



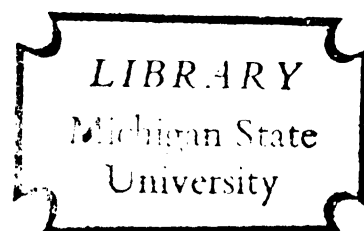
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RORSCHACH ANATOMY RESPONSES
AND SOMATIC COMPLAINTS

Thesis for the Degree of M. A.
MICHIGAN STATE UNIVERSITY

Robert J. Cohen

1959



RORSCHACH ANATOMY RESPONSES AND
SOMATIC COMPLAINTS

BY
ROBERT J. COHEN

A THESIS

Submitted to the College of Science and Arts
Michigan State University of Agriculture and
Applied Science in partial fulfillment of
the requirements for the degree of

MASTER OF ARTS

Department of Psychology

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Robert J. Cohen

(Gerald F. King, Ph.D., Major Professor)

ABSTRACT

Designed as a study of the concurrent validity of Rorschach anatomy (An) responses, this study investigated the commonly posited relationship between An responses and hypochondriacal symptoms (somatic complaints).

A controlled interview, the Rorschach, and the Wechsler-Bellevue Verbal Scale (Form I) were administered to 100 recently hospitalized neuropsychiatric patients, all of whom were males. The Rorschach protocols were scored for number of general An responses, skeletal anatomy (Sk-An), and visceral anatomy (Vi-An) responses. Responses to the interview were classified for somatic complaints in accordance with the following schema: presence or absence of somatic complaints, multiple somatic complaints, focal somatic complaints, and diffuse somatic complaints, plus centrality of the somatic component in the patient's over-all problem. Acceptable levels of reliability were obtained for An responses (inter-rater) and somatic complaints (inter-rater and interview-reinterview).

High general An, Sk-An, and Vi-An groups were formed and each compared with a control No-An group on the classifications used for somatic complaints. With age, IQ, and number of Rorschach responses controlled, tests of significance with chi square revealed no

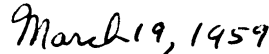
reliable differences in any of the comparisons. Consistent trends in favor of the high anatomy groups were not even obtained.

The results were viewed as adding to the large number of Rorschach studies reporting negative findings for standard interpretations, a situation which seems to call for explorations with new Rorschach interpretations. In regard to the relationship between An responses and hypochondriacal symptoms, some recent conceptual and empirical contributions suggest that future research in this area should take into consideration an additional variable, level of hostile drive strength.

Approved



Major Professor



Date

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I. Introduction

In Psychodiagnostics, Rorschach indicates that "in subjects who are not physicians" anatomy (An) responses represent "either a complex impelling the subject to try to give the impression of intelligence or a tendency to hypochondriacal rumination, or to both" (9, pp. 198-199). Along with Klopfer (4), Beck (1) shares the belief that anatomy associations indicate an excessive concern with health. Rapaport (7), while accepting feelings of intellectual adequacy and bodily preoccupations as meanings of An, suggests that responses stem from two additional sources, namely, generalized anxiety and extreme blocking.

In making interpretations of An responses, most clinicians take into consideration certain qualitative differences. Rapaport (7) distinguishes between skeletal (Sk) and visceral (Vi) An, ascribing different meanings to each type. Phillips and Smith (6) include the following under An responses: general anatomy, x-ray, bony anatomy, visceral anatomy, and gums and teeth. They say that "persons with psychosomatic disorders....produce bony anatomy contents beyond expectancy" (6, p. 127).

It has been generally acknowledged that inferring hypochondriacal traits from a Rorschach protocol is more complex than merely noting the presence of An (4, 5, 6).

Mons outlines the problem in the following manner:

The response must therefore be examined and assessed in relationship to (several) factors. Their relative number, their special character - e.g., whether scientific or merely morbid - and their relation to colour will help decide in each instance whether one is dealing with a justifiable association or with a hypochondriacal tendency.

The anatomy responses must therefore always be viewed with some suspicion, and only be discarded as 'normal' when their number and quality can be logically accounted for by a 'normal' thought content (5, p. 81, 82).

The current investigator is aware of only one empirical study of the relationship between An and hypochondriasis. Rav (8) obtained, by group administration, Rorschach protocols from a large sample of unselected normal males. Instead of using an outside criterion of hypochondriasis, he hypothesized that the number of An responses should be correlated with other signs on the Rorschach indicative of hypochondriasis, e.g., high Dd, high M, etc. The results failed to support any of the predictions. While one might disagree with some of his predictions, the study can be viewed as a test of the Rorschach's internal interpretative consistency.

Although a review of Rorschach literature reveals differences of opinion regarding the interpretations of An responses, there is general agreement concerning one interpretation, i.e., investigators believe that it taps something called hypochondriasis, somatic pre-occupation, or concern with health. It is surprising that this basic interpretation has received so little controlled empirical attention. The present research represents an attempt to test the concurrent validity of An responses, using reported somatic complaints as an outside criterion. While a quantitative analysis is employed, the study takes into consideration the type of An responses and the nature of the somatic complaints.

II. Methodology

A study done by King (3) contributed the raw data employed in the present investigation. Thus, it is desirable that a brief summary of the methodology he used be presented here. For a more detailed account of this research design, the reader is referred to the original source.

In his experiment, a controlled interview, the Rorschach Test, and the Wechsler-Bellevue Verbal Scale (Form I) were administered to 100 carefully screened, recently admitted male neuropsychiatric patients at the Fort Custer Veterans Administration Hospital, Battle Creek, Michigan. The controlled interview was used to obtain data to test certain hypotheses concerning the neuropsychiatric patient's orientation toward his illness. The first section of the interview focused on the patient's conception of his problem. A copy of the outline of this section follows:

Introduction. As a patient here in the hospital, the hospital staff is interested in you and your problem. If we are to help you, we must get certain information about you. I am going to ask you some questions. I would like you to listen carefully and answer the questions the best you can. Think each question over before answering. I would appreciate your talking slowly because I want to write down as much as I can of what you say.

1. (Nature of the Problem) Like every person who comes to this hospital, there is a reason. We will call this your problem. Now, first of all, I would like you to tell me in your own words what your problem is.

(If hesitant, the subject should be encouraged. The question can be repeated and paraphrased. If paraphrasing is necessary, only minor variations should be used. If the subject's account of his problem is brief and confined to such general descriptive terms as tense, nervous, emotionally upset, etc., more information should be obtained by asking the general question: "What are you tense (nervous, etc.) about?" At the end of the subject's account, he should be asked: "Anything else?")

Every other subject of the first 50 was reinterviewed six to eight days later by another person. The reinterview was essentially a repetition of the interview except for the introduction.

Analysis of Somatic Complaints

The 100 interview protocols were scored for the presence or absence of a) somatic complaints, b) multiple somatic complaints, c) focal somatic complaints, d) diffuse somatic complaints, as well as e) centrality of somatic component in the patient's overall problem. The following is a copy of the definitions of these categories that were included in the instructions¹ to the judges:

Presence of somatic complaints. Somatic complaints are defined as any verbalization, spontaneous or otherwise, indicating some degree of discomfort and/or

¹The complete instructions are available in Appendix A.

malfunctioning in any bodily organ or locus (e.g., stomach trouble, headaches, backaches) as well as any overall disturbance in bodily status (e.g., fatigue, malnutrition, loss of weight). Various responses symptomatic of anxiety (e.g., nerves, jumpiness, tension) are not to be classified as somatic complaints unless they are in some way explicitly connected with bodily disturbances. Examples of the latter would be the following. (I worry so much that my head aches. I become very jumpy, even my muscles twitch. This tension and restlessness gets so bad that I get a sinking feeling in my stomach.) With this frame of reference, it is still difficult to make decisions about certain symptoms as to whether they are somatic or not, e.g., sleeplessness (insomnia) and loss of appetite. Symptoms of this nature are to be classified as somatic since they represent disturbances in cyclical bodily activities.

Multiple somatic complaints. The criteria for multiple somatic complaints is two or more somatic complaints.

Focal somatic complaints. Focal somatic complaints are ones in which the disturbances are localized in specific organs or regions of the body (e.g., stomach aches, pain in arm muscles).

Diffuse somatic complaints. The disturbances tend to encompass the entire body in diffuse somatic complaints, with no particular focus or localization (e.g., run-down, tired).

Classifications for centrality of somatic component in overall problem. Central: The patient gives the major emphasis to somatic factors (regardless of type) in his account of his problem. Peripheral: The patient includes somatic complaints in his account of his problem, but they are secondary in importance to other factors non-somatic in nature. Absent: The patient does not report somatic complaints in his account of his problem.

Analysis of An Responses

In this study, the 100 Rorschach protocols were scored for the number of general An, Sk-An, and Vi-An responses. The criteria for forming the Rorschach anatomy groups were two or more An responses for the High-An group, two or more Sk-An responses for the High-Sk-An group, one or more Vi-An responses for the High-Vi-An group, and no An responses for the No-An group, which yielded preliminary groups of 34, 26, 23 and 42 Ss, respectively. The distribution of these groups in terms of age, Verbal IQ, and number of Rorschach responses (R) were examined for the purpose of equating the groups on these variables. Table 1 gives the results of equating the groups on age, IQ, and R, along with the final N for each group.²

Reliability

The author scored all of the Rorschach protocols for the number of An, Sk-An, and Vi-An responses, according to Beck's (1) definition of An and dictionary (10) definitions of visceral and skeletal. Using the same criteria, another judge independently scored every other protocol. There was 94 per cent agreement for An, 90 per cent agreement for Sk-An, and 88 per cent agreement for Vi-An.

²The groups were equated by discarding Ss with extreme scores.

Table 1

Comparison of the Rorschach Anatomy (An)
Groups on Age, Verbal IQ, and Number of
Rorschach Responses (R)

Groups	<u>N</u>	Age			Verbal IQ (WB)			R		
		<u>M</u>	Range	<u>SD</u>	<u>M</u>	Range	<u>SD</u>	<u>M</u>	Range	<u>SD</u>
High- <u>An</u>	32	31.16	22-42	4.95	107.28	83-129	11.90	26.31	15-40	6.79
High- <u>Sk-An</u>	22	30.82	22-42	4.99	107.64	83-129	11.53	28.68	16-40	6.53
High- <u>Vi-An</u>	20	31.15	22-42	4.94	106.30	86-128	11.61	26.55	15-40	7.28
No- <u>An</u>	32	30.22	20-44	5.21	106.94	86-130	11.70	26.43	15-40	6.58

The interview protocols were equally divided into two samples of 50, and each sample was rated in accordance with the definitions of the categories of somatic complaints by three independent judges. The only common judge in the two samples was the author. The mean inter-rater reliability for the five judges on the interview categories was as follows: 97 per cent for somatic complaints, 95 per cent for multiple somatic complaints, 95 per cent for focal somatic complaints, 86 per cent for diffuse somatic complaints, and 87 per cent for centrality of somatic component in overall problem. More details concerning the obtained reliabilities can be found in Appendix B.

One of the judges scored the 25 reinterview protocols for the five categories of somatic complaints. The following interview-reinterview agreement was obtained: 96 per cent agreement for somatic complaints, 96 per cent agreement for multiple somatic complaints, 100 per cent agreement for focal somatic complaints, 84 per cent agreement for diffuse somatic complaints, and 80 per cent agreement for centrality of somatic component in overall problem.

III. Results

A preliminary analysis revealed that 59 of the 100 Ss were judged to have somatic complaints. Of these, 38 had multiple somatic complaints, 42 had focal somatic complaints, and 42 had diffuse somatic complaints. Twenty-four Ss reported somatic complaints of central importance in the overall problem, while the somatic complaints of the remaining 35 Ss were classified as peripheral.

In analyzing the data, each of the Rorschach anatomy groups was compared with the No-An group for the five classifications of somatic complaints. Contingency tables were constructed, and significance was tested by chi square.

High-An Group vs. No-An Group

Tables 2 and 3 provide a comparison of the High-An and No-An groups for the categories of somatic complaints. As can be seen, none of the differences were statistically significant. The data in Table 2 indicate that more Ss in the High-An group reported the presence of somatic complaints, multiple somatic complaints, and diffuse somatic complaints than did Ss in the No-An group. In Table 3, it is seen that the High-An group gave more centrality to somatic components in the overall problem than

Table 2

Comparison of the High-An and No-An Groups
on Somatic Complaints

Groups	Somatic Complaints		Multiple Somatic Complaints		Focal Somatic Complaints		Diffuse Somatic Complaints	
	P*	A*	P	A	P	A	P	A
<u>High-An</u>	21	11	14	18	17	15	14	18
<u>No-An</u>	16	16	12	20	21	11	13	19
Chi square	1.024		0.064		0.582		0.000	

* Key: P refers to "present"; A to "absent."

Table 3

Comparison of the High-An and No-An Groups
on Centrality of the Somatic Component in
Overall Problem

Groups	Central	Peripheral	Absent
High- <u>An</u>	9	12	11
No- <u>An</u>	6	10	16

Chi square = 1.704

the No-An group. However, all of the trends are minor in nature.

High-Sk-An Group vs. No-An Group

Tables 4 and 5 provide a comparison of the High-Sk-An and No-An groups for the categories of somatic complaints. It can be readily seen that none of the chi squares were statistically significant. An examination of Table 4 reveals that there are not even consistent trends in favor of the High-Sk-An group. Table 5 shows that the High-Sk-An group placed slightly more emphasis on the centrality of the somatic component than did the No-An group.

High-Vi-An Group vs. No-An Group

A comparison of the High-Vi-An and No-An groups, on somatic complaints is seen in Tables 6 and 7. Again, the pattern of cell frequencies reveals little difference or consistent trends between the groups. All chi squares were low and not significant.

Statistical Summary

The results offer a fairly simple summary: none of the Rorschach An groups reported significantly more somatic complaints of any type or gave more emphasis to somatic complaints than the control No-An group. Consistent trends

Table 4

Comparison of the High-Sk-An and No-An Groups
on Somatic Complaints

Groups	Somatic Complaints		Multiple Somatic Complaints		Focal Somatic Complaints		Diffuse Somatic Complaints	
	P	A	P	A	P	A	P	A
High- <u>Sk-An</u>	14	8	9	13	11	11	11	11
No- <u>An</u>	16	16	12	20	21	11	13	19
Chi square	0.523		0.321		0.751		0.151	

Table 5

Comparison of the High-Sk-An and No-An Groups
on Centrality of the Somatic Component in
Overall Problem

Groups	Central	Peripheral	Absent
High- <u>Sk-An</u>	7	7	8
No- <u>An</u>	6	10	16

Chi square = 1.572

Table 6

Comparison of the High-Vi-An and No-An Groups on
Somatic Complaints

Groups	Somatic Complaints		Multiple Somatic Complaints		Focal Somatic Complaints		Diffuse Somatic Complaints	
	P	A	P	A	P	A	P	A
<u>High-Vi-An</u>	14	6	8	12	11	9	9	11
<u>No-An</u>	16	16	12	20	21	11	13	19
Chi square	1.899		0.004		0.031		0.053	

Table 7

Comparison of the High-Vi-An and No-An Groups
on Centrality of the Somatic Component in
Overall Problem

Groups	Central	Peripheral	Absent
High- <u>Vi-An</u>	7	7	6
No- <u>An</u>	6	10	16

Chi square = 2.498

in favor of the An groups were not even obtained. It should be pointed out, however, that the statistical tests with the three An groups (High-An, High-Sk-An, and High-Vi-An) were not independent, as the three groups showed considerable overlap in terms of common Ss. Derived from chi squares computed from median tests³, the phi coefficients among the three types of An responses were as follows: An vs. Sk-An, .89; An vs. Vi-An, .50; and Sk-An vs. Vi-An, .36.

³Chi squares: An vs. Sk-An, 79.6; An vs. Vi-An, 25.7; and Sk-An vs. Vi-An, 13.2 (all significant beyond the .01 level of confidence).

IV. Discussion

In considering negative results, the immediate question usually arises as to what is the most adequate interpretation. Should the conclusion be that the results do not lend support to the notion that number of Rorschach An responses is related to hypochondriacal complaints? Or, would it be more appropriate to say that the results are inconclusive due to certain methodological deficiencies?

Let us turn to the methodology employed in this research. The results cannot be attributed to differences in age, IQ, or number of Rorschach responses as the groups were equated for these variables. There is the matter of the controlled interview, a crucial aspect of the methodology. This instrument yielded fairly good inter-rater and interview-reinterview reliability. It should also be pointed out that the same controlled interview yielded positive results in another Rorschach study (3). What remains are the Ss and the setting of the study, "functional" neuropsychiatric patients in a neuropsychiatric hospital. It is granted that it would be desirable to try a variation of this study with another population (e.g., general hospital patients); but if the posited relationship between An responses and hypochondriasis

is a general one, it should have held up in the present study. The most appropriate interpretation then seems to be that the results do not support a relationship between number of An responses and hypochondriacal complaints.

This study contributes to the growing reservoir of negative research results for standard Rorschach interpretations. It would appear that the situation calls for explorations with new interpretations for some of the Rorschach variables. King's (3) study of human movement (M) indicates that new conceptual schemas can lead to fruitful results.

In regard to An responses, Phillips and Smith have recently offered the following different interpretation of this variable: "Anatomy content reflects a sensitivity to, and concern with, the expression of destructive impulses. Paradoxically, those individuals who act out their destructive impulses do not develop anatomy content..." (6, p. 123). Using this frame of reference, Wolf (11) compared a group of patients who had histories of hostile acting out with a group classified as "non-actors," finding that An responses were a significant factor only when hostile drive level, as derived from Rorschach content, was taken into consideration. He offers the interpretation that An responses in the presence of high hostile drive operate as

a control factor which channels these impulses into somatization and other substitutive activities. Further, An responses produced in individuals with low hostile drive probably have some other meaning.

Wolf's findings and interpretations indicate that level of hostile drive should be taken into consideration in any future study of the relationship between An responses and hypochondriacal complaints. A possible procedure for the present data would be to divide the Ss, on the basis of Rorschach content, into two groups, one with high and one with low hostile drive strength. The suggestion is that An responses would be related to hypochondriacal symptoms in the high group but not in the low one.

V. Summary

Designed as a study of the concurrent validity of Rorschach anatomy (An) responses, this study investigated the commonly posited relationship between An responses and hypochondriacal symptoms.

A controlled interview, the Rorschach, and the Wechsler-Bellevue Verbal Scale (Form I) were administered to 100 recently hospitalized neuropsychiatric patients (all males). The Rorschach protocols were scored for number of general An responses, skeletal anatomy (Sk-An), and visceral anatomy (Vi-An) responses. Responses to the interview were classified for somatic complaints in accordance with the following schema: presence or absence of somatic complaints, multiple somatic complaints, focal somatic complaints, and diffuse somatic complaints, plus centrality of the somatic component in the patient's overall problem. Acceptable levels of reliability were obtained for An responses (inter-rater) and somatic complaints (inter-rater and interview-reinterview).

High general An, Sk-An, and Vi-An groups were formed and each compared with a control No-An group on the classifications used for somatic complaints. With age, IQ,

and number of Rorschach responses controlled, tests of significance with chi square revealed no reliable differences in any of the comparisons. Consistent trends in favor of the high anatomy groups were not even obtained.

The results were viewed as adding to the large number of Rorschach studies reporting negative results for standard interpretations, a situation which seems to call for explorations with new Rorschach interpretations. In regard to the relationship between An responses and hypochondriacal symptoms, some recent conceptual and empirical contributions suggest that future research in this area should take into consideration an additional variable, level of hostile drive strength.

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Appendix A

Analysis of Somatic Complaints

Instructions to Raters

You are asked to read carefully the following protocols and make certain judgments or ratings. The protocols represent close to verbatim recordings of the responses of hospitalized neuropsychiatric patients when they were asked to describe their problems (reasons for being in the hospital). Thus, each patient has given his version of his illness.

Presence of somatic complaints. Score each protocol for the presence or absence of somatic complaints. If a somatic complaint (or complaints) is included as part of the problem by the patient, record P for present in the appropriate column of the Rating Sheet. If somatic complaints are absent, record an A. Use the following definition of somatic complaints as a frame of reference in making the judgments:

Somatic complaints are defined as any verbalization, spontaneous or otherwise, indicating some degree of discomfort and/or malfunctioning in any bodily organ or locus (e.g., stomach trouble, headaches, backaches) as well as any overall disturbance in bodily status (e.g., fatigue, malnutrition, loss of weight). Various responses symptomatic of anxiety (e.g., nerves, jumpiness, tension) are not to be classified as somatic complaints unless they are in some way explicitly connected with bodily disturbances. Examples of the latter would be the following. (I worry so much that my head aches. I become very jumpy, even my muscles twitch. This tension and restlessness gets so bad that I get a sinking

feeling in my stomach.) With this frame of reference, it is still difficult to make decisions about certain symptoms as to whether they are somatic or not, e.g., sleeplessness (insomnia) and loss of appetite. Symptoms of this nature are to be classified as somatic since they represent disturbances in cyclical bodily activities.

Multiple somatic complaints. The criterion for multiple somatic complaints is two or more somatic complaints. Score each protocol for the presence (P) or absence (A) of multiple somatic complaints in the appropriate column of the Rating Sheet.

Focal somatic complaints. Focal somatic complaints are ones in which the disturbances are localized in specific organs or regions of the body (e.g., stomach aches, pain in arm muscles). Consider only focal somatic complaints and score each protocol either P or A.

Diffuse somatic complaints. The disturbances tend to encompass the entire body in diffuse somatic complaints, with no particular focus or localization (e.g., run-down, tired). Consider only diffuse somatic complaints and record either P or A for each protocol.

Centrality of somatic component in overall problem. Now evaluate the importance of any somatic component in the patient's overall version of his problem. You are to judge how much emphasis is given somatic factors by the patient in relation to other non-somatic factors. Use the following

categories in rating each protocol.

Central (C): The patient gives the major emphasis to somatic factors (regardless of type) in his account of his problem.

Peripheral (P): The patient includes somatic complaints in his account of his problem, but they are secondary in importance to other factors non-somatic in nature.

Absent (A): The patient does not report somatic complaints in his account of his problem.

Appendix B

Classification of Somatic Complaints: Reliability

First 50 Interview Protocols

Somatic Complaints

<u>Judges</u>	<u>Percentage of Agreement</u>
A vs. B	94
A vs. C	98
B vs. C	96

Multiple Somatic Complaints

A vs. B	90
A vs. C	96
B vs. C	94

Focal Somatic Complaints

A vs. B	98
A vs. C	96
B vs. C	96

Diffuse Somatic Complaints

A vs. B	80
A vs. C	84
B vs. C	84

Centrality of Somatic Component

A vs. B	80
A vs. C	92
B vs. C	84

Second 50 Interview Protocols

Somatic Complaints

D vs. E	98
D vs. F	98
E vs. F	100

Multiple Somatic Complaints

D vs. E	98
D vs. F	98
E vs. F	96

Focal Somatic Complaints

D vs. E	90
D vs. F	92
E vs. F	98

Diffuse Somatic Complaints

D vs. E	86
D vs. F	94
E vs. F	88

Centrality of Somatic Component

D vs. E	84
D vs. F	88
E vs. F	96

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