoring system was clear and that the index scores did not mask any underlying differences between raters, percent agreements were calculated to see how much agreement was reached on the presence and absence of each of the
dependent variables before conversion to index scores. These findings (Table 1) demonstrate a high degree of agreement between the raters. Kappa correlations for chance agreement (see Meyer, 1999) were calculated for the trauma and dissociation variables because of their relatively low base rate.

Results

The dissociation group scored significantly higher on the DES ($t = 5.96, df = 36, p = .000$) than the control group, providing further validation of the dissociative diagnoses assigned to the experimental and control groups (see Table 2). $T$ tests were run to see whether dissociative and control participants significantly differed in terms of age, years of education, and word count. No significant differences were found for age (dissociative group: $M$ age = 36.4, $SD = 8.8$; control group: $M$ age = 35.1, $SD = 8.6$) and years of education (dissociative group: $M$ years education = 13.7, $SD = 2.0$; control group: $M$ years education = 13.5, $SD = 1.9$). Likewise, the two groups did not significantly differ (dissociative group: $M$ = 39.8 words per story, $SD = 9.8$; control group: $M$ = 42.4 words per story, $SD = 11.5$) in word count, allowing the following analyses to be run without having to correct for this variable.

Mean emotionality, trauma dissociation, and object-relation index scores for the dissociative and control groups are presented in Table 3. A significant overall difference was found between the dissociation group and the control group, $F(1,36) = 2.68, p = .000$, using Hotelling’s $T$ for a two-group MANOVA. Follow-up univariate analyses were conducted to determine which variables contributed to this overall difference. While these analyses revealed that dissociative and control participants did not significantly differ in terms of their Emotionality Index Scores, significant differences were noted on the Trauma,

<p>| Table 1 |</p>
<table>
<thead>
<tr>
<th>Intrarater Reliability Estimates for Converted Index Scores and for Presence/Absence of the Four Dependent Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indices/Dependent Variables</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Emotionality Index</td>
</tr>
<tr>
<td>Object-Relation Index</td>
</tr>
<tr>
<td>Trauma Index</td>
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<tr>
<td>Dissociation Index</td>
</tr>
</tbody>
</table>

*Presence/absence of the raw form dependent variables. **Correlations significant at the $p < .001$ level. ***Chance corrected intrarater agreements. |

<p>| Table 2 |</p>
<table>
<thead>
<tr>
<th>Mean DES Scores and SD for the Dissociation and Control Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Dissociation</td>
</tr>
<tr>
<td>Control</td>
</tr>
</tbody>
</table>
F(1,36) = 16.15, p = .000; Dissociation, F(1,36) = 17.14, p = .000; and Object-Relation Indices, F(1,36) = 34.56, p = .000.

A stepwise discriminant function analysis was conducted to evaluate the power of the trauma, dissociation, and object-relation indices for diagnostic discrimination. As Table 4 indicates, these variables correctly identified 18 of 19 dissociative participants and 18 of 19 control participants for a sensitivity rate (percentage of true dissociative cases classified as dissociative) of 94.7% and a specificity rate of 94.7% (only 5.3% of nondissociative cases classified as dissociative). The overall classification yielded a 94.7% hit rate. In terms of contribution, the object-relation variable had the highest discriminant function loading (−.868) followed by the trauma (.619) and dissociation (.517) variables.

**Exploratory Analyses**

Several exploratory post hoc analyses were conducted regarding emotional references, supernatural responses, and testing behaviors. Ratings of all these responses were conducted by the first author with the testing behaviors recorded as they occurred during testing. Using the ratings of Rater 1, the examiner evaluated the number of positive and

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**Table 3**

*Mean Emotionality, Trauma, Dissociation, and Object-Relation Index Scores, SD, and Univariate Significance Tests for Dissociative and Control Groups*

<table>
<thead>
<tr>
<th>Group</th>
<th>Dissociative (n = 19)</th>
<th>Control (n = 19)</th>
<th>Univariate F-test p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Emotionality Index</td>
<td>0.46</td>
<td>0.27</td>
<td>0.55</td>
</tr>
<tr>
<td>Trauma Index</td>
<td>0.23</td>
<td>0.15</td>
<td>0.07</td>
</tr>
<tr>
<td>Dissociation Index</td>
<td>0.19</td>
<td>0.17</td>
<td>0.02</td>
</tr>
<tr>
<td>Object-Relation Index</td>
<td>0.31</td>
<td>0.12</td>
<td>0.60</td>
</tr>
</tbody>
</table>

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**Table 4**

*Predictive Validity of Trauma, Dissociation, and Object-Relation Indices*

<table>
<thead>
<tr>
<th>Actual Group</th>
<th>n</th>
<th>DID-DDNOS</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>DID-DDNOS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>19</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td>94.7%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>19</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td>5.3%</td>
<td>94.7%</td>
</tr>
</tbody>
</table>

*Note.* Percent of grouped cases correctly identified = 94.7%.
negative emotions. As post hoc analyses, these findings need to be noted with caution and the consideration of possible rater bias.

While the univariate $F$ test revealed that dissociative and controls participants did not significantly differ regarding number of emotional responses, further analysis of the data revealed that control participants reported a significantly greater number of positive emotions than dissociative participants ($t = -2.60, df = 36, p = .013$). Stories with positive emotion, in fact, were almost nonexistent for the dissociative group (reported in one dissociative story), whose stories were marked by feelings of anger, fear, depression, and sadness. One set of responses that stood out during testing was responses depicting supernatural phenomena including references to ghosts, exorcisms, séances, devil sacrifices, and witchcraft. These responses were noted among 12 dissociative participants compared to 1 control participant, a finding which proved significant at the $p = .017$ level using a Yates corrected chi square.

Barach (1986), Armstrong and Loewenstein (1990), and Silberg (1998) described the hidden participation of alters during testing. This study focused on three behaviors indicative of switching/hidden participation: trance states, intrainterview amnesias, and card rejections. Trance states, defined in this study as episodes in which the participant broke from the task, appeared to be staring into space, and remained unresponsive to initial attempts at reorientation, were noted in seven of the dissociative participants and only one control participant. This difference proved significant at the $p = .047$ level using a Yates corrected chi square. Intrainterview amnesias, defined in this study as participants forgetting where they were, who they were with, and what they were instructed to do, were noted in five dissociative participants and none of the controls. This difference approached significance ($p = .055$) using a Yates corrected chi square. In terms of card rejections, 11 cards were rejected by six dissociative participants while only three rejections were noted among three control participants. Although the number of dissociative and control participants who rejected cards proved nonsignificant, it is interesting to note that all of the dissociatives’ card rejections were accompanied by fearful or angry expressions, with the majority coming on Card 8BM and Card 14. Only one of the control rejections was accompanied by the intense affect shown by dissociative participants, and this was displayed by a borderline personality. In the other cases, the control participants told the examiner that they could not come up with a story and handed the cards back to the examiner.

Discussion

The results suggest that dissociative psychiatric patients can be distinguished from general psychiatric patients on the TAT. Results from the discriminant function analysis demonstrated that the Trauma, Dissociation, and Object-Relation indices correctly identified all but one of the dissociative participants while yielding only one false-positive (diagnosing a control as dissociative). Some caution should be used in interpreting these results due to the limited sample size on which these analyses were run. However, with a 94.7% classification rate, it is not likely that these findings were merely the result of chance.

Dissociative patients tell stories about characters who impress as alone in the world, whose world is marked by trauma, and who experience dissociative-like phenomena. They also show some tendency toward the supernatural. Behaviorally, these patients exhibit emotional volatility and reactivity to the cards, trance states, switching behaviors, and intrainterview amnesias. The findings are consistent with Silberg’s (1998) research on dissociative children and adolescents; in particular, the presence of malevolent religiosity
(defined in this study as supernatural responses), violence (correlating with trauma responses), and multiplicity responses (paralleling, at least conceptually, with the dissociation responses in the current study) in addition to test behaviors marked by emotional fluctuations, card reactivity, trance states, and amnesia. The dissociative group experienced strong reactions to Cards 6GF, 7GF, 8BM, 12M, and 14. These cards often pulled on strong affects which for dissociative patients may trigger trance states, switching behaviors, and trauma and dissociation responses in addition to affectively loaded card rejections in which the cards were thrown across the table or were called “evil” or “disgusting” in some cases. These sorts of reactions are not surprising given the content and dynamics of these cards which are believed to pull on father/daughter and mother/daughter themes, issues of personal control, and feelings of depression and aggression. Of interest was the response of dissociative participants to Card 2, the family card (see Henry, 1956), in which the responses of dissociative patients were marked by statements of disconnection, isolation, and detachment.

These findings aside, the study is not without limitations. First, the sample was predominantly female. One implication is that the findings might not generalize to male dissociative patients. Another limitation is the study being conducted on an inpatient unit specializing in the treatment of dissociation where patients take part in process-oriented groups and psychoeducational groups designed to deal with dissociation. It is not clear that dissociative outpatients or inpatients treated in a general treatment center would respond in such ways. Directions for future research might focus on comparing dissociative inpatients housed in specialty programs and general treatment centers with an outpatient sample of dissociative patients to see whether there are any differences between the groups. Another issue pertains to a nonblind investigator testing the participants. Although every effort was made to keep him blind to the diagnosis of the participant, some participants announced their diagnosis during testing. In other cases, the manifestation of trance states and intrainterview amnesias at different points in testing cued the investigator into a dissociative condition. It is possible that with such cues, the investigator may have unconsciously led the participants to respond in certain ways through facial expressions or other body gestures. Future research might employ an examiner who is blind to the nature of the study and the features of dissociative patients. However, given the testing of behaviors of dissociative patients, the examiner should be competent enough to work with such patients should they experience distress or begin to switch during the session.

A further issue to consider is the control group. In this study, the control group was comprised of a variety of diagnostic categories, many of whom had been found to exhibit significant dissociative psychopathology. The inclusion of a heterogeneous control group may have masked similarities between dissociative patients and patients with borderline personalities, PTSD, bulimia, and depression who might project violence, dissociation, isolation, and detachment into their stories in addition to responding with trance states, emotional volatility, and intrainterview amnesias. It would be interesting to see how the stories of dissociative patients are similar to and different from homogenous groups of patients with bulimia, depression, PTSD, and borderline personality disorder. These issues might be addressed in future research.

A final methodological issue to consider is the scoring system. High interrater reliabilities were obtained in this study. However, the first author invested considerable time training the raters. Given lesser circumstances, it is not clear that one would obtain such results. Moreover, many of the responses were short and simple, making the variables relatively easy to score. It is not clear whether these sorts of responses were specific to this sample or indicative of psychiatric patients in general. One might find more diffi-
difficulty using the system to score the stories of outpatients, who often experience less debilitating pathology and provide more elaborate and complex stories, than provided here. While this may not have much of an effect on the trauma and dissociation variables, it may cause problems scoring for object-relations. Because of these issues, we caution against using the scoring system until it is further tested and refined with various samples and more interrater reliability estimates are gathered.

Given the controversy that surrounds the field of dissociation, it is important to consider how the findings contribute to that area of discussion. On the surface, one could argue that the findings support the iatrogenic position that dissociative symptoms are manufactured by needy, impressionable patients who enact the role for therapists on the lookout for dissociation. Supporters of this position might point to the unit on which the sample was drawn, noting that these patients were treated as “dissociative” and surrounded by dissociative patients and clinicians who specialize in the treatment of dissociation. Exposure to such an atmosphere could teach patients how to be dissociative and reinforce the manifestation of dissociative symptoms. Following this logic, it should come as no surprise that patients create stories that depict trauma, dissociation, and supernatural responses, information that is dissociative in nature and could be learned by observing others and participating in the treatment milieu.

On the other hand, some important points should be considered. First, while trauma, dissociation, and supernatural responses could be learned in the aforementioned ways, portraying characters who are lonely, isolated, and disconnected from others would seem a less obvious “dissociation” response to make. In addition, there is the issue of testing behaviors marked by emotional fluctuations, trance states, and a hypersensitivity to specific cards. It would seem difficult to imagine that a group of patients would respond in such a similar manner to the examiner. Moreover, it would be difficult to imagine that even the most skilled dissociative patient, from the iatrogenic perspective, would know how a dissociative patient responds on the TAT (i.e., that they should show spontaneous trance states, emotional fluctuation, and strong emotional reactions to a specific group of cards). While Spanos, Weeks, and Bertrand (1985) were able to show how college students could fake the most obvious symptoms of DID under hypnotic trance, it would be something to see if the average college student, after being exposed to “Eve,” “Sybil,” or other media representations of DID, could play a dissociative patient during administration of the TAT.

It also is important to consider the applicability of the findings to clinical practice. A criticism of using the TAT to diagnose dissociation is that the examiner could arrive at the same diagnosis without having to spend time administering, scoring, and interpreting the testing. In other words, why use the TAT when you can cut your time using a structured clinical interview? The problem with this thinking is that it assumes all professionals are tuned into the subtleties of dissociation and are thinking dissociation when a patient acts in certain ways on the inpatient unit. Testing referrals are typically made by psychiatrists who are interested in understanding the factors underlying their patients’ behaviors, whether they are due to a personality disorder, psychotic process, or mood disorder or whether the patient is a danger to self or others. In this case, the patient may not begin to reveal dissociative symptoms until he or she is administered a Rorschach or a TAT. Relative to this particular study, the TAT can tune the examiner into the possibility of a dissociative disorder, something he or she can clarify later with a diagnostic interview.

Finally, it is important to note that the findings are just a starting point. Coupled with a high DES score, a history of multiple diagnoses, and a known history of childhood abuse, TAT stories characterized by interpersonal distance, trauma, dissociation, supernatural responses, trance states, intrainterview amnesias, and negative affectively loaded
card rejections might suggest the presence of a dissociative disorder and further consideration of this diagnosis. However, note that the findings are specific only to the cards used in this study. One should not conclude that different cards will evoke the same results. For instance, there is nothing to suggest that the cards would have the same effect on males. With this in mind, directions for future research include replicating the findings with similar and different sets of cards to find the most powerful cards for administration as well as testing the cards on a more balanced sample of males, outpatients, and inpatients being treated in general treatment centers. This would begin to clarify whether the results were specific to inpatient females or could be generalized to outpatients and males as well.

Appendix 1

FOR RESEARCH PURPOSES ONLY

SCORING INSTRUCTIONS

Your job as a research assistant in this study is to rate TAT stories. You will rate the stories on four dimensions: the number of emotional references in the stories, the number of trauma responses, the number of dissociation responses, and whether object-relations are present in the story.

You have two folders, one that contains 38 sets of rating forms and one that contains 38 stories from 38 subjects. On the top of each story is the subject number. You are to start by selecting a story and a blank set of rating forms. Write the subject number on the top of the rating form where it says subject number. Next, write the card number on the rating form. The card number can be found on the front of the folder which contains the stories. Once you have recorded the subject and card numbers, read the story and rate it based on the four scoring criteria. When you have completed the entire form, select the next story and another blank rating form. Again, write the subject and card numbers on the top of the rating form, read the story, and complete the scoring criteria. Do the same thing for subject three, four, five . . . until you have completed all of the stories in that folder. When you have finished, put the stories and rating forms in their respective folders.

Subject # __________
Card # __________

I. An emotional reference refers to the number of times emotion is referred to in the story, whether it refers to a character, characters, or the story as a whole. Emotion is defined in this study as a feeling state, including, but not limited to feeling happy, sad, mad, angry, worried, frightened, bored, hopeful, ecstatic, content, in love, etc. These are just a few examples. Please mark with a tally whenever you have come across an emotional reference in the story you just read.

Happy = __________
Sad = __________
Frightened = __________
Angry = __________
II. In this section, you are to mark references to trauma depicted in the story. Trauma responses include mention of physical or sexual trauma in the form of beatings, stabbings, shootings, murder, torture, domestic violence, incest, child abuse/molestation, kidnapping, druggings, or rape, confinement abuse in which an individual is chained or tied to an object or locked in a room, neglect or abandonment of a child, or verbal abuse in which a character is depicted as swearing at, screaming, degrading, or ridiculing another character. The trauma may have already happened, be in the process of happening, or about to take place. Please mark with a tally whenever you come across a trauma response in the story you have just read.

Physical/Sexual Trauma:        Confinement Abuse:
Beating(s) = __________        Chained to object = __________
Stabbing(s) = __________      Tied to object = __________
Shooting(s) = __________      Locked in room = __________
Mugging(s) = __________
Murder = __________
Torture = __________         Swearing at another = __________
Domestic Violence = __________  Ridiculing another = __________
Rape = __________         Degrading another = __________
Incest = __________
Child Abuse/Molestation = __________  Other:
Child Neglect = __________
Kidnapping(s) = __________
Drugging(s) = __________
Total Number of Trauma Responses = __________
III. Dissociation responses refer to responses in which a character or characters are described as “dissociating,” feeling unreal, looking unreal, experiencing a flashback, feeling like they have left their body, or entering a trance state. Dissociation responses also include mention of alter personalities or other “parts” of the character appearing in the story and mention of the cards looking unreal, blurry, or foggy.

Please mark with a tally when you come across a dissociation response in the story you have just read.

- Character(s) “dissociating” = 
- Character(s) feels unreal = 
- Character(s) looks unreal = 
- Character(s) experiencing a flashback = 
- Character(s) feel out of body = 
- Character(s) enters trance state = 
- Mention of an alter personality = 
- Mention of other “parts” = 
- Card or part of card looks blurry, foggy, unreal = 

Total Number of Dissociation Responses = 

Subject # 
Card # 

IV. In this last section, you are to rate the presence or absence of object-relations.

Score a “1” for object-relations if one of the criteria below are present and there is no mention of a character or characters feeling isolated, distant, abandoned, disconnected, detached, disengaged, or alienated from one another or other characters in the story and if there is no mention of a character or characters actively trying to disengage from or sever object-relations by walking away, leaving, avoiding, ignoring, or not paying attention to another character or characters in the story. It should be noted that any mention of a character or characters feeling isolated, distant, abandoned, disconnected, detached, disengaged or alienated from other characters, or trying to sever object relations by walking away, leaving, avoiding, ignoring, not paying attention to other characters automatically receives a score of “0” indicating no object-relations, even if some of the criteria indicating the presence of object-relations is present.

Criteria that indicates the presence of object-relations:

1) Mention of characters engaged in physical or verbal interaction.

Examples include a mother talking to her daughter about school, a family making breakfast or eating dinner together, children playing, people laughing, a couple kissing, hugging,
fighting, having sex, consoling one another, or saying good-bye, a family working together on the farm, a father and son praying in a religious ceremony, a little boy who was hiking with his family, a therapist putting a patient in trance.

2) Mention of at least one character attempting to relate to another character in some way.

Examples include a mother reading a story to her daughter who is listening to every word as she looks out the window, a man sneaking up to surprise his girlfriend, a wife calling her husband in for dinner, a mom who’s getting up to make dinner for her daughter, a woman pleading with a man to help her, a father who yelled at his son for making a mess.

3) Mention of a character or characters thinking about interacting with another character or characters.

Examples include a young boy thinking about playing football with his friends, a girl thinking about meeting with her boyfriend for a midnight kiss, a boy thinking about going fishing with his father, a girl wishing she was sewing with her grandmother, a man sitting by the window waiting for his wife to come home so he can tell her some news.

4) Mention that characters are feeling close to, connected, attached, bound, intimate, in love, admire, or respect one another.

Examples include a very close family working on the farm, a little girl who really feels close to her mother, a couple that is in love, a couple who have a really strong bond, a boy practicing the violin who admires his music teacher, a family who mutually respect one another, a woman watching her husband work thinking how much she loves him, etc.

Criteria indicating no object-relations:

1) None of the four criteria indicating the presence of object-relations have been met.

2) Or, a character is acting in a way to avoid/sever connections with another character or character.

Examples include a daughter looking out the window wishing she was somewhere else as her mother reads her a story, a man turning away from his girlfriend as she tries to hug him and tells him how much she loves him, a boy who refused to go on a trip with his family, a man ignoring what the woman is telling him because he is not interested in talking to her.

3) Or, mention of a character or characters feeling out of place, lonely, isolated, distant, abandoned, detached, disconnected from, or disinterested in other characters in the story.

Examples include a young girl who doesn’t feel like part of her family, a little boy sitting by himself feeling lonely, a little girl sitting on her mother’s lap but feels distant from her mother, a lonely man sitting in a dark room waiting for something to happen, someone who feels disconnected from the world, an abandoned little boy.

In some cases it may be difficult to determine whether or not object-relations are present in the story you just read. In these cases feel free to circle a “can’t score.” Examples of “can’t score” responses include a character praying over a dead person, a priest giving the last rites, a man standing over a young boy who is sleeping, doctors working on a wounded soldier.
Please circle one of the following responses:

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<td>Object-Relations Present</td>
<td>Object-Relations Absent</td>
<td>Can’t Score</td>
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References


