On various occasions, I have characterized blind diagnosis using a single test as a stunt. Such an exercise is not representative of good clinical practice, and it does not validate a test or a method of analyzing it; indeed, it does nothing more than show what one person can do with one kind of data—a performance that says little or nothing even about that person’s clinical prowess under normal circumstances. Yet the fact remains that it subjects a diagnostic method to a searching test, and if the method can give rise to judgments that are independently verifiable, a presumption of validity is created more quickly than in any other way I know. Because I believed that much more could be done with the TAT than most clinicians seemed to think, I agreed to take part in two such blind diagnostic demonstrations, with the understanding in advance that the reports and results of independent clinical diagnostic studies would be published. Both are reprinted here (as Chapters 6 and 7). I have gone out on this kind of limb on about half a dozen occasions (the others not published), and none has proved a disaster. The number is not large, but at least the two examples that follow are representative of this small population.

These cases are not presented, I want to reiterate, as evidence of the TAT’s validity, nor can the degree of success and failure attained in them be directly attributed to the approach described in the preceding pages. Rather, they illustrate concretely a way to analyze data and to synthesize a portrait of a person in trouble, in which the influence of my teachers—particularly, Henry A. Murray and David Rapaport—will be apparent. (I presented and exemplified it in a somewhat different way in my 1972 book, Assessing Personality.)

I have a special feeling for the case of John Doe, because it initiated a friendship of several decades with a delightful and creative psychologist, Ed Shneidman. He asked me (largely on the basis of having read my chapter in Anderson and Anderson, 1951, here reprinted as Chapter 2), along with 16 other proponents of scoring systems and other methods of working with the TAT, to apply our techniques to a TAT and a MAPS test, which he had given to a 25-year-old male subject. We were asked to begin with an account of our method of thematic test analysis, followed by full working notes or scoring sheets, and ending with an integrative report. I omit here the MAPS test protocol (which I did not examine until I had finished analyzing and writing up the TAT) and my analysis of it. It differed largely in being filled with much more blatantly schizophrenic material, wild and bizarre ideas presented with an exhibitionistic flourish.

Though I have altered the text of my notes and interpretative summary only to make minor corrections, the format is different. It seemed that the reader’s task would be
simplified if the working notes were printed immediately following the stories to which they pertain. Some material on “the clinical story” concludes this chapter, to give you an idea of how John Doe appeared to those who interviewed and treated him.

A Blind Interpretation of Doe’s TAT

To the extent that I could be said to have a method, it consists in reading over the stories and making notes on aspects of form and content that strike my attention as being deviant or as fitting together with impressions from other stories or from other tests. (In clinical work I always use a battery of tests.) These notes, which are more or less copious, depending on the time pressure under which I am working and on the purpose for which the TAT is being used, are quite similar to the ones reproduced here. They consist mainly of three types of material: notations of significant formal aspects of the record (where I depend heavily on Rapaport), rather unsystematic skeletonizing of content in terms of need-press themas (where my debt to Murray is most clear), and speculations about the symbolic and dynamic significance of anything in the record. I try to be free and undisciplined in these speculations (which derive mainly from what knowledge of psychoanalysis I have) but keep a watch on the extent to which I am projecting myself, and treat them only as speculations until they are corroborated.

After these notes have been made, I read them through again, often making additions, and collate them with similar notes from any other material I have about the subject, in pretty much the usual way: looking for repeated themas, for congruences and overlaps between different stories and between different tests.

In diagnostic studies, I believe very strongly in the position argued most clearly by Schafer (1948), that tests allow us to make inferences about aspects of personality and the organization or disorganization of thought and affect, not directly about diagnostic categories. From the picture of personality that emerges out of the interpenetrating mosaic of these immediately inferred features, it is usually possible to form a diagnostic impression, couched in the terms of whatever nosology one may be currently using.

So far as I know, no one has reported anything very helpful on the final process, the synthesis of all one’s more or less scattered ideas and impressions into a unified, more or less self-consistent picture of a personality. Here is where experience and knowledge of psychopathology are usually invoked, to help explain the more or less creative process that goes on, but I do not think that it contributes much to an understanding of thematic analysis to fall back on such truisms. Trying to introspect, I am inclined to think that it is a kind