More Oral Sadism and the Vegetarian Personality

Readings from the Journal of Polymorphous Perversity®

EDITED BY
Glenn C. Ellenbogen, Ph.D.
More Oral Sadism
and the Vegetarian
Personality

Readings From the Journal of Polymorphous Perversity®
Also by Glenn C. Ellenbogen, Ph.D.

*Oral Sadism and the Vegetarian Personality: Readings From the Journal of Polymorphous Perversity®*

*The Primal Whimper: More Readings From the Journal of Polymorphous Perversity®*

*Freudulent Encounters for the Jung at Heart: Still More Readings From the Journal of Polymorphous Perversity®*

*The Directory of Humor Magazines and Humor Organizations in America and Canada*
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BRUNNER/MAZEL, Publishers • New York
To Ilene—my partner in laughter, love, and play
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Preface

The study of human behavior is a serious matter, right? Fortunately, I've never seen it that way. Throughout my studies toward earning my doctorate in clinical psychology, I came across many situations that struck me as, well, funny. Take, for example, the incident that happened while I was on my three-month "rotation" through the psychiatric emergency room of Kings County Hospital during my one-year internship. A patient, waiting the typical four or five hours to be seen in the psychiatric E.R., complained to the triage nurse that he experienced everything as "foreign and strange." The reward for the wait was to finally be escorted into a small examination cubicle. There he was introduced to Dr. Gandhi, who was apparently unable to speak more than a few words of English (although the words "schizophrenic" and "manic depressive" seemed to roll right off his tongue). The patient told Dr. Gandhi that he perceived everything as foreign and strange. In fact, he even shared that he experienced Dr. Gandhi as foreign and strange. Dr. Gandhi, who had no appreciation of the concept that even a broken clock is correct at least twice a day, understood little, if anything, the patient was saying, and the patient was immediately carted off to the locked unit for treatment.

My clinical internship came in the last of my five years of doctoral training. I had managed to keep some semblance of sanity during the first four years of formal coursework—surrounded though I was by intensely earnest graduate students and somber graduate-school faculty—by writing spoofs of psychology, which were published in various magazines. In 1980, having successfully survived the oral defense of my doctoral dissertation—"the primal hump"—I was awarded my Ph.D., whereupon I promptly founded Wry-Bred Press, a small publishing company. Around the same time, I wrote a lampoon of the No. 1 intelligence test in use in psychology, calling my
IQ measure "The Scale of Mental Abilities Requiring Thinking Somewhat" (SMARThs). Wry-Bred Press published the piece as a free-standing "monograph," under the banner of a fictitious journal—the *Journal of Polymorphous Perversity*. Soon I began receiving letters of encouragement from mental health professionals, and, more important, humorous submissions to a journal that did not really exist. The message was clear: the field of psychology was in desperate need of some good laughs.

On January 2, 1984, the first issue of the *Journal of Polymorphous Perversity* was launched, with "Psychotherapy of the Dead" as its lead article. But I knew that it would be an uphill battle to successfully market this irreverent magazine. The American Psychoanalytic Association outright banned its display at the group's annual convention, declaring that humor was "inappropriate."

Eventually, however, more issues of the *Journal of Polymorphous Perversity* made their way into the field, and I started to see signs that the magazine was beginning to have an impact. Reprints of articles (such as "The Etiology and Treatment of Childhood") were creeping into college psychology textbooks. I began to receive invitations to present humorous talks before state and regional psychological associations. Finally, Brunner/Mazel, a leader in decidedly serious professional psychology texts, asked me to put together an anthology of *Journal* pieces.

In 1986, Brunner/Mazel published *Oral Sadism and the Vegetarian Personality*, taking a gamble on publishing its first humor book—and one that satirized its bread and butter to boot. To the publisher's relief, the book was enthusiastically received, becoming a bestseller, translated into both German and Japanese. A second anthology—*The Primal Whimper*—followed in 1989, with a third collection, *Freudulent Encounters for the Jung at Heart*, published in 1992.

Which brings us to 1996 and *More Oral Sadism and the Vegetarian Personality*. (The original article that started it all—"Oral Sadism and the Vegetarian Personality"—appears as the second piece in this wacky new collection of spoofs drawn from the pages of the *Journal of Polymorphous Perversity*.) Brunner/Mazel has once again made it possible for me to unleash a full frontal assault on the stuffy, the stodgy, the stoic, and the stolid. It's a tough job but ...

*New York, New York*  
Glenn C. Ellenbogen
Acknowledgments

I would like to gratefully acknowledge the help of the following Journal of Polymorphous Perversity® associate editors, who were kind enough to review manuscripts that touched upon their specialty areas:


As the definition of what constitutes "good" humor is very subjective, the associate editors were rarely in agreement, either among themselves or with me, about which articles merited publication. The responsibility for making the final selections for the regular journal issues and for this anthology was ultimately mine and mine alone. The presence of any given article in this anthology should not be construed as reflecting the endorsement of the associate editors.

Finally, I would like to thank the many authors whose works appear in this anthology.
GLENN C. ELLENBOGEN earned a BA and MA, both in Psychology, from New York University, and a second MA in Psychology from Hofstra University. Psychologically unable to cope with having MAMA after his name, he resolved his problem by earning a PhD in clinical psychology from Hofstra University.

Successfully surviving graduate school with some sanity intact, Dr. Ellenbogen founded the Wry-Bred Press and launched the *Journal of Polymorphous Perversity*, a humorous and satirical journal of psychology aimed at “injecting a dose of humorous medicine into the aging veins of psychology.” Writing under his own name and such pseudonyms as Ernst von Krankman (literal translation from German meaning “seriously from a sick person”), Seymour Fruitlooper, and William Goodenough (reflecting his modest self perception that his writing was, well, good enough), Dr. Ellenbogen has written and published in the *Journal of Polymorphous Perversity* ground-breaking articles on such topics as oral sadism and the Vegetarian Personality, tactics for keeping one’s shrink awake during the therapy session, and a new fragrance by Calvin Kline—Borderline.
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Personality

Readings From the Journal of Polymorphous Perversity®
1

Psychodiagnstics
Psychometric Infallibility Realized: The One-Size-Fits-All Psychological Profile

David A. Levy, Ph.D.
Pepperdine University

Throughout the 20th century, reliability and validity have been the dual goals of psychological testing. Although these standards were adequate for the clinician of yesteryear, they have failed to keep pace with the ever-growing demands of modern society. As we stand at the threshold of the 21st century, the time has arrived for psychological testing to come of age by setting its sights on the third, and most important, psychometric property: interpretive infallibility.

Despite decades of painstaking research on countless batteries of psychological tests, we have scarcely begun to quench people’s insatiable thirst for security in the belief that someone out there understands them better than they understand themselves. This simple but powerful principle—which astrologists, palm readers, psychics, cult leaders, and authors of self-help books have known (and capitalized on) for years—underlies the astonishing success of the consummate method of interpretive infallibility, the One-Size-Fits-All Psychological Profile (OSFAPP).

As its name denotes, the OSFAPP system has been shown to be equally effective for clients of all ages, vocations, races, cultures, religious backgrounds, sexual preferences, political affiliations, and presenting problems. Further, its results are guaranteed irrespective of the clinician’s education, training, or experience. In fact, this system is especially useful to clinicians of limited intelligence.

However, the greatest strength of the OSFAPP lies in its atheoretical nature. Much like the latest installment of the Diagnostic and
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Statistical Manual of Mental Disorders (APA, 1987), the OSFAPP can be used by clinicians of varying theoretical orientations, by clinicians with no theoretical orientation, and even by clinicians who are not quite sure what a theory is. For example, you are free to explain to your client that the results of the OSFAPP were based on a meticulous analysis of any one of a number of the client’s offerings: dreams; free associations; stories about a series of out-of-date, black-and-white pictures; statements to an empty chair; drawings of people, houses, and trees; or favorite fairy tale, color, or television game show host. If none of these techniques appeals to you (or if you wish to add an extra touch of mystique to the process), simply inform the client that you drew upon your finely tuned powers of “clinical intuition.”

Armed with the OSFAPP, the clinician of tomorrow will never again run the risk of being embarrassed by an incorrect test interpretation. Why settle for empirically derived, data-based, or scientifically validated interpretations—all of which are subject to error—when you now have it within your power to provide the client with irrefutable truths? At the very least, clients will feel that they have gotten their money’s worth. At best, the OSFAPP method ensures a permanent place for psychological testing in clinical practice, sure to thrive and prosper well into the next century.

The One-Size-Fits-All Psychological Profile

Developmental History

You are the kind of person who was biologically conceived by two, opposite-sexed parents. However, no one, including your mother or father, ever asked you if you wanted to be born. For a period of time, you were totally dependent on others for food, shelter, and safety. Your vocabulary was extremely limited, you found it impossible to stand up without assistance, and you were incapable of doing even the most mundane of tasks, such as brushing your teeth. In fact, for awhile there, you didn’t even have any. On more than one occasion, your cries went unheeded.
Things are different now. You are not as young as you were. You’ve had numerous experiences in your life. You’ve had some problems and suffered some disappointments. When things haven’t worked out the way you intended them to, you wished that they had.

**Physiological Processes**

You’re the type of person who has many and varied physical needs. For example, when deprived of oxygen, you are likely to experience feelings of suffocation. Sometimes you are thirsty; at other times, you just aren’t. When you are thirsty, you crave something to drink. When you are hungry, you crave something to eat. During periods of intense hunger, you are likely to seek, procure, and ingest food. When you’ve eaten too much food, you usually don’t feel hungry. You are prone to have very little appetite when you are in the act of vomiting.

If you go without sleep for several days in a row, you are prone to experience feelings of fatigue, weariness, or even exhaustion. The longer you go without sleep, the more tired you are likely to become. When you are asleep, you don’t know it. In fact, it’s only after you’ve woken up that you know that you were.

You’re the kind of person who derives pleasure from scratching an itch. Pain hurts you. In fact, you typically attempt to avoid pain. When you are too cold, you have a strong tendency to seek heat. When you are too hot, you try to cool down. When you feel sick, you desire to feel better. When having sex, you’re the type of person who would prefer to have an orgasm rather than not have one. You experience a sense of satisfaction, even pleasure, after relieving your bladder or bowels. You prefer the smell of your own excreta to that of other people’s.

Many of your bodily processes have an “automatic” quality to them. For example, when engaging in strenuous physical activity, your heartbeat, blood pressure, and respiration increase—whether you like it or not. When your skin is cut, you are prone to bleed. You’re the type of person who is likely to experience a “gagging” sensation whenever a foreign object (such as a stick, screwdriver, or cooking utensil) is shoved down your throat.
Personality Characteristics

You have many sides to your personality. There are some parts of your personality that you like more than others. Deep down, you have some pretty deep feelings. These feelings are likely to be much deeper than those feelings that are closer to the surface. When your feelings are hurt, you’re the kind of person who doesn’t like it. Given the choice, you’d rather feel good than bad. Sometimes you are happy; sometimes you aren’t. You like feeling happy, but you don’t like feeling lonely, depressed, or anxious. In fact, the more miserable you are, the more you dislike it. You are more critical of yourself than other people are of you.

Interpersonal Functioning

You are similar to other people in some ways, but not in other ways. There are many people whom you just do not know. You enjoy having the respect of others. You like some people more than others. When you lose someone dear to you, you are likely to feel sad. In your relationships with others, you’re trying to strike a balance between autonomy and closeness. Deep down, you crave love and approval. You want to be understood. You don’t want to be rejected. You are the kind of person who prefers not being ridiculed, mocked, or tortured by others.

Goals and Expectations

You wish that you could be more like the person who you really want to be. You wish that you had more control over your life. You want to accomplish more. You would prefer to be successful than unsuccessful.

Diagnostic Impressions

(Check as many as desired, depending on the clinician’s theoretical orientation.)
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___ You have intrapsychic conflict
___ You have control issues
___ You have boundary issues
___ You have trust issues
___ You have self-esteem issues
___ You have inner-child issues
___ You have codependency issues
___ You have issues around intimacy and commitment
___ You have ambivalent feelings toward your parents
___ You have maladaptive learning patterns
___ You have unfinished business
___ You have repressed introjects
___ You are searching for meaning in life
___ You are your own worst enemy
___ You come from a dysfunctional family
___ You have a biochemical imbalance

Future Prognosis

If you continue to live, you will grow older. The longer you live, the more experiences you are likely to have. You will always be older than your younger siblings. At some point in your future, you
will be completely unable to talk, walk, or even breathe. And this condition will last for a very, very long time.

References

Oral Sadism and the Vegetarian Personality

Glenn C. Ellenbogen, Ph.D.

A review of the clinical literature on vegetarianism to date reveals that little attention has been given to the psychodynamic mechanisms that govern the behavior of those individuals who choose to restrict their diet to foods other than dead animals. Fruitlooper's (1895) case study of Julia V., a 39-year-old pregnant hysteric unable to refrain from regurgitating Wienerschnitzels, had first thrown light upon the meatless phenomenon, but Fruitlooper's contemporaries rejected his psychosexual interpretation of Wienerschnitzels and interest in his discovery soon waned. It was not until von Krankman, one of Fruitlooper's more brilliant students, a tireless theoretician and jogger and, later, founder of the "neo-Fruitloopian school" of psychoanalysis, that interest in vegetarianism was renewed.

The connection between vegetarianism and sadism was first highlighted in von Krankman's (1939) seminal paper, "A Treatise on the Psychodynamics of the Meatless Choice." Von Krankman theorized that consumption of vegetables, to the exclusion of sinewy flesh, represented a "fixation" at an "oral-sadistic stage" of development.¹

The fixation is by the rigid cathexis of energy to but one category of objects represented.² While the vegetarian not so very often to

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¹I would like to thank Mr. Angelo Augratini, A.A., adjunct assistant instructor of European languages, Hempstead Community College, for his translation of this passage from von Krankman's original text.

²Translator's note: I kind of had some trouble translating a pretty short sentence that came after this one so I just left it out.
other equally erogenous zones these organic substances placed observed have been, so can we say that the use of these vegetables truly, no, almost exclusively, to the oral zone placed are! Also, have we a sadistic impulse with the vegetarian character. The man who kills animals for meat gives the pursued animal a chance to escape. How more and more sadistically cruel is the non-meat eating man. The keen theoretician must himself this question deeply ask—What is the likelihood that the tranquil carrot from its vicious predator successfully outrun can?

During his American lecture series, delivered at the New School for Social Research in the Fall of 1941, von Krankman (1942) introduced a refinement and expansion of his work, outlining the process by which the vegetarian defends himself against conscious awareness of his sadistic impulses.

The orally fixated vegetarian deals with his early prototypic loss of the love object through compensatory defense mechanisms, which serve to conceal from himself, significant others, and his Saturday night dates, his deep-seated feelings of anger, hostility, hatred, rage, and, to some extent, dislike for his fellow man. Nor is his like for women too keen. Since the vegetarian character identifies man with animals (and rightfully so), he utilizes the defense mechanisms of reaction formation, denial, and sublimation in order to portray a façade whereby he is perceived as loving man, the animal, and hence animals, while displacing his true oral-sadistic impulses onto the non-man non-animal—vegetables. Thus it is that the orally sadistic vegetarian character comes to take delight in aggressively consuming vegetables while zealously and defensively maintaining his dis-taste for animals.

Although von Krankman was making inroads in the exploration of the psychodynamics of the vegetarian character, it was not until his now famous 1947 Invited Psychoanalysts Address before the faculty and candidates of the prestigious Advanced Institute for Psychoanalytic Psychotherapy that his thinking was crystallized with the conceptualization of "the Vegetarian Personality." Von Krankman's long and arduous theorizing was finally complete.
The Vegetarian Personality is characterized by ruthless acts of an oral-sadistic nature directed against vegetables. Through a series of complex and difficult (even for the analyst) to understand processes, a tripartition of the ego develops. This splitting of the ego leads to the gradual emergence of three compartmentalized senses of reality—"the good-food," "the bad-food," and "the not-food." Vegetables are perceived as "the good-food" because engaging in the consummatory act does not threaten to unleash the underlying currents of anxiety. Animals are perceived as "the bad-food" because even the thought of devouring them is threatening enough to arouse the vegetarian's fear of dealing with his repressed oral-aggressive and oral-sadistic urges toward his fellow man. Finally, there is the primitive taboo against phylogenetic self-destruction, so that man himself becomes "the not-food" and the impulse toward cannibalism is successfully defended against.

Von Krankman's tragic and untimely death from ingestion of poisonous mushrooms deprived the psychoanalytic community of a great mind. Nonetheless, his pioneering work in the area of oral sadism and the Vegetarian Personality had an enormous impact upon the field of psychoanalysis, prompting, if not a great deal of research, or any research for that matter, at least a great deal of heated debate among psychoanalysts.

It was a fitting tribute to von Krankman's greatness as a theoretician, clinician, and taxpayer that members of the American Psychiatric Association, in revising their outdated Diagnostic and Statistical Manual of Mental Disorders (DSM), spontaneously chose, upon unanimous recommendation of the Task Force on Nomenclature and Statistics, and at the adamant urging of the American Psychological Association, to incorporate von Krankman's work into their newly revised third edition, the DSM-III. The influence of von Krankman's penetrating thinking is clearly evident in the passage from the DSM-III reproduced below.

301.85 Vegetarian Personality Disorder

The essential feature is a Personality Disorder in which there is a severe preoccupation with food consumption, schizoid-like inability
to empathize with certain living organisms (usually vegetables) within the environment, hypersensitivity to issues revolving around food ingestion, paranoid suspiciousness concerning the content of the dinner plate, and impaired social relationships, particularly in restaurant settings, due to rigidity in eating patterns.

**Associated features.** Individuals with this disorder usually are unable to express anger, hostility, or aggressiveness toward others, but fare well in expressing such feelings toward vegetables. Because of these people's intense preoccupations with food, they commonly have impaired social relationships and often they attempt to band together in self-help groups, called “food collectives.” The rigidity of their eating behavior tends to contribute to their social impairment, and individuals with this disorder are frequently known to seek out partners who suffer from the same disorder.

**Impairment.** Eating behavior, by definition, is severely compartmentalized and rigid. Social relationships usually become impaired, as the individual gets into arguments with others over where to dine. While occupational functioning is rarely disturbed, the individual with this disorder usually brings lunch or buys a yogurt to go.

**Complications.** A common complication is Unintentional Substance Use Disorder, with toxicity appearing in the form of “MSG overdose” from eating in Chinese restaurants too often.

**Predisposing factors.** Finicky eating patterns in childhood may in some way be associated with the onset of this disorder in later adolescence or early adulthood, although the relationship is not clearly established.

**Prevalence.** This disorder appeared to be fairly common beginning in the late 1960s and continuing into the 1970s, but it seems to be tapering off.

**Sex ratio.** This disorder is diagnosed about equally among men and women.
Differential diagnosis. In Paranoid Personality Disorder there is, by definition, pervasive and systematic mistrust of people, whereas the Vegetarian Personality Disorder involves mistrust specifically related to the content of the dinner plate. In both the Schizoid Personality Disorder and Narcissistic Personality Disorder, conspicuous absence of any ability to empathize is a primary feature, whereas the Vegetarian Personality Disorder is characterized by an ability to empathize, at least on a superficial level, with other people and related animals.

Diagnostic Criteria for Vegetarian Personality Disorder

A. Loss of the love object early in life without subsequent resolution of at least five of the following emotions toward the love object:

(1) anger
(2) hostility
(3) rage
(4) hatred
(5) dislike

B. Onset of the disorder in late adolescence or early adulthood.

C. Rigidity in eating patterns.

D. Inability to empathize with certain living organisms within the environment as indicated by:

(1) an overconcern for the feelings and physical well-being of animals (e.g., verbalizing that it is "animalistic" to eat animals)

(2) a conspicuous lack of empathy for the feelings of murdered vegetables (e.g., verbalizing, "But vegetables don't have feelings!")
E. Paranoid and hypervigilant preoccupation with the oral zone and food consumption, as manifested by at least one of the following:

(1) hypersensitivity to the issue of food ingestion

(2) paranoid suspiciousness about food content:
   (a) individual thinks that there are pieces of dead animals on his plate
   (b) in advanced stages of the disorder, individual suspects that there are minuscule animal by-products mixed in with his food

F. Impairment of social and interpersonal relationships as indicated by at least one of the following:

(1) decreased socializing at restaurants with friends because of the individual’s arguing over where to dine

(2) need to join a self-help group (e.g., a “food collective”)

(3) socializing exclusively with individuals also diagnosed as suffering from the Vegetarian Personality Disorder

G. “MSG overdose” from eating in Chinese restaurants too often.

References


Understanding the Psychological Report: Differences Between What Clinicians Write and What They Really Mean

Loreto R. Prieto
University of Iowa

The discrepancy between what people truly mean and what they communicate to others, and the dire consequences that can result from such miscommunications, has received much attention in the pages of the Journal of Polymorphous Perversity. For example, Feingold (1990, 1992a) warned that graduate students who fail to recognize the underlying messages of their graduate advisors risk an abrupt and untimely end to their academic careers. In a similar vein, Pierce (1990) noted that doctoral candidates face failing their oral defense if they do not pay adequate attention to the subtext of the dissertation committee’s verbalizations. Piersma (1990) cautioned that disaster will result if internship site interviewers take letters of recommendation at face value, instead of reading between the lines. Feingold (1992b) clarified how beginning professors risk being denied tenure by misinterpreting the statements of their graduate students. Most recently, Gawthrop (1993) noted that patients could suffer negative therapeutic outcomes if they do not recognize the disparity between their therapists’ verbalizations and their therapists’ underlying messages.

All too often, mental health professionals, when faced with reading psychological reports, fail to correctly interpret the latent messages conveyed therein. In the present paper, the author provides key interpretations to statements appearing in the psychological reports of clinicians. It is hoped that a clearer understanding of what clinicians really mean in their psychological reports will ensure that
mental health professionals will pick up on all of the subtle, and not-so-subtle, cues in these reports, thereby avoiding the possibility of mistakenly accepting into treatment "difficult" patients or those who lack excellent insurance coverage.

<table>
<thead>
<tr>
<th><strong>What the Clinician Writes</strong></th>
<th><strong>What the Clinician Means</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>This clinician examined the patient for one hour.</td>
<td>The examination took 40 minutes, but we bill by the hour.</td>
</tr>
<tr>
<td>The patient approached the interview in a cooperative manner.</td>
<td>The patient answered all of my questions, including the embarrassing ones.</td>
</tr>
<tr>
<td>The patient’s affect was constricted in range, incongruent with the content of speech, and grounded within a dysphoric mood.</td>
<td>The patient did not laugh at my jokes.</td>
</tr>
<tr>
<td>The patient’s rate of speech was normal.</td>
<td>The patient spoke in a manner that gave me time to take notes.</td>
</tr>
<tr>
<td>The patient’s marital relationship appears appropriate, functional, and secure.</td>
<td>The patient and his wife fight about the same stuff my wife and I do.</td>
</tr>
<tr>
<td>The patient leads an irresponsible and carefree life.</td>
<td>Boy, am I jealous.</td>
</tr>
<tr>
<td>The patient engages in superficial sexual relationships with multiple partners without establishing meaningful emotional ties.</td>
<td>Amazing. I never did that well when I was single.</td>
</tr>
<tr>
<td>What the Clinician Writes</td>
<td>What the Clinician Means</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>The patient has an erratic work history.</td>
<td>The patient hasn’t been stuck in as many crappy jobs as I’ve been.</td>
</tr>
<tr>
<td>The patient denies any substance use.</td>
<td>Yeah, right.</td>
</tr>
<tr>
<td>The patient has a significant history of extensive substance abuse.</td>
<td>Better keep the patient’s number in the Rolodex for the next staff party.</td>
</tr>
<tr>
<td>The psychological test results are inconclusive.</td>
<td>The computer scoring service lost the patient’s MMPI in the mail.</td>
</tr>
<tr>
<td>The patient took an inordinate amount of time to complete the assessment measure.</td>
<td>I had to stay late and missed my bus.</td>
</tr>
<tr>
<td>The patient was not goal oriented and needed frequent encouragement during testing.</td>
<td>The patient couldn’t even handle a measly seven-hour testing session.</td>
</tr>
<tr>
<td>Testing was not indicated for this patient.</td>
<td>The patient has no insurance.</td>
</tr>
<tr>
<td>The patient was unresponsive to empathy.</td>
<td>The patient refused to accept my only slightly used handkerchief to dry his tears.</td>
</tr>
<tr>
<td>The patient displayed a remarkable acuity for environmental stimulus cues within interpersonal interaction.</td>
<td>The patient complimented me on my new suit.</td>
</tr>
<tr>
<td><strong>What the Clinician Writes</strong></td>
<td><strong>What the Clinician Means</strong></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>The patient demonstrated good conceptual, abstraction, and judgment skills.</td>
<td>The patient bought my self-help book and liked it.</td>
</tr>
<tr>
<td>The patient was histrionic and demanding.</td>
<td>The patient was shocked at my fees and asked if there was a sliding scale.</td>
</tr>
<tr>
<td>The patient shows an ability to meet social demands.</td>
<td>The patient didn’t mind that I kept him waiting in the lobby for 20 minutes.</td>
</tr>
<tr>
<td>The patient was oppositional and unable to appropriately respond to social interaction.</td>
<td>The patient did not accept the appointment time that worked best for me.</td>
</tr>
<tr>
<td>This patient may benefit from referral to group therapy.</td>
<td>Talk about disturbed—there's no way I'm treating this guy!</td>
</tr>
<tr>
<td>This patient appears to be dealing with a complex clinical pathology that might possibly be ameliorated by a regimen of intensive, carefully executed psychotherapeutic intervention.</td>
<td>I can manage this one.</td>
</tr>
</tbody>
</table>

**References**

Feingold, A. (1992a). Understanding your advisor II: More survival tips for fledgling graduate students unfamiliar with interpreting


By now, every self-respecting psychotherapist knows how many therapists it takes to change a lightbulb, right? But have you ever wondered how many Axis II personality disorders it takes to handle that classic problem? Let's take a look.

- How many Narcissistic Personality Disorders does it take to change a lightbulb?
  Just one—to hold the lightbulb, but he has to wait for the whole world to revolve around him.

- How many Borderline Personality Disorders does it take to change a lightbulb?
  Just one—to threaten suicide if you don’t change it for her.

- How many Obsessive Compulsive Personality Disorders does it take to change a lightbulb?
  Just one—but he has to check it a hundred times, once for each watt.

- How many Passive Aggressive Personality Disorders does it take to change a lightbulb?
  “Oops! I can’t believe I broke the last one. I guess you’ll just have to sit in the dark, Honey.”

---

1 Just one—but only if the lightbulb really wants to change.
• How many Dependent Personality Disorders does it take to change a lightbulb? None. She’s still clinging to the old lightbulb.

• How many Histrionic Personality Disorders does it take to change a lightbulb? “You want me to change lightbulbs?! I could burn my hand! I could be electrocuted! I could fall off of the ladder and be paralyzed for life! You don’t love me anymore!”

• How many Self-Defeating Personality Disorders does it take to change a lightbulb? Just testing you . . . We’re waiting for the DSM-IV on that one!

• How many postal workers does it take to change a lightbulb? Oh, I’m sorry, aren’t all postal workers by definition personality disordered?
Free the *DSM-IV*

Judith Schlesinger, Ph.D.

The *DSM-IV* (*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*) was coming in June—the new Bible of mental disorders and reimbursements. Because of the controversy surrounding its predecessor, the *DSM-III-R*, also published by the American Psychiatric Association (APA), I was assigned to interview one of the chief editors, Dr. Richard Shpritzer. My mission: to see if things were different this time around.

Our group is called PLOTZING (People Leery of the Zeitgeist in New Guidelines [in Mental Health]). Our concern: that the new manual would contain more politics than science.

“Oh, no,” said Shpritzer when I brought the matter up, “this time, we asked everybody for their opinions. Jelly bean?”

“No, thanks,” I said.

I looked around his office, which was large, airy, and dominated by stacks of books in proof—the *DSM-IV* itself, the *DSM-IV Sourcebook*, the *DSM-IV Notebook*, the *DSM-IV Guidebook*, the *DSM-IV Casebook*, the *DSM-IV Coloring Book (Kategories for Kids)*, and the *DSM-IV Diagnosis-a-Day Desk Calendar*.

He saw me looking. “You like this stuff?” he asked, smiling. “The APA hasn’t had to raise its dues in years.” He showed me the coloring book. “This one’s my favorite. Here, look at this picture of an Obsessive Compulsive Disorder. It really captures its essence, don’t you think?”

He put down the book, which, I noticed, was half colored in, and took another handful of candy. “You’re never too young to
understand science. Even with all their problems, we’re still behind the Russians, you know.”

“But is science what we’re talking about?” I wondered. “The DSM-III-R was built on political trade-offs—categories put in or thrown out, changed and bartered, depending on which pressure groups were squawking. I can think of at least six examples right now . . .”

“Squawking? That’s absurd!” declared Shpritzer. “Squawking has no place in science. Look . . .” He picked up the order form for the DSM-IV and its accessories.

“See this, right here? It refers to our ‘open process’ and the ‘quality and diversity’ of our participants. There’s no squawking when there’s full inclusion. I think we even let the psychologists vote this time. It was a swell group. Jelly bean?”

“No, really, thanks. Diversity’s important, sure, but it still sounds like the science-by-consensus thing all over again.”

“Then read our Sourcebook, if you’re so interested. That’s where the empirical data and rationale are.” He was getting agitated: grabbing more and more jelly beans. He ate only the red ones, and threw the rest away.

“And about that Sourcebook, Dr. Shpritzer.” I said, “if you really want people to understand the scientific basis for the DSM-IV, why price the Sourcebook at more than twice the DSM-IV itself, with no option to get it in paperback? What are you hiding?”

“We are hiding nothing,” he said, icily, “because we have nothing to hide. In fact, our market research shows that most clinicians have no interest in empirical matters at all. They have enough trouble getting the codes and Axes right.”

“And besides,” he continued, “this is the 90s. There’s science, but there’s also empowerment. We have to be sensitive, you know. After all,” he leaned forward, “we are healers. We don’t want to make things worse for people.”

“I’m glad you mentioned that, Sir, because . . .” Suddenly his attention became focused on the window. One could hear chanting from the street. I couldn’t quite make out the words.

“Oh, no, not again,” he groaned, as he picked up the phone. “Excuse me a minute.”

“No problem,” I said. I touched up my notes and scanned the
More Oral Sadism and the Vegetarian Personality

bookcases. There was the usual batch of Freud and Jung, Rank and Adler, Krantz and Steele—along with an interesting collection of new titles: *The Therapist Giveth and Taketh Away: False Memory Syndrome; Diagnosis as a Political Act; Science Can Be Friendly*; and *Who Sez?*

The chant grew louder: the people were yelling, “Free the DSM Four! Free the DSM Four!” A lot of people.

Shpritzer shut the window and got back on the phone. “I thought you said we were going to include Frustrated Entitlement in the main section,” he growled. “No, these guys won’t go for it. . . . Yeah. . . . No, we can’t. . . . Hey, that Late Luteal Phase Dysphoric Disorder almost sandbagged the whole thing, remember? . . . What? . . . Who? . . . Well, do what you can.”

He hung up, frowning, and reached for his beans.

“Dr. Shpritzer . . .” I began, but he seemed distracted, chewing, staring into space, and playing with a new *DSM-IV* key chain (“Keys to the Mind”—$6.95, plus shipping and handling).

He looked at me, frowning again. “You still here? Listen, I really don’t have time to continue this interview right now.” I could tell he was rattled. He was spitting out the red jelly beans, and eating the rest.

And despite the closed window, the noise below was steadily increasing.

“Free the DSM Four!” was suddenly joined by a new chant: “Two, four, six, eight, you don’t hafta medicate!” A siren sounded in the distance.

“Listen to them!” Dr. Shpritzer said. “It doesn’t matter how many meetings you have, they still don’t understand.” He sighed. “Excuse me: I’m going to have to make some more calls.”

“Just one more question, please. What was the role of political correctness in creating the *DSM-IV*?”

He looked at me, his eyes narrowing. “Say, what is this PLOTZ-ING thing anyway?” he asked. “How many are you, and what do you want? I’m a busy man.”

I gave him our official speech: “We have about 10,000 members. Our issues include the arbitrary nature of diagnosis and treatment, and the fact that there are too many financial and political influences on what’s supposed to be a science.”
"Supposed to be? Suppose to be? Young lady, you can tell your PLOTTING friends that we adhered to the strictest standards of scientific rigor in compiling our diagnostic criteria!" He glared at me. "Have you ever heard of consensual validation?"

"Well sure, but . . ."

"And don't you think there are thousands of people out there who are suffering because of how others perceive them?"

"Yes, but . . ."

"So why shouldn't they have their own category and be able to be reimbursed for treatment?"

"Not being 'liked' is a mental disorder?"

"It is now," he said proudly. "It's called the Dangerfield Dysphoric Disorder; it's also known, informally, as the 'I Can't Get No Respect' Syndrome. No reason why we can't have a little humor in our humanity, right?" he chuckled.

"I heard there's also a category called the Milli Vanilli Syndrome, for people who let others speak for them?"

"That's in the section for future study, but, yes, we believe it may be a viable clinical entity."

I consulted my notes. "The Baby Boomer Sudden Mortality Recognition and Regret for the Paths Not Taken Dysphoric Disorder?"

He smiled. "It's a mouthful, yes, but we're working on it. Lots of reports coming in on that one. Jelly bean?"

"I'm trying to cut down, thanks. Organic Brain Syndrome Not Otherwise Specified But Possibly Due To Backward Baseball Caps?"

"I told you, we wanted to include everyone. And, yes, there is some very impressive evidence connecting cognitive problems with habitual cap reversal."

Meanwhile, the protest downstairs was intensifying—they'd added a bullhorn and a bass drum. "FREE THE DSM FOUR! FREE THE DSM FOUR!" blended with a new chant from a group on the periphery: "Managed care, mangled care, get Big Brother out of our hair!"

Dr. Shpirtizer got up from his desk and went to the window. His eyes fastened on one of the group. "Oh no, I went to medical school with him. This is really getting out of hand."

Turning to me, he said, "Look, it's been nice chatting with you,
but I really must get back to work now. And you must go back to PLOTZING."

"I intend to," I replied. "Thanks for your time." I shook his sticky hand, and before I'd even left the room, he was back on the phone again.

"Stop the presses!" he commanded. "They're back!"
Colonphilia: A Grammatical Personality Disorder Involving the Excessive Use of the Colon

Lawrence C. Katz, M.S.
Loyola University of Chicago

An extensive review of any body of literature in the field of psychology reveals the emergence of a disturbing malady prevalent among researchers: an uncontrollable urge to use a colon in the titles of their works. This appears to be a chronic disorder with a deteriorating course, if left untreated.

Introduction

The colon is primarily a mark of introduction, informing the reader that the preceding statement is about to be explained, amplified, or summarized. A colon may be appropriately used to separate titles and subtitles (Fowler & Aaron, 1989). However, this seemingly innocent usage may lead to a compulsion among those who write and publish, such that one becomes hopelessly incapable of completing a scholarly work without slapping some wordy colon-separated label on the title page.

For the researcher addicted to colons, life is an endless maze of extensions and elaborations. Hans Awf (1992), in his paper "A Case Study of Colonphilia with an Obstinate Researcher: Mostly Interventions that I Think are Pretty Good and Treatment Recommendations and a Discussion Section that is Not as Well-Written Because My Graduate Assistant Did It," describes a once prominent professor who became so obsessed with colons that he could only speak in elaborated sentences. An illustrative example follows:
Hans: Hello, Doctor.
Dr. X: Hi, how are you?: A salutation and rhetorical question.
Hans: How is your research going?
Dr. X: It’s going fine: An obvious lie. I still can’t seem to keep
the titles down to an acceptable length: Confession of a
colonphiliac. It’s quite distressing: A desperate cry for
help. I hope I can get over this: Thinly veiled self-doubt.
Hans: I think I can help.
Dr. X: That would be great: Reaction to an empty promise that
this fool is unlikely to be able to fulfill.

This segment clearly demonstrates how an excessive reliance on
the colon may become debilitating to interpersonal relationships.

**Etiology**

Some psychoanalytic theorists (e.g., Anna, Lizum, & Billum, 1992;
Onda, Couch, & Spillit, 1991) posit that colonphilia stems from a
fixation at the oedipal phase of development. According to this
theory, the colonphiliac feels the need to insert his upright phallus
between the primary, all-powerful part of the title (the father) and
the supportive, nurturing part of the title (the mother).

Cognitive theorists (Hunt & Beck, 1991) point to the irrational
belief system behind the use of the colon. They propose that research­
ers tend to believe, “If I don’t extend this title, my work will be
dismissed, because people will have to read the article to find out
what it’s really about, and no one will want to do that because it’s
quite meaningless and because I’m worthless. If people dismissed
this work, it would be awful, because I would forever be worthless.
Therefore, I must include a colon to extend this title.”

**Treatment**

Given the opposing etiological assumptions across the various
theoretical orientations, no consensus exists as to the optimal course
of therapy for colonphilia. Psychodynamic theorists recommend a
course of approximately 40 years to life, consisting of three one-hour sessions per week. The goal is resolution of the oedipal conflict through illumination of the displacement of unresolved castration fears, with neurotic ego defenses and fetishist libidinal impulses sublimated primarily through the transferential phallic fixation.

Cognitive therapists attempt to challenge the underlying irrational belief that having no one read their works would be “awful.” Attempts to convince researchers that their articles are worthwhile and interesting enough to be widely read even without a cumbersome title tend to be ineffective, because this perspective has no basis in reality. Therefore, cognitive treatment aims to encourage colonphiliacs to just accept that their works are unlikely to be read, with or without an expanded title. The patient is given instructions that, when titling an article, he or she is to say, “Stop. Nobody will read this anyway, and that’s okay. I might as well make this title brief. I do not have to use a colon.”

Behavioral theorists favor an even more direct approach. Studies have shown that administering an electric shock to subjects as they reach for the colon key on a keyboard significantly reduces the length and general wordiness of titles. For a complete review, see Zappum and Good, 1990.

Finally, international Colonphiliacs Anonymous (CA) groups, focusing on the addictive nature of the disorder, are beginning to form. These groups have developed a 12-step treatment program, including such therapeutic landmarks as, “Acceptance: I am powerless over the colon” and “Relinquishment of responsibility: There is a higher grammatical power.” Unlike other 12-step support groups, this program actually takes tokens away from participants for saying, “My name is John: I am a colonphiliac.”

**Proposed DSM-IV Criteria for Colonphilia**

**Diagnostic Criteria for Colonphilia**

A. The individual is chronically and progressively unable to resist impulses to expand titles with the use of the colon.
B. The use of the colon compromises, disrupts, or damages family, personal, and vocational pursuits, as indicated by at least three of the following:

(1) Titles of works are so long that they exceed the limits for Abstracts in most journals.

(2) Loss of work due to absenteeism and inability to meet submission deadlines. This may be a result of excessive deliberation over a final title, given the multitude of seemingly good possibilities afforded by the use of a colon.

(3) Disruption in relationships due to the overly revealing use of colons in speech (e.g., “I love you: An expected prerequisite to sexual relations”).

(4) Inability to title written works (including journal articles, grocery lists, birthday cards, etc.) without the use of a colon.

C. The colon use is not due to another Grammatical Personality Disorder.

The recognition of colonophilia as a debilitating and annoying disorder resulting in excessively wordy titles and the conceptualization of an optimally effective treatment are critical: The time has come.

References


Awf, H. (1992). A case study of colonophilia with an obstinate researcher: Mostly interventions that I think are pretty good and treatment recommendations and a discussion section that is not
as well-written because my graduate assistant did it. *Journal of Quick and Easy Case Studies, 1*(1), 1.


Hunt, U., & Beck, I. M. (1991). The etiology of colonophilia: The irrational belief that, if I don’t extend this title, my work will be dismissed, because people will have to read the article to find out what it’s really about, and no one will want to do that because it’s quite meaningless and because I’m worthless and if people dismissed this work, it would be awful, because I would forever be worthless and, therefore, I must include a colon to extend this title. *Mental Masturbation, 1*(23), 45.


Toward the Application of Diagnostic Criteria to Personality-Disordered Psychotherapy Patients: Understanding Axis II of the DSM-III-R as It Has Never Been Understood Before

David J. Robinson, M.D.
St. Joseph’s Health Center
London, Ontario, Canada

With the advent of the American Psychiatric Association’s (1987) most recent tome on psychiatric diagnosis—the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised (DSM-III-R)—mental health professionals have been treated to a new classification system, one in which various mental disorders are coded on different “Axes,” with “Personality Disorders” confined to Axis II. Whereas the DSM-III-R’s Axis II focuses on the application of diagnostic criteria to the behaviors of individuals in general, the author presents here the seminal work on the application of diagnostic criteria to the behaviors of psychotherapy patients in specific, to the way in which these individuals relate to the therapist and to the therapy process. It is hoped that these specific criteria for diagnosing personality-disordered psychotherapy patients will help clinicians everywhere pigeonhole, treat, and bill their patients more quickly.

Paranoid Personality Disorder

Before session

Checks to see if followed, confirms authenticity of therapist’s diploma

Copyrighted Material
More Oral Sadism and the Vegetarian Personality

<table>
<thead>
<tr>
<th>Waiting room reading</th>
<th>Looks for Soldier of Fortune magazine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td>Horn rimmed glasses with rear-view mirrors</td>
</tr>
<tr>
<td>Employment</td>
<td>Full-time projectionist</td>
</tr>
<tr>
<td>Fantasizes about . . .</td>
<td>Demanding a full explanation of therapist’s jokes</td>
</tr>
<tr>
<td>Relationship with animals</td>
<td>Questions pet dog’s fidelity</td>
</tr>
<tr>
<td>Talks about during session</td>
<td>Questions partner’s fidelity</td>
</tr>
<tr>
<td>Relationship with therapist</td>
<td>Questions therapist’s fidelity</td>
</tr>
<tr>
<td>Behavior during session</td>
<td>Complains about lack of warmth in office</td>
</tr>
<tr>
<td>Leaves with therapist</td>
<td>Scrapbook of injustice collection</td>
</tr>
</tbody>
</table>

Schizoid Personality Disorder

<table>
<thead>
<tr>
<th>Before session</th>
<th>Walks to session, takes back alleys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting room reading</td>
<td>Avoids waiting room, reads Abstract Science magazine in hallway</td>
</tr>
<tr>
<td>Appearance</td>
<td>Stove-pipe pants and wide tie</td>
</tr>
<tr>
<td>Employment</td>
<td>Runs a bowling alley between 1–7 a.m.</td>
</tr>
<tr>
<td>Fantasizes about . . .</td>
<td>Pines away for philosophy course instructor</td>
</tr>
<tr>
<td>Relationship with animals</td>
<td>Brings dog to session</td>
</tr>
<tr>
<td>Talks about during session</td>
<td>Marvels over new surveillance cameras in building entrance</td>
</tr>
<tr>
<td>Relationship with therapist</td>
<td>Asks therapist to play Dungeons and Dragons</td>
</tr>
<tr>
<td>Behavior during session</td>
<td>Teeters on edge (of chair)</td>
</tr>
<tr>
<td>Leaves with therapist</td>
<td>Copy of latest fad diet, shows collection of mail order catalogues</td>
</tr>
</tbody>
</table>

Copyrighted Material
Schizotypal Personality Disorder

Before session
Reads palms, tea leaves, and Tarot cards of others in waiting room

Waiting room reading
Astrology Weekly

Appearance
Tin foil hat, shirt stapled together, unpaired socks

Employment
Developer for a UFO landing pad

Fantasizes about . . .
A weekly show with the Canadian Thought Broadcasting Corporation

Relationship with animals
Laments that pet budgie is dead, despite séances

Talks about during session
Starts session by talking to self

Relationship with therapist
Casts a spell on the therapist

Behavior during session
Rubs camphor on knee to prevent spleen cancer

Leaves with therapist
Book on neologistics—“How to Call 'Em As I See 'Em”

Histrionic Personality Disorder

Before session
Flirts with others in waiting room

Waiting room reading
Does quiz from fashion magazines

Appearance
Matching earrings, purse, nails, and shoes

Employment
Cosmetician

Fantasizes about . . .
Being a sex therapist

Relationship with animals
Owns 3 fluffy white cats: Puffy, Buffy, and Muffy

Talks about during session
Gives quiz results to therapist

Relationship with therapist
Writes best-selling novels based on sex fantasies with therapist
Behavior during session: Faints when quiz results are interpreted
Leaves with therapist: Perfumed handkerchief, with private phone number in lipstick, on chair

**Narcissistic Personality Disorder**

Before session: Grooming in a portable mirror
Waiting room reading: *GQ*; lies to others that a model with a close resemblance is really him
Appearance: Silk suit, cubic zirconium cuff-links, alligator belt
Employment: Men’s store as a window dresser
Fantasizes about . . .: What he’s like in bed
Relationship with animals: Walks friend’s Afghan in order to meet women
Talks about during session: Every sentence begins with “I . . .”
Relationship with therapist: Self-appointed fashion consultant to therapist
Behavior during session: Behaves as if session were being filmed
Leaves with therapist: A flyer for a 50%-off sale from his clothing store

**Antisocial Personality Disorder**

Before session: Holds up the pharmacy in the lobby of the therapist’s building
Waiting room reading: Steals magazines, leaves old copies of *Playboy* with centerfolds missing
Appearance: Sideburns, muscle shirt, cowboy boots, tattoo
### More Oral Sadism and the Vegetarian Personality

<table>
<thead>
<tr>
<th>Employment</th>
<th>Worked on “career” since childhood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fantasizes about . . .</td>
<td>Sexual encounter with probation officer</td>
</tr>
<tr>
<td>Relationship with animals</td>
<td>Shows the innate sensitivity of a taxidermist</td>
</tr>
<tr>
<td>Talks about during session</td>
<td>Starts each sentence with “!@#$%&amp;* . . .”</td>
</tr>
<tr>
<td>Relationship with therapist</td>
<td>Pickpocketed therapist’s calling card: placed several long distance calls</td>
</tr>
<tr>
<td>Behavior during session</td>
<td>Carves up armrest with switchblade, copies down Histrionic’s phone number</td>
</tr>
<tr>
<td>Leaves with therapist</td>
<td>Advice to get a car alarm</td>
</tr>
</tbody>
</table>

### Borderline Personality Disorder

<table>
<thead>
<tr>
<th>Before session</th>
<th>Has fight with ex-lover outside office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting room reading</td>
<td>Castrates all pictures of men in magazines</td>
</tr>
<tr>
<td>Appearance</td>
<td>Dresses completely in black or white; today it’s black</td>
</tr>
<tr>
<td>Employment</td>
<td>Summer camp counsellor</td>
</tr>
<tr>
<td>Fantasizes about . . .</td>
<td>Wants to sleep with therapist and therapist’s partner</td>
</tr>
<tr>
<td>Relationship with animals</td>
<td>Sleeps with pet cat and stuffed teddy bear</td>
</tr>
<tr>
<td>Talks about during session</td>
<td>Smells perfume from Histrionic, goes into a rage</td>
</tr>
<tr>
<td>Relationship with therapist</td>
<td>Threatens blackmail after above sexual encounter</td>
</tr>
<tr>
<td>Behavior during session</td>
<td>Widens hole in chair made by Antisocial</td>
</tr>
<tr>
<td>Leaves with therapist</td>
<td>Weekly suicide note on way out of session</td>
</tr>
</tbody>
</table>
## Avoidant Personality Disorder

<table>
<thead>
<tr>
<th>Before session</th>
<th>Followed Schizoid’s route to the session; hoped they might meet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting room reading</td>
<td>Rather than take a magazine someone else might want to look at, reads nothing</td>
</tr>
<tr>
<td>Appearance</td>
<td>Coordinates clothes with wallpaper in therapist’s office</td>
</tr>
<tr>
<td>Employment</td>
<td>Model for “before” pictures in weightlifting ads</td>
</tr>
<tr>
<td>Fantasizes about . . .</td>
<td>Having Dale Carnegie reincarnated as his uncle</td>
</tr>
<tr>
<td>Relationship with animals</td>
<td>Trained dog to walk itself</td>
</tr>
<tr>
<td>Talks about during session</td>
<td>The best detours, exits, and off-ramps in the city</td>
</tr>
<tr>
<td>Relationship with therapist</td>
<td>Follows therapist daily, hides in shadows to protect car from Antisocial</td>
</tr>
<tr>
<td>Behavior during session</td>
<td>Spends most of session with head in lampshade</td>
</tr>
<tr>
<td>Leaves with therapist</td>
<td>Invisible Man comic book</td>
</tr>
</tbody>
</table>

## Dependent Personality Disorder

<table>
<thead>
<tr>
<th>Before session</th>
<th>Arrives from another therapist’s office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting room reading</td>
<td>Brings autographed self-help book written by yet another therapist</td>
</tr>
<tr>
<td>Appearance</td>
<td>Athletic shirt with “Just Take Me” on it—underneath a big fuzzy sweater</td>
</tr>
<tr>
<td>Employment</td>
<td>Food bank, pet hotel, block parent, neighborhood sandwich maker</td>
</tr>
<tr>
<td>Fantasizes about . . .</td>
<td>Chaining up therapist in home</td>
</tr>
</tbody>
</table>
More Oral Sadism and the Vegetarian Personality

Relationship with animals
Chains dog up inside house to prevent it from running away

Talks about during session
Nightmares after watching Home Alone

Relationship with therapist
Sits in therapist’s car when Avoidant not watching it

Behavior during session
Moves chair next to therapist; tape records session for relaxation therapy.

Leaves with therapist
Invitation to dinner, every night for a month

Obsessive-Compulsive Personality Disorder

Before session
Washes hands before and after trip to washroom

Waiting room reading
Rearranges magazines, no time to read

Appearance
Ironed socks, pressed jeans, starched underwear

Employment
Molecule counter for a chemical company

Fantasizes about . . .
Not flushing the toilet

Relationship with animals
Has sent dog to obedience school for 8 years

Talks about during session
Reads therapist the new rules of conduct from work

Relationship with therapist
Demands therapist synchronize watch at start of each session

Behavior during session
Repairs hole in chair with pocket sewing kit

Leaves with therapist
Copy of an etiquette book

Passive-Aggressive Personality Disorder

Before session
Arrives late, blames Obsessive for setting therapist’s watch ahead
<table>
<thead>
<tr>
<th>Waiting room reading</th>
<th>Tears out articles of interest from magazines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td>Models fashion after <strong>Borderline</strong>; except wears black and white together</td>
</tr>
<tr>
<td>Employment</td>
<td>Somewhere in government</td>
</tr>
<tr>
<td>Fantasizes about . . .</td>
<td>Being not disgruntled</td>
</tr>
<tr>
<td>Relationship with animals</td>
<td>Makes dog drag food home by itself</td>
</tr>
<tr>
<td>Talks about during session</td>
<td>Waits 5 seconds, interrupts therapist repeatedly, then forgets what to say</td>
</tr>
<tr>
<td>Relationship with therapist</td>
<td>Left wrong insurance number after forgetting it three times</td>
</tr>
<tr>
<td>Behavior during session</td>
<td>Somewhere between Miss Manners and the Terminator</td>
</tr>
<tr>
<td>Leaves with therapist</td>
<td>Gives notice of termination to secretary, after session</td>
</tr>
</tbody>
</table>

**References**

References

1 Psychodiagnosis


A review of the clinical literature on vegetarianism to date reveals that little attention has been given to the psychodynamic mechanisms that govern the behavior of those individuals who choose to restrict their diet to foods other than dead animals. Fruitlooper's (1895) case study of Julia V., a 39-year-old pregnant hysteric unable to refrain from regurgitating Wienerschnitzels, had first thrown light upon the meatless phenomenon, but Fruitloopers contemporaries rejected his psychosexual interpretation of Wienerschnitzels and interest in his discovery soon waned. It was not until von Krankman, one of Fruitlooper's more brilliant students, a tireless theoretician and jogger and, later, founder of the "neo-Fruitloopian school" of psychoanalysis, that interest in vegetarianism was renewed. The connection between vegetarianism and sadism was first lighted in von Krankman's (1939) seminal paper, "A Treatise on the
Psychodynamics of the Meatless Choice.” Von Krankman theorized

that consumption of vegetables, to the exclusion of sinewy flesh,

represented a “fixation” at an “oral-sadistic stage” of development. 1 The fixation is by the rigid cathexis of energy to but one category

of objects represented. 2 While the vegetarian not so very often to

1 I would like to thank Mr. Angelo Augratini, A.A., adjunct assistant instructor of

European languages, Hempstead Community College, for his translation of this

passage from von Krankman’s original text.

2 Translator’s note: I kind of had some trouble translating a pretty short sentence

that came after this one so I just left it out. 9 other equally erogenous zones these organic substances placed observed have been, so can we say that the use of these vegetables truly, no, almost exclusively, to the oral zone placed are! Also, have we a sadistic impulse with the vegetarian character. The man who kills animals for meat gives the pursued animal a chance to escape. How more and more sadistically cruel is the non-meat eating man. The keen theoretician must himself this question deeply ask—What is the likelihood that the tranquil carrot from its vicious predator successfully outrun can? During his American lecture series, delivered at the New School

for Social Research in the Fall of 1941, von Krankman (1942) intro

duced a refinement and expansion of his work, outlining the process

by which the vegetarian defends himself against conscious awareness

of his sadistic impulses. The orally fixated vegetarian deals with his early prototypic loss of the love object through compensatory defense mechanisms, which serve to conceal from himself, significant others, and his Saturday
night dates, his deep-seated feelings of anger, hostility, hatred, rage, and, to some extent, dislike for his fellow man. Nor is his like for women too keen. Since the vegetarian character identifies man with animals (and rightfully so), he utilizes the defense mechanisms of reaction formation, denial, and sublimation in order to portray a façade whereby he is perceived as loving man, the animal, and hence animals, while displacing his true oral-sadistic impulses onto the nonman non-animal—vegetables. Thus it is that the orally sadistic vegetarian character comes to take delight in aggressively consuming vegetables while zealously and defensively maintaining his dis-taste for animals. Although von Krankman was making inroads in the exploration of the psychodynamics of the vegetarian character, it was not until

his now famous 1947 Invited Psychoanalysts Address before the faculty and candidates of the prestigious Advanced Institute for Psychoanalytic Psychotherapy that his thinking was crystallized with the conceptualization of "the Vegetarian Personality." Von Krankman's long and arduous theorizing was finally complete. The Vegetarian Personality is characterized by ruthless acts of an oral-sadistic nature directed against vegetables. Through a series of complex and difficult (even for the analyst) to understand processes, a tripartition of the ego develops. This splitting of the ego leads to the gradual emergence of three compartmentalized senses of reality—"the good-food," "the bad-food," and "the not-food." Vegetables are perceived as "the good-food" because engaging in the
Inconsummatory act does not threaten to unleash the underlying currents of anxiety. Animals are perceived as "the bad-food" because even the thought of devouring them is threatening enough to arouse the vegetarian's fear of dealing with his repressed oral-aggressive and oral sadistic urges toward his fellow man. Finally, there is the primitive taboo against phylogenetic self-destruction, so that man himself becomes "the not-food" and the impulse toward cannibalism is fully defended against.

Von Krankman's tragic and untimely death from ingestion of poisonous mushrooms deprived the psychoanalytic community of a great mind. Nonetheless, his pioneering work in the area of oral sadism and the Vegetarian Personality had an enormous impact upon the field of psychoanalysis, prompting, if not a great deal of research, or any research for that matter, at least a great deal of heated debate among psychoanalysts.

It was a fitting tribute to von Krankman's greatness as a theoretician, clinician, and taxpayer that members of the American Psychiatric Association, in revising their outdated Diagnostic and
Statistical Manual of Mental Disorders (DSM), spontaneously chose, upon unanimous recommendation of the Task Force on Nomenclature and Statistics, and at the adamant urging of the American Psychological Association, to incorporate von Krankman's work into their newly revised third edition, the DSM-III. The influence of von Krankman's penetrating thinking is clearly evident in the passage from the DSM III reproduced below.

301.85 Vegetarian Personality Disorder

The essential feature is a Personality Disorder in which there is a severe preoccupation with food consumption, schizoid-like inability to empathize with certain living organisms (usually vegetables) within the environment, hypersensitivity to issues revolving around food ingestion, paranoid suspiciousness concerning the content of the dinner plate, and impaired social relationships, particularly in restaurant settings, due to rigidity in eating patterns.

Associated features. Individuals with this disorder usually are unable to express anger, hostility, or aggressiveness toward others,
but fare well in expressing such feelings toward vegetables. Because of these people's intense preoccupations with food, they commonly have impaired social relationships and often they attempt to band together in self-help groups, called "food collectives." The rigidity of their eating behavior tends to contribute to their social impairment, and individuals with this disorder are frequently known to seek out partners who suffer from the same disorder. Impairment. Eating behavior, by definition, is severely compartmentalized and rigid. Social relationships usually become impaired as the individual gets into arguments with others over where to dine. While occupational functioning is rarely disturbed, the individual with this disorder usually brings lunch or buys a yogurt to go. Complications. A common complication is Unintentional Substance Use Disorder, with toxicity appearing in the form of "MSG overdose" from eating in Chinese restaurants too often. Predisposing factors. Finicky eating patterns in childhood may in some way be associated with the onset of this disorder in later adolescence or early adulthood, although the relationship is not clearly established. Prevalence. This disorder appeared to be fairly common begin.
ning in the late 1960s and continuing into the 1970s, but it seems to be tapering off. Sex ratio. This disorder is diagnosed about equally among men and women.

Differential diagnosis. In Paranoid Personality Disorder there is, by definition, pervasive and systematic mistrust of people, whereas the Vegetarian Personality Disorder involves mistrust specifically related to the content of the dinner plate. In both the Schizoid Personality Disorder and Narcissistic Personality Disorder, conspicuous absence of any ability to empathize is a primary feature, whereas the Vegetarian Personality Disorder is characterized by an ability to empathize, at least on a superficial level, with other people and related animals.

Diagnostic Criteria for Vegetarian Personality Disorder

A. Loss of the love object early in life without subsequent resolution of at least five of the following emotions toward the love object: (1) anger (2) hostility (3) rage (4) hatred (5) dislike

B. Onset of the disorder in late adolescence or early adulthood.

C. Rigidity in eating patterns.


Understanding the Psychological Report: Differences Between What Clinicians Write and What They Really Mean. Loreto R. Prieto University of Iowa

The discrepancy between what people truly mean and what they communicate to others, and the dire consequences that can result from such miscommunications, has received much attention in the pages of the Journal of Polymorphous Perversity. For example, Fein gold (1990, 1992a) warned that graduate students who fail
to recognize the underlying messages of their graduate advisors risk an abrupt and untimely end to their academic careers. In a similar vein, Pierce (1990) noted that doctoral candidates face failing their oral defense if they do not pay adequate attention to the subtext of the dissertation committee's verbalizations. Piersma (1990) cautioned that disaster will result if internship site interviewers take letters of recommendation at face value, instead of reading between the lines. Feingold (1992b) clarified how beginning professors risk being denied tenure by misinterpreting the statements of their graduate students. Most recently, Gawthrop (1993) noted that patients could suffer negative therapeutic outcomes if they do not recognize the disparity between their therapists' verbalizations and their therapists' underlying messages. All too often, mental health professionals, when faced with reading psychological reports, fail to correctly interpret the latent messages conveyed therein. In the present paper, the author provides key interpretations to statements appearing in the psychological reports.
of clinicians. It is hoped that a clearer understanding of what clinicians really mean in their psychological reports will ensure that mental health professionals will pick up on all of the subtle, and not-so-subtle, cues in these reports, thereby avoiding the possibility of mistakenly accepting into treatment "difficult" patients or those who lack excellent insurance coverage. What the Clinician Writes

This clinician examined the patient for one hour. The patient approached the interview in a cooperative manner. The patient's affect was constricted in range, incongruent with the content of speech, and grounded within a dysphoric mood. The patient’s rate of speech was normal. The patient's marital relationship appears appropriate, functional, and secure. The patient leads an irrespon
sible and carefree life.
The patient engages in superficial sexual relationships with multiple partners without establishing meaningful emotional ties. What the Clinician Means The examination took 40 minutes, but we bill by the hour. The patient answered all of my questions, including the embarrassing ones. The patient did not laugh at my jokes. The patient spoke in a manner that gave me time to take notes. The patient and his wife fight about the same stuff my wife and I do. Boy, am I jealous. Amazing. I never did that well when I was single.

18 More Oral Sadism and the Vegetarian Personality What the Clinician Writes The patient has an erratic work history. The patient denies any substance use. The patient has a significant history of extensive substance abuse. The psychological test results are inconclusive. The patient took an inordinate amount of time to complete the assessment measure. The patient was not goal oriented and needed frequent encouragement during testing. Testing was not indicated for this patient. The patient was unresponsive to empathy. The patient displayed a remarkable acuity for environmental stimulus cues within interpersonal interaction. What the Clinician Means The patient hasn't been stuck in as many crappy jobs as I've been. Yeah, right. Better keep the patient's number in the Rolodex for the next staff party. The computer scoring service lost the patient's MMPI in the mail. I had to stay late and missed my bus. The patient couldn't even handle a measly seven-hour testing session. The patient has no insurance. The patient refused to accept my only slightly used handkerchief to dry his tears. The patient complimented me on my new suit.

More Oral Sadism and the Vegetarian Personality 19 What the Clinician Writes

The patient demonstrated good conceptual, abstraction, and judgment skills.
The patient was histrionic and demanding.
The patient shows an ability to meet social demands.
The patient was oppositional and unable to appropriately respond to social interaction.
This patient may benefit from referral to group therapy.
This patient appears to be dealing with a complex clinical pathology that might possibly be ameliorated by a regimen of intensive, carefully executed psychotherapeutic


Many Personality Disorders Does It Take to Change a Lightbulb? Jerry L. Jennings, Ph.D. By now, every self-respecting psychotherapist knows how many therapists it takes to change a lightbulb, 1 right? But have you ever wondered how many Axis II personality disorders it takes to handle that classic problem? Let’s take a look.

- How many Narcissistic Personality Disorders does it take to change a lightbulb? Just one—to hold the lightbulb, but he has to wait for the whole world to revolve around him.

- How many Borderline Personality Disorders does it take to change a lightbulb? Just one—to threaten suicide if you don’t change it for her.

- How many Obsessive Compulsive Personality Disorders does it take to change a lightbulb? Just one—but he has to check it a hundred times, once for each watt.

- How many Passive Aggressive Personality Disorders does it take to change a lightbulb? "Oops! I can’t believe I broke the last one. I guess you’ll just have to sit in the dark, Honey."

1

Just one—but only if the lightbulb really wants to change.
• How many Dependent Personality Disorders does it take to change a lightbulb? None. She’s still clinging to the old lightbulb.

• How many Histrionic Personality Disorders does it take to change a lightbulb? “You want me to change lightbulbs?! I could burn my hand! I could be electrocuted! I could fall off of the ladder and be paralyzed for life! You don’t love me anymore!”

• How many Self-Defeating Personality Disorders does it take to change a lightbulb? Just testing you . . . We’re waiting for the DSM-IV on that one!

• How many postal workers does it take to change a lightbulb? Oh, I’m sorry, aren’t all postal workers by definition personality disordered? Free the DSM-IV Judith Schlesinger, Ph.D.

The DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) was coming in June—the new Bible of mental disorders and reimbursements. Because of the controversy surrounding its predecessor, the DSM-III-R, also published by the American Psychiatric Association (APA), I was assigned to interview one of the chief editors, Dr. Richard Shpirtzer. My mission: to see if things were different this time around.

Our group is called PLOTZING (People Leery of the Zeitgeist in New Guidelines [in Mental Health]). Our concern: that the new manual would contain more politics than science. "Oh, no," said Shpirtzer when I brought the matter up, "this time, we asked everybody for their opinions. Jelly bean?"
"No, thanks," I said. I looked around his office, which was large, airy, and dominated by stacks of books in proof—the DSM-IV itself, the DSM-IV Sourcebook, the DSM-IV Notebook, the DSM-IV Guidebook, the DSM-IV Casebook, the DSM-IV Coloring Book (Categories for Kids), and the DSM-IV Diagnosis-a-Day Desk Calendar. He saw me looking. "You like this stuff?" he asked, smiling. "The APA hasn't had to raise its dues in years." He showed me the coloring book. "This one's my favorite. Here, look at this picture of an Obsessive Compulsive Disorder. It really captures its essence, don't you think?" He put down the book, which, I noticed, was half colored in, and took another handful of candy. "You're never too young to understand science. Even with all their problems, we're still behind the Russians, you know." "But is science what we're talking about?" I wondered. "The DSM-III-R was built on political trade-offs—categories put in or thrown out, changed and bartered, depending on which pressure groups were squawking. I can think of at least six examples right now..." "Squawking? That's absurd!" declared Shpritzer. "Squawking has no place in science. Look..." He picked up the order form for the DSM-IV and its accessories. "See this, right here? It refers to our 'open process' and the 'quality
and diversity' of our participants. There's no squawking when there's full inclusion. I think we even let the psychologists vote this time.

It was a swell group. Jelly bean?" "No, really, thanks. Diversity's important, sure, but it still sounds like the science-by-consensus thing all over again." "Then read our Sourcebook, if you're so interested. That's where the empirical data and rationale are." He was getting agitated: grab bing more and more jelly beans. He ate only the red ones, and threw the rest away. "And about that Sourcebook, Dr. Shpritzer," I said, "if you really want people to understand the scientific basis for the DSM-IV, why price the Sourcebook at more than twice the DSM-IV itself, with no option to get it in paperback? What are you hiding?" "We are hiding nothing," he said, icily, "because we have nothing to hide. In fact, our market research shows that most clinicians have no interest in empirical matters at all. They have enough trouble getting the codes and Axes right." "And besides," he continued, "this is the 90s. There's science, but there's also empowerment. We have to be sensitive, you know. After all," he leaned forward, "we are healers. We don't want to make things worse for people." "I'm glad you mentioned that, Sir, because . . ." Suddenly his
attention became focused on the window. One could hear chanting from the street. I couldn't quite make out the words. "Oh, no, not again," he groaned, as he picked up the phone.

"Excuse me a minute." "No problem," I said. I touched up my notes and scanned the bookcases. There was the usual batch of Freud and Jung, Rank and Adler, Krantz and Steele—along with an interesting collection of new titles: The Therapist Giveth and Taketh Away: False Memory Syndrome; Diagnosis as a Political Act; Science Can Be Friendly; and Who Sez? The chant grew louder: the people were yelling, "Free the DSM Four! Free the DSM Four!" A lot of people. Shpritzer shut the window and got back on the phone. "I thought you said we were going to include Frustrated Entitlement in the main section," he growled. "No, these guys won't go for it. . . ."

Yeah. . . . No, we can't. . . . Hey, that Late Luteal Phase Dysphoric Disorder almost sandbagged the whole thing, remember? . . .

don't have time to continue this interview right now." I could tell

he was rattled. He was spitting out the red jelly beans, and eating

the rest. And despite the closed window, the noise below was steadily in

creasing. "Free the DSM Four!" was suddenly joined by a new chant:

"Two, four, six, eight, you don't hafta medicate!" A siren sounded

in the distance. "Listen to them!" Dr. Shpritzer said. "It doesn't matter how many

meetings you have, they still don't understand." He sighed. "Excuse me: I'm going to have to make some more calls." "Just one more question, please. What was the role of political

correctness in creating the DSM-IV?" He looked at me, his eyes narrowing. "Say, what is this PLOTZ

ING thing anyway?" he asked. "How many are you, and what do you want? I'm a busy man." I gave him our official speech: "We have about 10,000 members.

Our issues include the arbitrary nature of diagnosis and treatment,

and the fact that there are too many financial and political influences

on what's supposed to be a science." "Supposed to be? Supposed to be? Young lady, you can tell your

PLOTZING friends that we adhered to the strictest standards of

scientific rigor in compiling our diagnostic criteria!" He glared at

me. "Have you ever heard of consensual validation?" "Well sure, but . . ." "And don't you think there are thousands of people out there
who are suffering because of how others perceive them?"
"Yes, but . . ." "So why shouldn't they have their own
category and be able to
be reimbursed for treatment?" "Not being 'liked' is a
mental disorder?" "It is now," he said proudly. "It's
called the Dangerfield Dysphoric
Disorder; it's also known, informally, as the 'I Can't Get
No Respect'
Syndrome. No reason why we can't have a little humor in our
human
ity, right?" he chuckled. "I heard there's also a category
called the Milli Vanilli Syndrome,
for people who let others speak for them?" "That's in the
section for future study, but, yes, we believe it may
be a viable clinical entity." I consulted my notes. "The
Baby Boomer Sudden Mortality Rec
ognition and Regret for the Paths Not Taken Dysphoric
Disorder?" He smiled. "It's a mouthful, yes, but we're
working on it. Lots of
reports coming in on that one. Jelly bean?" "I'm trying to
cut down, thanks. Organic Brain Syndrome Not
Otherwise Specified But Possibly Due To Backward Baseball
Caps?" "I told you, we wanted to include everyone. And,
yes, there is
some very impressive evidence connecting cognitive problems
with
habitual cap reversal." Meanwhile, the protest downstairs
was intensifying—they'd added
a bullhorn and a bass drum. "FREE THE DSM FOUR! FREE
THE DSM FOUR!" blended with a new chant from a group on the
periphery: "Managed care, mangled care, get Big Brother out
of
our hair!" Dr. Shpritzer got up from his desk and went to
the window. His
eyes fastened on one of the group. "Oh no, I went to medical school with him. This is really getting out of hand." Turning to me, he said, "Look, it's been nice chatting with you, but I really must get back to work now. And you must go back to PLOTZING." "I intend to," I replied. "Thanks for your time." I shook his sticky hand, and before I'd even left the room, he was back on the phone again. "Stop the presses!" he commanded. "They're back!" Colonphilia: A Grammatical Personality Disorder Involving the Excessive Use of the Colon Lawrence C. Katz, M.S. Loyola University of Chicago

An extensive review of any body of literature in the field of psychology reveals the emergence of a disturbing malady prevalent among researchers: an uncontrollable urge to use a colon in the titles of their works. This appears to be a chronic disorder with a deteriorating course, if left untreated. Introduction

The colon is primarily a mark of introduction, informing the reader that the preceding statement is about to be explained, amplified, or summarized. A colon may be appropriately used to separate titles and subtitles (Fowler & Aaron, 1989). However, this seemingly innocent usage may lead to a compulsion among those who write
and publish, such that one becomes hopelessly incapable of completing a scholarly work without slapping some wordy colon-separated label on the title page.

For the researcher addicted to colons, life is an endless maze of extensions and elaborations. Hans Awf (1992), in his paper "A Case Study of Colonophilia with an Obstinate Researcher: Mostly Interventions that I Think are Pretty Good and Treatment Recommendations and a Discussion Section that is Not as Well-Written Because My Graduate Assistant Did It," describes a once prominent professor who became so obsessed with colons that he could only speak in elaborated sentences. An illustrative example follows: 28

Hans: Hello, Doctor.

Dr. X: Hi, how are you?: A salutation and rhetorical question.

Hans: How is your research going?

Dr. X: It's going fine: An obvious lie. I still can't seem to keep the titles down to an acceptable length: Confession of a colonphiliac. It's quite distressing: A desperate cry for help. I hope I can get over this: Thinly veiled self-doubt.

Hans: I think I can help.

Dr. X: That would be great: Reaction to an empty promise
that this fool is unlikely to be able to fulfill.

This segment clearly demonstrates how an excessive reliance on
the colon may become debilitating to interpersonal relationships. Etiology

Some psychoanalytic theorists (e.g., Anna, Lizum, & Billum, 1992;
Onda, Couch, & Spillit, 1991) posit that colonphilia stems from a
fixation at the oedipal phase of development. According to this
theory, the colonphiliac feels the need to insert his upright phallus
between the primary, all-powerful part of the title (the father) and
the supportive, nurturing part of the title (the mother).

Cognitive theorists (Hunt & Beck, 1991) point to the irrational
belief system behind the use of the colon. They propose
that researchers tend to believe, "If I don't extend this title, my work will be
dismissed, because people will have to read the article to find out
what it's really about, and no one will want to do that because it's
quite meaningless and because I'm worthless. If people dismissed
this work, it would be awful, because I would forever be worthless.

Therefore, I must include a colon to extend this title."

Treatment

Given the opposing etiological assumptions across the
various theoretical orientations, no consensus exists as to the optimal course of therapy for colonphilia. Psychodynamic theorists recommend a course of approximately 40 years to life, consisting of three one hour sessions per week. The goal is resolution of the oedipal conflict through illumination of the displacement of unresolved castration fears, with neurotic ego defenses and fetishist libidinal impulses sublimated primarily through the transferential phallic fixation. Cognitive therapists attempt to challenge the underlying irrational belief that having no one read their works would be "awful." Attempts to convince researchers that their articles are worthwhile and interesting enough to be widely read even without a cumbersome title tend to be ineffective, because this perspective has no basis in reality. Therefore, cognitive treatment aims to encourage colonphiliacs to just accept that their works are unlikely to be read, with or without an expanded title. The patient is given instructions that, when titling an article, he or she is to say, "Stop. Nobody will read this anyway, and that's okay. I might as well make this title brief. I
do not have to use a colon." Behavioral theorists favor an even more direct approach. Studies have shown that administering an electric shock to subjects as they reach for the colon key on a keyboard significantly reduces the length and general wordiness of titles. For a complete review, see Zappum and Good, 1990. Finally, international Colonphiliacs Anonymous (CA) groups, focusing on the addictive nature of the disorder, are beginning to form.

These groups have developed a 12-step treatment program, including such therapeutic landmarks as, "Acceptance: I am powerless over the colon" and "Relinquishment of responsibility: There is a higher grammatical power." Unlike other 12-step support groups, this program actually takes tokens away from participants for saying, "My name is John: I am a colonphiliac." Proposed D S M I V Criteria for Colonphilia

Diagnostic Criteria for Colonphilia A. The individual is chronically and progressively unable to resist impulses to expand titles with the use of the colon. B. The use of the colon compromises, disrupts, or damages family, personal, and vocational pursuits, as indicated by at least three of the following: (1) Titles of works are so long that they exceed the limits for Abstracts in most journals. (2) Loss of work due to absenteeism and inability to meet submission deadlines. This may be a result of excessive deliberation over a final title, given the multitude of seemingly good possibilities afforded by the use of a colon. (3) Disruption in relationships due to the overly revealing use of colons in speech (e.g., "I love you: An
expected prerequisite to sexual relations”). (4)
Inability to title written works (including journal articles, grocery lists, birthday cards, etc.) without the use of a colon. C. The colon use is not due to another Grammatical Personality Disorder. The recognition of colonphilia as a debilitating and annoying disorder resulting in excessively wordy titles and the conceptualization


Awf, H. (1992). A case study of colonphilia with an obstinate researcher: Mostly interventions that I think are pretty good and treatment recommendations and a discussion section that is not

32 More Oral Sadism and the Vegetarian Personality as well-written because my graduate assistant did it. Journal of Quick and Easy Case Studies, 1(1), 1.


Hunt, U., & Beck, I. M. (1991). The etiology of colonphilia: The irrational belief that, if I don't extend this title, my work will be dismissed, because people will have to read the article to find out what it's really about, and no one will want to do that because it's quite meaningless and because I'm worthless and if people dismissed this work, it would be awful, because I would forever be worthless and, therefore, I must include a colon to extend this title. Mental Masturbation, 1(23), 45.


666. Toward the Application of Diagnostic Criteria to Personality-Disordered Psychotherapy Patients:

Understanding Axis II of the DSM-III-R

as It Has Never Been Understood Before David J. Robinson, M.D. St. Joseph's Health Center London, Ontario, Canada

With the advent of the American Psychiatric Association's (1987) most recent tome on psychiatric diagnosis—the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised (DSM III-R)—mental health professionals have been treated to a new classification system, one in which various mental disorders are coded on different "Axes," with "Personality Disorders" confined to Axis II. Whereas the DSM-III-R’s Axis II focuses on the application of diagnostic criteria to the behaviors of individuals in general, the author presents here the seminal work on the application of diagnostic criteria to the behaviors of psychotherapy patients in specific, to the way in which these individuals relate to the therapist and to the therapy process. It is hoped that these specific criteria for diagnosing personality-disordered psychotherapy patients will help clinicians everywhere pigeonhole, treat, and bill their patients more quickly.
Paranoid Personality Disorder
Before session Checks to see if followed, confirms authenticity of therapist's diploma

34 More Oral Sadism and the Vegetarian Personality
Waiting room reading Looks for Soldier of Fortune magazine
Appearance Horn rimmed glasses with rearview mirrors
Employment Full-time projectionist
Fantasizes about ... Demanding a full explanation of therapist's jokes Relationship with animals Questions pet dog's fidelity
Talks about during session Questions partner's fidelity Relationship with therapist Questions therapist's fidelity
Behavior during session Complains about lack of warmth in office
Leaves with therapist Scrapbook of injustice collection

Schizoid Personality Disorder Before session Walks to session, takes back alleys Waiting room reading Avoids waiting room, reads Abstract Science magazine in hallway Appearance Stove-pipe pants and wide tie Employment Runs a bowling alley between 1-7 a.m. Fantasizes about ... Pines away for philosophy course instructor Relationship with animals Brings dog to session
Talks about during session Marvels over new surveillance cameras in building entrance Relationship with therapist Asks therapist to play Dungeons and Dragons Behavior during session Teeters on edge (of chair) Leaves with therapist Copy of latest fad diet, shows collection of mail order catalogues

Schizotypal Personality Disorder
Before session Reads palms, tea leaves, and Tarot cards of others in waiting room
Waiting room reading Astrology Weekly

More Oral Sadism and the Vegetarian Personality

Schizotypal Personality Disorder
Appearance Tin foil hat, shirt stapled together, unpaired socks

Employment Developer for a UFO landing pad

Fantasizes about . . . A weekly show with the Canadian Thought Broadcasting Corporation

Relationship with animals Laments that pet budgie is dead, despite seances

Talks about during session Starts session by talking to self

Relationship with therapist Casts a spell on the therapist

Behavior during session Rubs camphor on knee to prevent spleen cancer

Leaves with therapist Book on neologistics—"How to Call 'Em As I See 'Em"

Histrionic Personality Disorder

Before session Flirts with others in waiting room

Waiting room reading Does quiz from fashion magazines

Appearance Matching earrings, purse, nails, and shoes

Employment Cosmetician

Fantasizes about . . . Being a sex therapist

Relationship with animals Owns 3 fluffy white cats: Puffy, Buffy, and Muffy

Talks about during session Gives quiz results to therapist

Relationship with therapist Writes best-selling novels based on sex fantasies with therapist

Behavior during session Faints when quiz results are interpreted

Leaves with therapist Perfumed handkerchief, with private phone number in lipstick, on chair

Narcissistic Personality Disorder Before session Grooming in a portable mirror

Waiting room reading GQ; lies to others that a model with a close resemblance is really him

Appearance Silk suit, cubic zirconium cufflinks, alligator belt

Employment Men’s store as a window dresser

Fantasizes about . . . What he’s like in bed
with animals Walks friend’s Afghan in order to meet women Talks about during session Every sentence begins with "I . . ." Relationship with therapist Self-appointed fashion consultant to therapist Behavior during session Behaves as if session were being filmed Leaves with therapist A flyer for a 50%-off sale from his clothing store

Antisocial Personality Disorder Before session Holds up the pharmacy in the lobby of the therapist’s building Waiting room reading Steals magazines, leaves old copies of Playboy with centerfolds missing Appearance Sideburns, muscle shirt, cowboy boots, tattoo 37 Employment Worked on “career” since childhood Fantasizes about . . . Sexual encounter with probation officer Relationship with animals Shows the innate sensitivity of a taxidermist Talks about during session Starts each sentence with "!@#$%&* . . .” Relationship with therapist Pickpocketed therapist’s calling card; placed several long distance calls Behavior during session Carves up armrest with switchblade, copies down Histrionic’s phone number Leaves with therapist Advice to get a car alarm

Borderline Personality Disorder Before session Has fight with ex-lover outside office Waiting room reading Castrates all pictures of men in magazines Appearance Dresses completely in black or white; today it’s black Employment Summer camp counsellor Fantasizes about . . . Wants to sleep with therapist and therapist’s partner Relationship with animals Sleeps with pet cat and stuffed teddy bear Talks about during session Smells perfume from Histrionic, goes into a rage Relationship with therapist Threatens blackmail after above sexual encounter Behavior during session Widens hole in chair made by Antisocial Leaves with therapist Weekly suicide note on way out of session

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Avoidant Personality Disorder

Before session Followed Schizoid’s route to the session; hoped they might meet

Waiting room reading Rather than take a magazine someone else might want to look at, reads nothing

Appearance Coordinates clothes with wallpaper in therapist’s office

Employment Model for “before” pictures in weightlifting ads
Fantasizes about . . . Having Dale Carnegie reincarnated as his uncle

Relationship with animals Trained dog to walk itself

Talks about during session The best detours, exits, and offramps in the city

Relationship with therapist Follows therapist daily, hides in shadows to protect car from Antisocial

Behavior during session Spends most of session with head in lampshade

Leaves with therapist Invisible Man comic book

Dependent Personality Disorder

Before session Arrives from another therapist's office

Waiting room reading Brings autographed self-help book written by yet another therapist

Appearance Athletic shirt with "Just Take Me" on it—underneath a big fuzzy sweater

Employment Food bank, pet hotel, block parent, neighborhood sandwich maker

Fantasizes about . . . Chaining up therapist in home

More Oral Sadism and the Vegetarian Personality 39

Relationship with animals Chains dog up inside house to prevent it from running away

Talks about during session Nightmares after watching Home Alone

Relationship with therapist Sits in therapist's car when Avoidant not watching it

Behavior during session Moves chair next to therapist; tape records session for relaxation therapy.

Leaves with therapist Invitation to dinner, every night for a month

Obsessive-Compulsive Personality Disorder
Before session Washes hands before and after trip to washroom

Waiting room reading Rearranges magazines, no time to read

Appearance Ironed socks, pressed jeans, starched underwear

Employment Molecule counter for a chemical company

Fantasizes about . . . Not flushing the toilet

Relationship with animals Has sent dog to obedience school for 8 years

Talks about during session Reads therapist the new rules of conduct from work

Relationship with therapist Demands therapist synchronize watch at start of each session

Behavior during session Repairs hole in chair with pocket sewing kit

Leaves with therapist Copy of an etiquette book

Passive-Aggressive Personality Disorder

In our hectic, fast-paced world, clients cannot always afford the time it takes for traditional therapy. Additionally, managed care companies have shown a growing reluctance to pay for therapy services that require more than a few sessions of treatment. This has led to the development of a new, time- and cost-effective therapeutic approach.
approach, which takes its cue from the fast food industry. The following case study illustrates the effectiveness of this new approach.

Therapist: Hello, may I help you, sir?
Client: Umm, yes, I'm here because things aren't going well with my job and I just don't know what to do.
Therapist: What would you like?
Client: To feel good and be happy in my life, that's what I'd like. That's why I'm here.
Therapist: Would you like a drink?
Client: Oh, no! Just because my mother was an alcoholic doesn't mean I'll be! There's no way I'll ever become like her!
Therapist: Is there something else I can do for you?
Client: Well, really the reason I'm here is because of my job. I'm just not satisfied at work and I'm constantly anxious.
Therapist: Chicken?
Client: A little, I guess. I'm afraid to try things. I guess it's because I think I'll fail. And then work just piles up and I'm never on top of it. I guess you'd call me a procrastinator. I put things off, then they accumulate and suddenly I'm overwhelmed.
Therapist: Ketchup?
Client: Exactly. I'm always behind and never seem to be able to catch up. Now and then I'll finally get a job done, but for some reason I still can't relax. I can never let up for a moment.
Therapist: Super fries, sir?
Client: Oh, yeah! My supervisor fries my nerves. She's always breathing down my neck making sure I'm not slacking
off. It's like having my mother around! Hey! I get it!
She's just like my mom! No wonder I always feel so tense
and incompetent at work! Wow, Doctor, you're great! I've
only been here a few minutes, but I feel so satisfied!

Therapist: Anything else?

Client: No, that's all. Thanks a lot, Doctor.

Therapist: Thank you. Come again. Have a nice day.

The Implications of City, Town, Village,

and Hamlet Names for Psychotherapeutic Treatment and
Outcome: When Normal [IL] is Indicated and Looneyville
[WV] Contraindicated Ernst von Krankman, Ph.D.

One of the basic tenets of modern-day psychodynamic theory

is

that people—and psychotherapy patients—can have very
different

emotional reactions to the same or similar events.
Capitalizing on the

subjective manner in which people interpret reality, von
Krankman

(1989a, 1989b) generated several studies demonstrating that
the

surnames of psychologists and psychiatrists might be
indicated or

contraindicated in working with psychotherapy patients
suffering

from specific diagnostic presenting problems. For instance,
he cited

the depressed patient who had a negative emotional reaction
(or

— reaction) to the news of being assigned to a therapist
named

Dr. Downs. On the other hand, manic-depressive patients
often
experienced favorable first reactions (+ reactions) when assigned
to a therapist named Dr. Balance. And then there were those really
tough, questionable (?) diagnostic judgment calls where it was un
clear whether the therapist's name was indicated or contraindicated.

For example, how wise, von Krankman asked, would it be to assign
a manic patient to Dr. Allbright?

However, subjective responses of patients with specific presenting
problems are not limited just to the surnames of therapists; patients
also may reveal a wide range of emotional reactions to the names
of locations. For example, would a patient who has had a life-long
history of bizarre behavior feel more positively disposed (or +) to
being treated in (or perhaps even just moving to) the city of Normal
(Illinois) than Looneyville (West Virginia)? (The question of
whether a person born and raised in Normal [IL] does indeed
evidence more mentally healthy attributes than one nurtured in 49
50 More Oral Sadism and the Vegetarian Personality
Looneyville [WV] is a highly complex one that is beyond the scope
of the present paper.) But for a patient with a history of serious
and prolonged depression, relocation to and/or treatment in Funk
(Nebraska) would clearly be contraindicated (or - ). And, it should
be kept in mind once again that there are some really tough
diagnostic
judgment calls. For instance, card-playing gambling addicts
may leap
at the opportunity to undergo treatment in the town of New
Deal
(Tennessee), but the wisdom of choosing such a location is
certainly
questionable (or ?). What other municipal names may be
indicated or contraindicated
for patients with various diagnostic presenting problems?
In order
to answer this question, and expanding upon the original
pioneering
work of von Krankman, the present author (von Krankman) per
formed an exhaustive (and exhausting) search of the
literature—the
2345 pages of the official U.S. Post Office zip code
directory (U.S.
Postal Service, 1990). The resultant data are presented
below. Municipal Name Diagnostic (and State) Indication
Presenting Problem Allgood (AL) + Any patient Ampere
(NJ) ? Patients given ECT Barker (NY) ? Tourette’s
disordered patients Beltline (AL) ? Eating disordered
patients Broadview (GA) ? Male chauvinistic patients
Bryte (CA) ? Learning disabled members of Mensa
Burnwell (AL) ? Firesetters

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Municipal Name Diagnostic (and State) Indication
Presenting Problem

Canon (GA) - Impotent patients
Climax (CO) - Impotent patients

Cloudland (GA) - Depressives

Coburn (PA) - Two firesetters acting in unison

Confluence (KY) - Multiple personality disordered patients

Crossville (AL) - Paranoid schizophrenics with active religious delusions

Cut and Shoot (TN) - Psychotic patients experiencing command hallucinations instructing them to "Kill!"

Cut Off (LA) - Patients with castration anxiety

Deposit (NY) - Encopretics

also Port

Deposit (MD)

Downers Grove (IL) - Depressives

also Downsville (LA)

Dozier (AL) - Narcoleptics Municipal Name Diagnostic (and State) Indication Presenting Problem Eek (AK) - Patients experiencing difficulty expressing intense emotion El Mirage (AZ) - Schizophrenics with visual hallucinations Enigma (GA) - Patients suffering from existential crises False Pass (AK) - Patients with hysterical pregnancy Flying H (NM) - Heroin addicts Footville (WI) - Fetishists (foot) Franktown (CO) - Patients who have learned to be communicative and straightforward with their feelings and thoughts - Vegetarians opposed to consuming hot dogs Free Soil (MI) - Encopretics Froid (MT) - Learning disabled psychology majors unable to correctly spell "Freud" Fruitland Park (FL) - Patients with homosexual panic 53 Municipal Name Diagnostic (and State) Indication Presenting Problem

Funk (NE) Depressives

Goodview (VA) - Voyeurs

Goodyears Bar (CA) - Alcoholics
Grand Ledge (MI) ? Suicidal patients
Grubville (MO) ? Eating disordered patients
Gusher (UT) ? Premature ejaculators
Hancock (IA) ? Compulsive masturbators
Hilo (HI) ? Manic-depressives
Hippo (KY) ? Bulimics
Hungry Horse (MT) ? Eating disordered patients
Hytop (AL) ? Adolescent sneaker aficionados
Kayjay (KY) ? Learning disabled who cannot correctly sequence letters of the alphabet
Kill Devil Hills (NC) ? Floridly psychotic patients experiencing sinister delusions and hallucinations More Oral Sadism and the Vegetarian Personality Municipal Name Diagnostic (and State) Indication Presenting Problem
Leakesville (MS) ? Enuretics
and Leakey (TN)
Little Creek (DE) ? Young enuretics
also Little River (AL)
Lilburn (GA) ? Toddler firesetters
Littleport (IA) ? Patients suffering
also Lockport (LA) from vaginismus
Load (KY) ? Encopretics
Loco Hills (NM) ? Patients with florid psychotic symptomatology
Lone Jack (MO) ? Schizoid personality
also Lone Pine (CA) disordered patients
Looneyville (WV) ? See Loco Hills
Lovelady (TN) ? Nymphomanics
also Loveland (CO)

Lowpoint (IL) - Depressives

Lulu (FL) ? See Loco Hills

McLean (IL) ? Anorectics of Scottish
also McLeansboro descent (IL)

Manley Hot Springs ? Male patients experiencing homosexual panic (AK)

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Municipal Name Diagnostic (and State) Indication Presenting Problem

Maybee (MI) ? Patients suffering from existential dilemmas and unable to make decisions

Napolean (IN) ? Schizophrenics

Needville (TN) ? Dependent personality disordered patients

Newfoundland (KY) ? Dissociative disordered patients

New Deal (TN) ? Card-playing gambling addicted patients

New Hope (AR) +Depressives

New Market (AL) ? Compulsive shoppers

New River (FL) ? Children and adolescents exhibiting enuretic symptoms as a regressive behavior

New Sharon (IA) ? Transsexual patients

Nodaway (IA) ? Narcoleptics

Normal (IL) + All patients
also Normalville (PA)

Nut Tree (CA) ? See Loco Hills
also Nuttsville (VA) Municipal Name Diagnostic (and State) Indication Presenting Problem

Orderville (UT) ? Obsessive compulsive disordered patients

Outing (MN) ? Agoraphobics

Palm City (CA) ? Kleptomaniacs

Paw Paw (IL) ? Stutterers Panorama City (CA) ? Voyeurs

Parker (ID) ? Catatonic

also Parkmoor (CA) Peculiar (MO) ? Schizotypal personality disordered patients Purgatory (CO) ? Patients suffering from over-punitive superegos Queen Creek (AZ) ? Homosexuals man also Queen Valley festing feminine be (A2) behavior Rainbow City (AL) ? Patients with a history of hallucinogen abuse Red Bluff (CA) ? Anorectic patients who no longer have menstrual flow

Rockwell (AR) ? Autistics also Rockwell City (IA) More Oral Sadism and the Vegetarian Personality 57 Municipal Name Diagnostic (and State) Indication Presenting Problem

Rough and Ready ? Sadists and masochists

(CA)

Sale City (GA) ? Compulsive shoppers

Snug Harbor (MA) ? Patients suffering from vaginismus

Soft Shell (KY) ? Patients with poor ego defenses, particularly schizophrenics

South of the Border ? See Loco Hills

(SC)

Sugar City (CO) ? Suicidal diabetics

Talking Rock (GA) ? Schizophrenics experiencing auditory and visual hallucinations

Terminal Island (GA) ? Patients with suicidal ideation

Thunderbolt (GA) ? Patients given ECT
Tuba City (AZ) ? Bulimics

Turtletown (TN) ? Patients suffering from psychomotor retardation

Twig (MN) ? Anorectics Municipal Name Diagnostic (and State) Indication Presenting Problem

Typo (KY) ? Patients prone to passive-aggressive accidents

Volcano (CA) ? Explosive personality disordered patients

Wacker Drive (IL) ? Compulsive masturbators

Walla Walla (WA) ? Verbally perseverative patients ? Regressed patients imitating Fozzy Bear from Sesame Street

Wetmore (CO) ? Unsuccessfully treated enuretics

Whale Pass (AK) ? Patients attracted to, and actively engaged in flirting with, obese members of the opposite sex

Why (AZ) ? Patients suffering from existential dilemmas

Wilburn (AZ) ? Unbridled firesetters

Wynot (NE) ? Oppositional adolescent patients Future Directions

The author has highlighted here municipal names that may elicit strong emotional reactions from patients suffering from a wide range of presenting symptomatology. In previous papers, the author has explored the impact of therapist surname on the subjective reactions of therapy patients. It still remains to be seen what interaction effects may exist between location name and therapist surname. For in stance, is it really a good idea for a newly trained therapist, Dr.
Looney, to set up shop in Nut Tree (CA) if he plans on working with patients suffering from gross reality testing problems? Or for Dr. Overton to start seeing eating disordered patients in Beltline (AL)? And what of establishing a group practice in Gusher (UT), where premature ejaculators will be seen and treated by Drs. Popoff, Cummings, Getoff, and Quick?

No doubt studies to follow will investigate the impact that street address may have upon the emotional reactions of patients suffering from a variety of presenting problems. Then, too, there is the complex issue of street address as it interacts with municipal name and therapist surname. For example, certainly, Dr. Warm, a humanistic therapist concerned with presenting a positive mental health image, would be just as well advised to seek a therapy office on Helping Hand Avenue in Normal (IL) as Dr. Graves, specializing in treating suicidal patients, would be to avoid a practice on Dead End Lane in Farewell (AK). The street numbers themselves may form a significant component of the Street Address x Municipal Name x Therapist Surname interaction. The floridly paranoid
schizophrenic patient preoccupied with sinister ruminations may re
act quite adversely to treatment rendered by Dr. Spyer of
666 Devil's Landing, Hell Gate (NY).

It should be obvious to the reader that there are not only
many avenues still to be explored in this exciting field of non
inal data, but many boulevards, streets, lanes, and alleys
as well. Future researchers will find that the raw data for
their investigations have already been systematically collected—in the
form of 10,000-plus telephone books—and simply await refined
analysis.


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problems of psychotherapy patients: Implications for treatment
and therapy outcome. Journal of Polymorphous Perversity,
6(2), 3-9.
Antidotes to Your Shrink's Falling Asleep During the Therapy Session:

A Patient's Guide to Keeping the Therapist's Attention
William Goodenough, Ph.D.

Let's face it. Patients on the analytic couch expect their analysts to be tuned into their every utterance, but sometimes analysts, comfortably seated in their black leather chairs, positioned behind the couch and out of the patient's field of vision, do doze off, leaving patients free associating to no one. Given that the chance of the analyst's making a timely interpretation, or any interpretation at all for that matter, is nil if the analyst has been snoozing and was oblivious to the patient's verbalizations, the analytic patient is at great risk of not getting "good value" for the money during the therapy hour. It is vital, then, that the analytic patient learn effective ways of keeping the analyst in a heightened state of alertness in order to prevent such nodding off. This paper presents concrete tactics that will ensure retaining the analyst's attention.

Insist that one of your other personalities already paid last month's therapy bill.
Tell your therapist that you had a critical dream last night, but someone stole it from your head on the way to the session.

Begin to drool.

Ask your therapist if malpractice insurance covers patients who jump out of the therapy room window. Lie down under the couch. Ask if your therapist gives triple-A discounts. Greet your therapist naked. Express concerns that you are not narcissistic enough. Wonder aloud what colors smell like. Come to the session precisely on time, then apologize for being so late. Suddenly begin free associating in a foreign language, preferably an unrecognizable one. Bark. Note aloud that your previous five therapists had more comfortable couches. Shout "Eureka!" after your therapist makes an interpretation. As your therapist hands you the therapy bill, put on a pair of latex rubber gloves to accept it. Sit up on the couch suddenly and ask your therapist, "Hey, why are you so manic today?" Comment that you are Jewish, and you are deeply committed to tithing 10 percent of your income to the church. Hold a mirror up to your therapist's face just as he is making an interpretation. As you enter the session, call your therapist Sigmund while slapping him on the back. (If your therapist is a woman, all the better!)

Play dead.

Note that you are a workaholic and that the only reason you have not killed yourself so far is that you couldn't fit it into your schedule. As you are leaving the session, casually comment that you forget to mention that this morning you were laid off by your employer.

Roll off the couch.

(For male patients only): Ask your therapist, "Is it cold in here,
or is it just that time of the month?"

Ask if your therapist accepts the Discover card. A
Therapist's Guide to Proper

Conduct During the Therapy Hour:

The Fine Art of Appearing to Care Susan C. Jenkins, M.D.
Associates in Psychiatry and Psychology

Many aspects of psychotherapy are eloquently addressed

out the arduous training process of becoming a
psychologist, psychiatrist, or clinical social worker. Learning to spell and

pronounce words

such as "psychopharmacotherapeutics" is certainly

important, as is

the careful attention given to observation of the patient's

posture,
gait, facial expression, grooming, dress, affect, gestures, speech, and

thought content. However, relatively little time is spent

on teaching

the therapist trainee techniques for managing his or her

behavior. Fledgling therapists must pay particular attention to

conforming

to expected social mores regarding therapist behavior. With

this in

mind, the following are offered as tested techniques for

use with pa

tients.

Try to pay attention to what the patient is saying.

The patient is convinced that he or she brings a problem of

impor
tance to the therapy hour. He or she is also convinced that as a
therapist, you will be keenly interested in this problem. One must
give that impression. This is best achieved by listening to the patient.

When it is not possible to listen, one must appear to be listening by
the use of appropriate listening behaviors. These include eye contact
(with the patient), animated facial expressions, posture gently in
clined toward the patient, and periodic movement, such as nodding
one's head. Asking a relevant question once in a while or offering
a timely comment is generally seen as evidence that you are listening. 64

If you haven't been listening, learn to recover gracefully.
The idea is to demonstrate to the patient that although you may not have heard a word so far, you remain intensely interested.

For example, "You are describing a complex situation, and I'm not quite following all the nuances of your story. Would you go over that last bit again?" If you remain clueless following this ploy, redirect the patient to a new subject with a transitional comment such as,

"Yes, but how does this relate to your relationship with your
mother?" This gives you another chance to pay attention. If what
the patient was saying before was really important, he or she will
get back to it.

Maintain alertness by diversion tactics.

If you're having an off day, visual imagery can help you maintain
focus. As the patient describes various relationships and the aspects
of inner life, try to visualize the persons and scenes. If these images
are too distracting or difficult, associate to metaphors from fiction.

For example, try to imagine which alien on Star Trek has the most
features in common with your patient. This can suggest new lines
of content to explore in terms of ego defenses. And some of those
aliens are really attractive! Then try to imagine which alien you would
most like to be stranded with on a shuttle that's lost navigational
control. . . . Oops! Back to the patient.

Take notes.

Taking notes helps you to listen and stay focused on the patient.

Discrete note taking persuades most patients that you are profes
sional and that you care about getting their story straight. It also
convinces managed care companies and peer reviewers that you are professional and a good liability risk. Keep a separate notepad next to the notepad of record for those special items that you may choose not to keep as part of the permanent patient record. An example of this side-by-side note taking is illustrated in Figure 1.

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[Notepad of Record] 'Patient complains: "It's been a terrible week. I've been wishing I could die. I even thought about taking an overdose." Sad facial expression, stooped posture; carries letter from her ex-boyfriend that she reads during the session. Tells me she'd like to get away from here... 'Discussed how this relates to her relationship with her mother. Provisional diagnosis: 'Borderline Personality Disorder. 'Patient experiencing reactive depression: she's reminded of Cost relationship in a letter she received. Have patient return for weekly therapy. Continue patient on antidepressants.

[Therapist's Personal Notepad] Remember to pickup son's meds at the pharmacy 'Buy stamps at post office Confirm reservations for upcoming CME conference Lost--'Where did I park today???

Figure 1. Sample of side-by-side note taking involving the notepad of record and the therapist's personal notepad.

Find something to do with your hands. Patients generally react tactfully, but have difficulty engaging in a therapeutic alliance when therapists unravel the hems of their trousers during sessions. Note taking is useful to keep one's hands busy, but constant note taking can be an impediment to good therapy.

The following techniques are suggested for therapists who fidget. Paper clip tricks. Paper clips may be manipulated with one hand,
or passed thoughtfully from hand to hand. During tense moments,

paper clips can be bent back and forth several times. Paper clips

that break during these manipulations should be discarded, as they

can cause nasty cuts and bleeding. One should avoid making paper

clip chains when in the presence of adult patients. And don't put

them in your mouth.

Stapler tricks should be avoided. Staplers jam too easily and trying

to get them unjammed is likely to be distracting to the patient.

Rubber band tricks. Rubber bands can be twisted thoughtfully in

the fingers. Rubber bands can also be used as a mildly aversive

stimuli to modify one's inattentive behaviors. A rubber band is worn

on the wrist and snapped when one finds one's attention wandering.

Avoid screaming "ouch!" as it will distract the patient from his or

her own content during the therapy hour.

Office chairs. You finally got one of those great chairs that spins

and rolls on casters! If you are especially fidgety, be honest about

whether you can maintain eye contact while seated in a chair that

has the capacity to spin and roll. If you can't maintain
eye contact,

switch chairs with your patient. Conclusions

I really think Trills are the best aliens the Star Trek writers ever came up with. I mean, you can put male souls in gorgeous female bodies. And the car is in the south lot. Curing a Phobia Art Buchwald One of the things that General Curtis LeMay said at a recent press conference was that Americans seem to have a phobia about nuclear weapons. This struck home because I have to admit I've had such a phobia for some time. But only after General LeMay brought it up did I decide to do something about it. I went to see Dr. Adolph Strainedluff, a psychiatrist who specializes in nuclear weapons phobias. "On the couch," he said. "What seems to be the trouble?" "Doctor," I said staring at the ceiling, "I have this fear of nuclear weapons. I know it's silly, but to me it's very real." "Aha, very interesting. When did you first become aware of such a phobia?" "I think it was around the time of Hiroshima or Nagasaki, I'm not sure which. I saw these photos of all these people killed and miles and miles of rubble, and suddenly I got this thing about atomic weapons." Dr. Strainedluff tapped a pencil against his knee. "So tell me, how does this phobia manifest itself?" "In peculiar ways,
Doctor. I get the feeling if I ever see a mushroom cloud, I'm going to die." "Very hinteresting, very hinteresting. You know it's all in the mind, don't you?" "Of course. That's why I came to you. I don't want to do any thing stupid." Dr. Strainedluff said, "You are a very sick man. You think that just because an atomic bomb killed a few thousand people more than twenty years ago, you are threatened. You are manifesting infantile repressed hostility toward the weapons of war. In psychiatry we call this a military-industrial inferiority complex."

"I know I'm sick. You've got to help me," I begged.

"All right. First, you haft to get over this absurd fear of nuclear bombs. You must think of them as just another weapon in our vast defensive arsenal. We haft bowie knives and H-bombs, and in war, one is just as good as another. You're not afraid of a knife, are you?"

"Well, I don't think about it a lot."

"So, why should you be afraid of an H-bomb? It's another form of a knife."

"I never thought of it like that."

"Okay, so now let's look at some facts straight in the eye. In Bikini we blew up twenty bombs in an experiment. So we thought..."
everything would be destroyed; that's how stupid we were.
Do you

know that now after all the boom-boom, the place is
flourishing and

the rats are fatter than they ever was before?"

"It's good to hear."

"The coconuts are hanging from the trees, the fish are
swimming

in the lagoon, and the voice of the turtle can be heard in
the land. The

only things that don't seem to be doing so good are the
land crabs."

"I don't like land crabs," I said.

"So then you don't haff anything to worry about."

Dr. Strainedluff started playing with the hand grenade
which was

attached to his watch fob. "If you're going to be a happy,
normal

human being," he shouted, "you're going to haff to stop
with all

these guilty peace feelings."

He was stomping around the room. "So get out of here with
your

lousy phobias and all this stuff about being afraid to die.
If you're

not willing to take a little fallout for the good of the
country, then

go back where you came from!"

In spite of Dr. Strainedluff's final outburst, he did cure
me of my

phobia. I'm no longer afraid of nuclear weapons. Now I'm
afraid

of him. Demystification of an Archetypal Symbol: Truth is Where You Find It Albert D. Smouse, Ph.D. University of Oklahoma

Many thinkers on the contemporary scene are familiar with the

Jungian notion that certain symbols have the capacity to temporarily take on, embody, and convey universal truths (DeLaszlo, 1959), only to have their meaning fade over time. Once in a great while, however,

a symbol is so powerful that it reemerges in its primitive form. Just such a case is exemplified by a message increasingly seen on the bumpers of pick-up trucks in the Southwestern United States. The symbol in its purest verbal form is "Shit Happens."

The demystification and explication of that symbol in order to restore its original richness of meaning represents a substantial contribution to the field. The methodology took a quantum leap forward when a review of the bulletin board literature revealed the data outlined in Table 1. This presentation stimulated the writer to take a parallel approach within the field of counseling psychology. Following a thorough search of the counseling psychology literature, a
period of intense analysis produced the results shown in Table 2. 70

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Table 1. Spiritual Truths Source Manifest Expression

Taoism Shit happens.

Confucianism Confucius say, "Shit happens."

Buddhism If shit happens, it really isn't shit.

Hinduism This shit happened before.

Islam If shit happens, it is the will of Allah.

Protestantism Shit happens to other people.

Catholicism If shit happens, you deserve it.

Agnosticism I won't believe this shit unless I see it.

Atheism I don't believe this shit.

Judaism Why does shit always happen to us?

Southern Baptist You go to Hell for saying "Shit."

Jehovah's Witness Let me into your house and I'll tell you why shit happens.

Alcoholics Anonymous I trust in my higher power and can accept when shit happens.

Table 2. Psychotherapeutic Truths Source Manifest Expression

Reality Therapy Shit happens.

Psychoanalysis Shit happens during the anal stage.

Gestalt You must get your shit together now.

Object Relations How does it feel to shit on me?

Rogerian You say "Feces occurs"?

Behavioral Shit happening is reinforcing.
Rational Emotive
It is not logical to say "Woe is me" when shit happens.

Logotherapy
One is always free to shit.

Existential
Mankind must create meaning when shit happens.

Systems Approach
Stink is the negative feedback when shit happens.

Supportive Therapy
You shit well!

Organismic
Shit happens throughout the biosphere.

Humanistic
How do you feel about shit?


Psychoproctology: A New Clinical Specialty
Mark L. Pantle, Ph.D. A Major Southwest University that Wishes to Remain Anonymous

The field of clinical psychology has been distending at a rapid rate, and practitioners are feeling increased pressure (some would even say "urge") to answer the call of specialization. A variety of specialties has been brought forth in recent years (e.g., neuropsychology, forensic psychology, administrative psychology), prompting some to opine that the generalist in clinical psychology is in danger of being wiped away (Brann & Prune, 1989). Although those dedicated to the generalist model have expressed distress at its passing (e.g., Magnesia, 1990), others have breathed a sigh of relief (Lax, 1990).
Despite the development of numerous specialties in clinical psychology, none has yet emerged that addresses the essence, and angst, of our age. The transformations of hippies to yuppies, protesters into stockbrokers, and VWs into BMWs have driven Freud (1987) to label our era "The Anal Retentive Age." Citing cultural evidence to support his notion, he stated, "It is no coincidence that the two most obsessively coveted cars of our time, the BMW and the Mercedes Benz, both have the initials 'BM'" (p. 214).

Obviously, what is needed is a clinical specialty that is relevant to the Anal Retentive Age. Such a specialty requires a new perspective on our lives and on ourselves; indeed, it demands that we turn the focus of psychology upside down. This article introduces this specialty for our time: Psychoproctology. The theoretical underpinnings for Psychoproctology are found in Freud's early, previously undiscovered, and as yet untranslated works (1878). As a poor student suffering from encopresis, Freud determined that the primary difference between him and the rich and successful, yet neurotic, people of Viennese society was
that they

had been successfully toilet trained. He abandoned the development

of this theory after Charcot resolved his encopresis with hypnosis;

however, the theory continued to color his later work. Indeed, the

influence of his early formulation is evident in the name he gave his

final product: psychoanalysis. In contrast to other aspects of Freudian theory, the relationship

between success in toilet training and success in society has been

empirically supported. In a study of the CEOs of Fortune 500 compa

nies (Douglas & Sheen, 1987), a .89 correlation was found between

salary and bowel control. It also found that these CEOs derived

much pleasure from the pressures associated with the accumulation

of material. However, such successful executives have been assessed

as prone to dramatic mood swings (Dow & Jones, 1929, 1987) and

other problems in living (Boesky & Keating, 1990). The therapeutic goal of Psychoproctology is, very simply, to help

clients "loosen up" by replacing the problems and pressures of mate

rial accumulation with the pride and pleasures of producing some

thing that comes from deep within the self. The primary technique
associated with the theory is Psychosuppository, which is alphabetically closer to psychotherapy than psychoanalysis. Psychosuppository is a short-term treatment technique, and significant therapeutic movement can occur within the first few sessions. Development of an implosive technique, labelled Emotional Enema, is currently underway. Testimonials from clients treated with Psychosuppository have been flooding the offices of the Psychoproctology Institute. Here are just a few samples: "I discovered that I was flushing my life down the toilet. Now I know that life is not a waste—life is waste!"

"Psychosuppository has given me a warm and wonderful feeling that"

I

Written on a yellow legal pad in ballpoint pen, this material was purchased from a reputable antique dealer in North Dakota, who assured me that it was authentic. 75 I haven't experienced in years." "I felt like a rat, man, until I got things worked out through Psychoproctology."

Every new therapeutic movement has its detractors, however, and Psychoproctology is no exception. Acknowledging the power of Psychosuppository as a treatment technique, Klisma and
Fee-Lea (1991) have warned that clients may become addicted to therapy.

Others have conducted a smear campaign against Psychoproctology,

claiming that it threatens order and productivity in the workplace

(O’Cee, 1991).

As a means of establishing itself as a viable and visible specialty,

Psychoproctology will soon be announcing its Diplomate. The Diplomate, awarded by the Professional Organization Of Psychoproctology (P.O.O.P), will be printed on fine quality, two-ply paper and will be suitable for framing. The requirements for attaining the Diplomate will be attendance at a Psychoproctology Workshop and payment of requisite fees. Indeed, the process of paying the fees is itself considered a demonstration of commitment to the principles of Psychoproctology.

The downward displacement of psychology as proposed by Psychoproctology represents a radical shift in clinical theory and practice. Although some will welcome this new movement, others are likely to respond with upturned, or even plugged, noses. What does
the future hold for Psychoproctology? We'll just have to wait to see


76 More Oral Sadism and the Vegetarian Personality


Annals of Banality, 81, 57-58.


3 Psychoanalysis


Swanson, D. R. (1977b). Critique of psychic energy as an explanatory concept. Journal of the American Psychoanalytic Association, 25, 603-633. California Dreamin' Lee Israel The following is one in a series of analyses by Sigmund Freud of

dreams he dreamt in the early spring of 1903. "Der kalifornische

Traüüm" (California Dreamin') is published here for the first time. The dream. I dream that I am riding horseback on a wide road somewhere in the western American state of California. At my side is a disgraced, fugitive Negro sports figure, once held in the highest regard in the hearts of the world, suspected now of having murdered most brutally his beautiful former wife and also a young man who arrived unfortunately at the killing site whilst returning a pair of spectacles. The fallen hero rides a large, white bucking horse and threatens from time to time to kill himself. I am calling him the Juice. I am imploring him not to kill himself, saying,
"Don't give up, Juice. The Dream Team (die Gangentraum) will set you free."

Meanwhile, we are all the time being chased by a massive constabulary, but they and we move at a slow, almost balletic tempo—quite surreal and typical of the altered dream state. There are flickering lights everywhere. We are plainly the focus of a hovering, tremendous attention: all eyes are upon the Juice and me. I am awaking with a full bladder, but not before Little Hans, a patient of yore, rides up beside me and addresses me with a galling familiarity. "Let's see you free-associate your way out of this one, Pops," he says, flashing a Tarot card at me. "You've just prophesied the trial of the century!" 87 Dream analysis. In the dream, I am on horseback throughout—and indeed the horse motif infuses the entire manifest content. As a matter of fact, I cannot ride and would not dream of doing so, although the equestrian theme is not uncommon in my sleeping thoughts. Some years ago, for instance, I had a boil in my scrotal area; so painful was the boil that it inspired a dream in which I also rode on the back of a horse precisely because the act of equitation was so contraindicated, would have been such pure meshugga,
that
doing so was like wishing away the boil. I was saying to myself,
"Freud, you couldn't possibly have a suppurating lump of disease
on your perineum the size of a small cabbage because you
are riding
a horse!" Now on the day previous to the present dream about
the fallen American sports figure, I ran into a lecturer at
Vienna
University whom we'll call Doctor Ü. (not his real
initial)—a man
whose recent monograph on plant biology impressed me
greatly.
After complementing him appropriately, I inquired as to
whether
he had yet seen the new Schnitzler play at the Ring
Theater. Ü.
rejoined, "Wild horses couldn't drag me thither! (Keine
zehn Pferde
bringen mich dahin." ) I experienced great resentment at the
tone
taken by Ü., at the haughtiness with which he had
dismissed my
distinguished friend Schnitzler and by extension me. I even
consciously wished him a suppurating boil on his testicle that
would drive
him to dreams of riding horses. But my conscious
ill-disposedness
apparently was not nasty enough because I had so plainly
represented
him in the dream as the dark, disgraced fugitive. This
became more obvious as I brought to my conscious thoughts the recollected knowledge that Doctor Ü., in his salad days, had been a remarkably talented sculler, thrice winner of the Kaiser Wilhelm Pole Vault medal (the "Villie"). And also Ü. was married happily to a very beautiful woman, Frau Ü.: the apple of his eye. Frau Ü., it happens, is outstandingly endowed: a Rubenesque, bosomy, one might even say saft or saftig little lady. Here the dream-work practically calls out to me, "Yoo-hoo, Freud!" Of course, saft translates to juice, the English word I am calling him in the dream. Bingo! By a process of displacement I am wreaking terrible vengeance on Ü. by placing him in harm's way, an utterly disgraced uxoricide, having murdered most brutally the great love of his life, the ample apple: Frau Ü. But just as I am about to put on my hat and take an afternoon's stroll about Vienna it comes to me that there might be some profoundly non-Ü. material with which I have not yet dealt. My thoughts pass immediately to the cameo appearance in my sleeping script of
the erstwhile patient, Hans. As anyone who has read my previous
work will by this time know, Little Hans was a mere
stripling when
his crippling phobias, particularly his fear of leaving the house be
cause he might be bitten by a horse, were brought on by his Mama
who had come upon him in the act of self-gratification and warned
him, "Keep it up, Hansel, and the doctor will make here a visit and
turn you into Gretel." The horses subsequently feared by Hans lest
they bite off his already tiny wienie represented, naturally, the Papa
(English: "hung like a horse," in The Dictionary of Dirt and Filth
[Die Enzkopadie mit Schmutzigkeit and Dreck]). After I helped
liberate Hans from his castration complex by persuading him that
he should fear neither horses nor Papa, but rather Mama, the little
guy left the house as often as possible, and also became a great
admirer of my work, particularly the theory of the dream as the
royal way to the nettlesome Unconscious. How comes it then that
he invades my dream flashing the Tarot card, preaching the pharaonic
doctrine of the dream as future predictor? I had begun to think of
Little Hans as my "pupil"; and now as I examine anew the material of the dream, I see him as my seditious, talkative, and "dilating pupil," an embarrassingly obvious reference to the expansion of the eye under the influence of a drug. His evocation of this "trial of the century" becomes my own titanic struggle with the decidedly mixed blessing of Erthroxylon coca, cocaine, under the influence of which I had been best and brightest, animated in work and in life with the most gorgeous excitement, exhilaration, and euphoria. Could anything be clearer than the meaning of the young man carrying the eyeglasses and dying for this venture, this "trip"? The spectacles symbolize the enhancement, the insight bestowed by the miraculous, but alas also murderous, cocaine. (German: Brille = eyeglasses, but klosett Brille = toilet seat. See also, in Lewis Carroll's obviously drug-induced poem, Jabberwocky [German: Yabberwocky], "T'was brillig, and the slithy toves . . . " [emphasis added].) I see now, of course, that the white bucking horse, the Bronco, stands for my desire still for the rambunctious, unmanageable highs (the high
horse = hohe Pferde) of the old days before I became aware of the

addicting, pernicious effects: the ca-ca of coca; the constabulary

becomes hence my own reining-in prudence. But in the dream, and

in many dreams, I am wishing still for the paradisal potency of the

white horse: my lieblich Kokain. I have tamed the beastly botanical

but the wish persists. And now I can put on my hat?


that there is a world of difference between what an academic advisor

says and what he or she actually means, and he offered some interpretations of "advisor-speak" for new students. This article is a

supplement to the earlier "survivor's guide," providing additional explanations of common advisor’s comments. Moreover, it illustrates

how understanding one's advisor is often not so much a matter of

interpreting what is said, but of being able to fill in what is left unsaid. What Your Advisor Says What Your Advisor Means

Because we're a "helping Welcome to the psychology profession," beginning studepartment from hell. dents are often surprised that we provide an individualistic and nonnurturing environment.

The faculty are competitive. The faculty are ruthless.
The faculty are friendly but the faculty are devious and ruthless.

The objective of the program... in the sense that the objective of a commercial is to inform consumers. What Your Advisor Says What Your Advisor Means Our undergraduate students... in contrast to our gradu get their B.S. upon leaving. A good graduate student is A good graduate student is flexible and sensitive to face easily controlled. We don't treat students like We try not to step on dirt. Psychology is the world's I'm an asshole. most important science, and I am one of its greatest scholars, although my contributions are often belittled by envious colleagues. I'd like to help you but given What's in it for me? the multitude of demands on my limited time. Our clinical students gain valuable psychotherapy experience with the problems of the underclass at the University graduates. Health Center. Judgments of the quality of If we like you, your research student research is great. If we don't, it sucks. I may be wrong... but who the hell are you to challenge me? What Your Advisor Says What Your Advisor Means

I like students who disagree... when I say things like, with me. "I may be wrong."

If you have a dispute with a... but the administration professor, you can file a always sided with the faculty, grievance with the Graduate School. If you have any problems, ... but if helping you con I'll always be there to give flicts with my own interests, you a hand. you'll only get the finger.

Graduate school grades... but a letter from your aren't important when you advisor is—so you'd better
are seeking a position. spend less time on your studies and
more time on my research.

Most of our students get . . . assuming they have an
good jobs. enthusiastic letter from their advisor.

Congratulations, you're now I've gotten all I can from

survivor's guide

for beginning graduate students. Journal of Polymorphous
Perversity, 7(1), 12-14. Etal Tells All: An Exclusive Interview
With the World's Most Prolific Scientist Mike Dubik,
M.D., and Brian Wood, M.D. Eastern Virginia Medical School
As everyone knows, there is no more frequently referenced
author

in the sciences, arts, and humanities than Etal. Although
often
quoted, he is rarely seen outside his mythical ivory tower.
Dr. Etal

has granted us this rare and exclusive interview.

Dr. Etal, please tell us about yourself.

Only the shallow know themselves. (Wilde. O.)

Well, tell us about your beginnings.

It is popular today to say that we have found the child
within us.

For me, this would be a short search. (Cosby, B.) I was the
kid next
door's imaginary friend. (Phillips, E.)

Why have you avoided interviews until now?

I'm afraid of losing my obscurity. Genuineness only thrives
in the
dark. Like celery. (Huxley, A.)
Well, you're certainly quite a celebrity in academic circles.

The nice thing about being a celebrity is that, if you bore people,

ey they think it's their fault. (Kissinger, H.)

We have noticed over the years that you are a senior investigator in

innumerable articles in diverse areas of science, medicine, humanities,

and the arts. We are intrigued and astounded by your productivity. 108

How do you explain your expertise in so many fields?

Do everything. One thing may turn out right. (Bogart, H.)

To our knowledge you are not the first author on any major research paper. Why?

I allow my junior colleagues to enjoy principal authorship. Besides,

there are only two kinds of researchers: those who do the work and

those who take the credit. I try to be in the first group; there is less

competition. (Gandhi, I.)

What do you hope to accomplish as a research scientist?

I hope to obtain grant money, of course. After all, it is better to

have a permanent income than to be fascinating. (Wilde, O.)

Have you ever had any bureaucratic hassles getting your work published?

If you're going to sin, sin against God, not the
bureaucracy. God
will forgive you but the bureaucracy won't. (Rickover, H. G.)

That almost sounds bitter, doctor.

Not really. I never attribute to malice that which is adequately explained by stupidity. (Hanlon)

We take it you have an opinion on government regulation of scientific research.

Indeed. I have found that when I work directly for the government I spend more and more time reporting on my work and less and less time actually working. On some projects I have achieved a steady state wherein I continually reported on work that is not getting done. (Anon)

Have you found the 'publish or perish' world of academic research to be a rat race?

Yes, and even when you win, you're still a rat. (Tomlin, L.)

Do you enjoy your work?

I know it's dangerous to enjoy your work too much (Snoopy) but, for me, work is much more fun than fun. (Coward, N.)

Do you feel your work is important?

I have come to realize that an early symptom of approaching mental illness is the belief that one's work is terribly
important. If you consider your work very important you should take a day off.

(Russell, B.)

How do you get your ideas?

The best way to have a good idea is to have a lot of ideas. (Pauling, L.)

You don't seem to have slowed down at all over the years. How have you stayed so active?

You're never too old to do goofy stuff (Cleaver, W.). Besides, when you're over the hill, you begin to pick up speed. (Schulz, C.)

How has science academia changed over the years?

Just because things are different doesn't mean anything has changed.

(Porter, I.)

That's an interesting judgment.

Good judgment comes from experience. Experience comes from bad judgment. (Anon)

You have been called one of the world's leading authorities on a wide variety of subjects.

Yes. As an expert I know tremendous amounts about very little.

(Butler, N. M.)

We think it is fair to say that you are a heroic figure to scientists and
researchers everywhere.

Maybe. But no one is a hero to his valet (Nietzsche, F. W.)
or his

spouse's psychiatrist. (Berne, E.)

Do you have any general advice for your fellow scientists?

Yes. When you have a lot to do, get your nap over with

first. (Anderson, J.) Also, never play cat and mouse games if you're a

mouse. (Dickson, P.) But, then again, no generalization is wholly

ture, not

even this one. (Holmes, O. W.) Besides, no one wants

advice—only

corroborations. (Steinbeck, J.)

Do you have any words of encouragement to budding

scientists?

Always look out for number one and be careful not to step

in number

two. (Dangerfield, R.)

You're a strong proponent of education?

Education is what survives when what has been learned has

been

forgotten. (Skinner, B. F.) So, I'm always ready to learn,

though

often I don't like being taught. (Churchill, W.)

So does everyone need to learn science?

One does not need to know science but he should at least

have

forgotten it. (Brander, M.)

Well then what is science all about?
The term science should not be given to anything but the aggregate of the recipes that are always successful. All the rest is literature.

(Valery, P.)

Why did you choose science as a career?

I like simple things. My mother recognized this tendency in me early and when she heard that science is the art of systematic over simplification (Popper, K.), she figured I was a natural.

You also teach?

Yes, and the hardest part has always been to keep the students awake. For every academic required to teach there are at least thirty reluctant students required to take the class, ready to be bored.

(Sellar, W. C.)

What is the hardest subject you’ve taught?

Never try to teach a pig to sing. It wastes your time and annoys the pig. (Anon)

How was the pay as a teacher?

I was certainly overpaid as a teacher but I was ludicrously underpaid as a babysitter. (Osborne, J.)

Have you also served as an administrator?

Yes. At various institutions and everywhere I was
confronted by the
same three problems: sex and rock & roll for the students; sports
for the alumni; and parking for the faculty. (Kerr, C.)

How do you balance being a scientist, teacher, and
administrator?

Simple. On good days I'm a scientist; on not so good days,
I teach; and
on really bad days, when I can't teach, I administrate.
(Shaw, G. B.)

What do researchers need to know these days?

It is better to know some of the questions than all the
answers.
(Thurber, J.)

Is there anyone to whom you owe your success?

I'm a self-made man, which shows what happens when you don't
follow directions. (Hoest, B.)

As we wind up the interview, are there any other
observations you
would like to share?

Yes. If dandelions were hard to grow, they would be most
welcome
on any lawn. (Mason, A. V.) Eighty percent of life is just
showing
up. (Allen, W.) Oh, yes, and spend the afternoon, you can't
take it
with you. (Dillard, A.)

What are your research interests now?

I'd like to know how a committee can make a decision dumber
than
any of its members. (Coblitz, D. B.) I'd like to know why life can't

present all its problems when you're 17 and know all the answers.

(Jolly, A. C.)

One last question. What does it all mean, Dr. Etal?

I don't know, I don't care, and it doesn't make any difference.

(Kerouac, J.)

So, what's the answer doctor?

There ain't no answer. There ain't going to be any answer. There

never has been an answer. That's the answer. (Stein, G.)

We tend to agree.

Well then, if we are in complete agreement then I propose we

postpone further interviewing to give ourselves time to develop dis

agreement and perhaps gain some understanding and insight into

what we are talking about. (Sloan, A. P.) Basic Concepts in the Behavioral Sciences: What I Learned in Psychology 101 Jamie Martindale, M.S. Several researchers (Mischel, 1977; Vaughan, 1977) in the field of psychology have investigated the degree to which untrained mem

bers of the general public can use common sense to understand
general principles of psychology. However, not yet studied in depth

is the phenomenon of the leap in understanding that typically occurs

after one's first course in introductory psychology. Along
these lines,

therefore, the following set of randomly selected data from exams,

journals, and projects is offered as a starting point for this investiga
tion. May these fragments—all direct quotes—help us piece together
the puzzle of what is truly learned in psychology.

Items of Historical Significance Pavlov studied the salvation of a dog. Food causes the salvation. Erikson created the identity crisis for teenagers and the midlife crisis for middle-aged people. Freud’s stages were oral, anal, phallic, lunatic, and gentle.

Key Scientific Facts His studies were sexiest, and he tended to use control groups of people that weren’t very large. 114

More Oral Sadism and the Vegetarian Personality 115

Constant reinforcement is easier to break than partial reinforcement.

Adopted by different families, they grew 45 miles apart in Ohio.

Learning about Abnormal Behavior

Bulimia is also called the binge-plunge syndrome.

I would look for symptoms like if he were having delusions, hallucinations, or being non-commutative.

What do you think about these others with fetishes and these transtesticles, or whatever?

C.P. is a condition in which interference with the control of motor systems arise as a result of liaisons occurring from birth trauma.
Infants develop their lounge skills and try them out by imitating brothers and sisters.

During the toddler stage you mimik what others say and do. They gain abilities like climbing, walking, and keeping balances. They learn by trial and error.

He was weaker in things like math and other classes where he is required to read and conceive.

Appreciation of Cultural Differences

Some cults even encourage members to kill people, such as Hare Krishnas. One of the main things I learned in this class was not to be prejudiced. These people are not censored from foul language. I was amazed at the whores, & the prostitutes with their costumes. They have learned to give the dolphins an award after a trick.

Insight into the Behavior of Others My mother is more of a mixed-brain. Scott enjoys being around people and making new ones all the time. Many believed their dreams reviled things about their future. My Uncle, for example, died of cancer a few years ago, and he took it pretty well at first. He stands out like a sour thumb. Mary was taken to a suicidal prevention center. He really went for the juggler.


The aim of this research was to study some incredibly interesting psychological issues. Specifically, I wanted to learn about how people,
men and women, think, talk, and feel about things. What things?

Lots of things, all kinds of things.

There have been absolutely no studies of this kind reported in the literature. I know because I used Psych Lit and typed in "things"
a tremendous need for this kind of study.

Following are some of the hypotheses and research questions I thought about:

1. How do people think and feel about the things that they think and feel about?

2. Why do people think about these things?

3. Are there any differences? How come?

All But Doctorate. Professor Allbright is an untenured assistant professor in the

Department of Psychology at Hempstead Community College.

125 Subjects

Lots of subjects were found for the study. Some were men; the rest were women. They came from all over the place. Although only some of them had children of their own, most of them had been children at some point. The mean age of this sample was somewhere between 15 and 70; that's about what the median was too. I'm not
sure what the mode was because some of them fell out of my briefcase on my way to the computer center.

Instruments

Just to be careful, I used every measure in the testing file. I used

the WAIS, Rorschach, TAT, MMPI, Draw-A-Person, and Millon.

I may have used a couple more but I really don't remember. I think

some of them may have been missing pieces. Is it the WAIS or the

MMPI that comes with dice? I also think some of the scoring manuals

may have gotten mixed up in different boxes. But everybody took

the same tests, so it probably doesn't make a difference. One thing

that may have made a difference though is that I couldn't find a

stopwatch. I hope it was O.K. that I counted "One-Mississippi, Two

Mississippi" while they were doing the puzzles. And some of those

puzzles are too damn hard, especially when you're missing pieces.

Procedure

Not every person took every test. That would have taken much too long. So, I gave each person the same number of tests (somewhere around five, I think) and told them to do the best they could. Still,
some people started complaining and asking questions about what
they were supposed to do. When that happened I just repeated, "Do
the best you can."

As for informed consent: I asked everyone if it was O.K. with
them that I was doing this. Almost everyone said "sure."

Results

Tons of data were scored and the reliability was more than ade
quate. Maybe even great. I didn't do test-retest reliability because
I didn't think I'd be able to find everyone again. Validity
was very,
very high except for one measure that was just so-so.

Besides, ac
cording to Steve, he's the stat consultant all the faculty members
use and couldn't get their stuff published without him, all the tests
had all the kinds of validity that start with the letter "C".

I ran a bunch of tests using a program that I copied from someone
and found some interesting results. For example, most of the tests
were correlated with each other. Let's put Table 1 here, O.K.?

Table 1. Correlations and One-way Analysis of Variance

Men 3.875 .678956 .2 .78954 F = 3.45

Women 1.24 3.21111 16.0 .89 .34 F = 6 (or maybe 8)
As Table 1 clearly shows, there were significant differences among men and women and others, even though most of the tests seem to be different from each other. Discussion

This study was about whether men and women are different on their gender. As you can see—and I expect you to look at the table now, O.K.?—the results are really incredible. The numbers show that "other" was much more consistent than men or women in the way they think and feel (though it’s also possible that this might have something to do with the fact that I spilled some soda on the computer disk).

Clearly, the ways that men and women think and feel about things is something that psychologists should be thinking about and studying and telling their students about and also their patients and their patients' friends, too, and they should be getting MacArthur genius grants to discover whether there is a biological difference between men and women or whether it’s because of cultural diversity issues.

This was an important piece of research because, as you can
see,

the F was significant at the 6 or 8 level. (If the F had gotten to 10,

would I have gotten a free game?)

I think there were a few limitations to this study, but, hey, so what?

In conclusion, people should continue to think and feel whether they

are men or women or other. I recommend future research on this

and every other topic. Barry A. Farber, Ph.D. Teachers College, Columbia University
Contemporary Issues in Psychology


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(or Notice of Acceptance of Preauthorization) from us within the next 6 to 12 months.

The following case studies are presented in order to help you to develop a better understanding of our review process and the rationale behind our decisions regarding the rejection/acceptance of preauthorization requests, the types of treatments rejected/accepted, and the limited number of sessions preauthorized. At first glance, many of the cases here appear to be extremely complex, requiring prolonged courses of psychological treatment rendered by highly skilled and sensitive therapists. However, we believe that too much has been made of what are, in fact, minuscule problems that can be quite effectively treated by briefer—and cheaper—therapeutic methods. In short, it is our view that much of what many clinicians consider the "drama, complexity, grandness, and mystery of human life" amounts to simple chemical imbalances and bad habits, treatable by medical or educational management.
ment. The treatment approaches that we recommend in each of the following clinical vignettes are merely guidelines and should not be considered mandatory, although, because we developed these guidelines, we will not authorize additional sessions beyond those specified in each case. Any arguments to the effect that the providers are experts in psychotherapy and assessment and have actually seen the patients, whereas neither is true of our in-house reviewers, will, as usual, have no bearing on our decision.

Case example: Adam and Eve (no surname given)

Sessions authorized: 4 (Adam); 2 (Eve); 0 (conjoint marital)

Rationale: Therapist presented case of a dysfunctional marital situation, requesting an initial block of 20 individual sessions plus additional sessions for couples counseling. Request for couples sessions is being denied as marital dysfunction is a V-code in the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition) and treatment is not medically necessary, even if, as therapist states, this will doom mankind forever to having to claw out a meager living from the dust of the earth and doom women,
in particular, to the excruciating pain of childbirth. (We are not really in the prevention business, and certainly not prevention of that magnitude!) Ms. Eve did manifest impulsive personality traits and a possible eating disorder (involving cycles of binging and eternal damnation), so two sessions were authorized for additional assessment, with a recommendation for referral to an Appleholics Anonymous group (if other members can be found in her garden area). Mr. Adam was seen as less impaired, in part because he is male, and so the apple incident described in your report was really Eve's fault; he was considered to be somewhat codependent, however, and so four sessions were authorized for treatment of this condition so that he can learn who is supposed to be in charge.

In the long run we think they and their progeny will be happier when he does.

Case example: Oedipus

Sessions authorized: 5

Rationale: Several therapists have made much of this man's difficulties, but we frankly don't see what the fuss has been about and we doubt that he truly has problems with a so-called Oedipus
complex. We could not decide if he was the victim or perpetrator of sexual abuse with regard to his mother, so no sessions were authorized for that situation. PTSD (Posttraumatic Stress Disorder) symptoms reported after the murder of his father were not significant; in fact, we note that he went on to function successfully as king and husband. Although there was some self-injurious behavior, it amounted to only one episode (blinding himself), so appeals to a possible "borderline" personality did not move us, and blindness is a condition not usually amenable to psychotherapy. Five sessions were allowed to process the various adjustment difficulties he has had and so that he could ponder the question of what walks on four legs in the morning, two in the afternoon, and three in the evening. In a time-limited group format, of course.

Case example: Hamlet, Prince of Denmark

Sessions authorized: 1 (medication management only)

Rationale: To authorize or not to authorize?—that was our question. The patient and his therapist wrote eloquently (in "Act I,
Scene 4” per therapist's notes—such an odd way of doing case reports) about the “vicious moles of nature” that undermine people's lives, and certainly he has demonstrated symptoms of either a psychotic depression or great cunning and deviousness in plotting a revenge. (The reviewers were unable to decide between the two.) He does come from a rather dysfunctional family, but as in the cases cited above, we do not consider that to be an automatic justification for extended treatment. We initially considered a recommendation for brief therapy, however upon review of the transcript of the session between him and Messrs. Rosencrantz and Guildenstern (Act III, Scene 2), in which he makes the point that if they can't learn to play a musical instrument in just a few sessions, they are unlikely to be able to learn enough about him to "play on him" in such a short time, we decided that his noncompliance with brief therapy would be too great. One session will be sufficient to get him on some Prozac before something really awful happens; we suggest that it be administered into his ear.
Case example: Faust

Sessions authorized: 0

Rationale: Case of a man worried about the fact that he had sold his eternal soul to the devil. Treatment is being denied based on a lack of data showing statistically significant relationships between selling one’s soul and diagnosable psychiatric conditions. In short, we don’t think that one automatically has a psychiatric condition just because one has sold one’s soul to the devil. Certainly, none of us have had any such problems!

Case example: Twist, Oliver

Sessions authorized: 1

Rationale: While this child has had a few minor adjustment difficulties following some unfortunate psychosocial experiences, we frankly don’t think his problems require psychotherapy so much as immersion in long days of backbreaking child labor to teach him to mind his manners—and his elders. He is merely one of the "worried well." Please don’t ask for more.

Case example: Ahab, Captain

Sessions authorized: 4 group sessions, no individual

Rationale: Middle-aged sea captain with obsessive behaviors, in
cluding polishing wooden leg and relentlessly pursuing a
great
white whale. We would consider a referral for medication for
obsessive behaviors; characterological features are not
covered, but we prefer to act as if they aren't, so they aren't. It
is noted that his condition has not interfered
significantly with his
vocational performance; i.e., he still manages to function as captain
of a whaling vessel, to command a ship's crew, and to pursue
great white whales with the energy and drive that should lead to
vocational success and eventually to a peaceful retirement.
Several
group sessions for PTSD symptoms are approved. In closing, we
would like to ask the therapist whether it was necessary to have
written such a long preauthorization request in this case.
Case example: Dorothy, Scarecrow, Tin Man, Lion, Toto
Sessions authorized: 0
Rationale: This group of four individuals and a little dog is being
denied in one paragraph since their reports were submitted to
gether; we concluded that none have conditions requiring medical
treatment, and that all of them would be considered prime
samples of "worried well" individuals who are constantly in search
of some kind of magical solution to their problems. While the little girl who ran away from her Aunty Em's home
may have a conduct disorder (after all, she did kill the so-called
wicked witch whose assertiveness she found threatening), and
there has been one incident of opiate intoxication ("poppies"
abuse), we would point out that running away from home, singing
and dancing, hanging around peculiar, oddly attired friends
with
grandiose expectations, experimenting with mood-altering sub
stances, and occasionally indulging a fetish for fancy footwear
are all normative among adolescents, just as among psychologists
attending out-of-town meetings. The conditions alleged by Messrs. Scarecrow and Tin Man are
not listed in either DSM-III-R (Diagnostic and Statistical Manual
of Mental Disorders, 3rd Edition-Revised) or DSM-IV. We
would add that the conditions of brainlessness and heartlessness,
far from being disabling, can be assets in certain professions, not
excluding our own. As for Mr. Lion's allegation, we acknowledge that his lack
of courage does resemble the DSM-III-R condition of Avoidant Personality Disorder. However, we are reluctant to fund
treatment

of Axis II issues. Moreover, in some cases, cowardice can also be

an asset. It might be argued that a society functions most smoothly

when its citizens lack the courage to question; certainly, a general

ized lack of courage among mental health professionals has made

our job easier. Finally, we feel that the most cost-effective alternative for the

little dog, Toto, is that he be put to sleep. Gregory Korgeski, Ph.D.

Critical Considerations in Choosing to Become a Psychologist Joseph J. Palladino, Ph.D. University of Southern Indiana Mitchell M. Handelsman, Ph.D. University of Colorado at Denver

The last decade has been very stressful for psychologists; research

suggests that a high percentage of psychologists, in both academic

and applied settings, would train in different fields if they had the

choice. Pressures from within and without the discipline have taken

much of the pleasure out of a once satisfying field.

Stories about dwindling research money and increasing competi

tion with our colleagues in biology, chemistry, and physics for the

shrinking supply of research dollars are all too common. More and

more, the public views psychologists as weird people who lie in order
to get at the truth, who appear on talk shows, or who do both. In
the applied realm, psychologists are in the midst of an era of managed
care; anticipated health care reform will diminish practitioners' re
munerative opportunities and professional independence. The prolif
eration of alternative mental health services has prompted psychol
ogy to become more adversarial and conservative, with little room
left for the innovation and intellectual excitement that has character
ized most of our history.
The implication of these trends are potentially grave. A generation
of students will be taught by psychologists who are not optimistic
about the future of the field, and these students will not graduate
with the spark that is necessary for an intellectual rebirth. Mental 152
health services will suffer without the conceptual rigor and high fees
that psychology has claimed for so many years. Moreover, social
hours at conventions will become deadly serious. Therefore, as a
first step to rebuilding the morale within our profession, we here
delineate a multitude of reasons to actually be proud of being psychologists. Through exhaustive research, we have developed a list that is designed to cover a broad range of psychological activities. Reasons We’re Proud to Be Psychologists

We know the correct answers to all items on intelligence tests. Our white lab coats stay clean for decades. Over 200 DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) diagnoses make for great cocktail hour small talk. The cornerstones of our science are drooling dogs, people squinting at different-length lines, and the recall of nonsense syllables. If we tell a seatmate on an airplane that we are psychologists, we have a friend for life. The Dr. Joyce Brothers giant balloon in the Macy’s Day Parade was so lifelike. Our introductory texts have 76% more boxes than all other disciplines combined. Rat-food pellets make great mid-afternoon snacks. Biologists don’t have their own radio shows.

Psychologists are second only to exotic dancers in number of appearances on Oprah, Sally, and Donahue.

Most people believe we can read minds.

We knew they would say that. A Living Will for Mental Health Professionals Ernst von Krankman, Ph.D.

To: My Family, My Lawyer, My Friends, My Training Analyst, and All Others to Whom It May Concern.

I, , being of sound and relatively analyzed mind (after years of -times-per-week sessions on the analytic couch), do hereby make, publish and declare this to be my Living Will. If the time comes when I can no longer take part in decisions regarding my own future, let this statement stand as an
expression of my wishes and directions while I am still of sound mind.

Should I suddenly take an unexplained turn for the worse, before any drastic or irreversible decisions are made, it is my desire that my membership in the (American Psychological Association, American Psychiatric Association, National Association of Social Workers) be cancelled and the prorated balance of the exorbitant annual membership ship dues be returned to me.

Ditto for my malpractice insurance premiums.

Should my physician determine that an organ transplant is necessary, it is my expressed wish that, if at all possible, the donor shall be of the same psychoanalytic orientation as myself, and under no circumstances should the donor be a Kleinian (Melanie, not Robert). 155

Should colleagues from the university psychology department visit me and attempt to elevate my mood at a time when I am incapacitated or in a coma, the following verbalizations from said colleagues shall be expressly prohibited: "Sure your present condition is unfortunate, perhaps it's even bad, but where's the evidence that it's awful?" "Remember: The sun always rises."
However, the following verbalizations are permissible: "You know, your condition does appear to be awfully bad." "I guess the sun also always sets."

No matter what my medical condition, at no time shall I be subjected to visitors while dressed in a gown with a slit up the middle of the back.

If, after reasonable medical intervention, it becomes apparent that I will not be able to resume my private practice, it is my expressed wish that the majority of my patients be referred to my dear friends, as well as able therapists, , , and Further, it is my wish that all of my difficult-to-treat borderline patients be referred to my obnoxious, know-it-all, may-(s)he-rot-in-hell colleague; may these patients drive you crazy.

It is my wish that, if confined to a hospital, my room be equipped with both a color television and a black-and-white television, so that I may watch colorized movies in their original black and white.

If after a second medical opinion it should be determined that the probability of my continuing to live longer than one billable cycle of my credit card is greater than 50-50, it is my
wish that my hospital bill and all related medical bills be charged to my Citibank American Airlines AAdvantage® credit card so that I can build up my frequent flier miles. Under no circumstance may a visitor bearing a gift of a copy of one of Jonathan Kellerman’s books be permitted to enter my room. Should there be a need for me to be hospitalized and, after consultation with other hospital specialists, should my treating physician determine that I will not live out the week, then a second container of vanilla ice cream on my dinner tray would be nice. This statement is made after careful consideration and is in accordance with my convictions and beliefs. It is my desire that the wishes and directions here expressed be carried out to the extent permitted by law. In Witness Whereof, I have hereunto set my hand and seal to this, my living will, on the day of 19 Signature Witness Just for the Health of It Richard Lederer

Doctors are generally very smart people. I know because, over the years, some of the most articulate and knowledgeable letters about language that I have received are from members of the medical profession.

But doctors sometimes find it as hard as anyone else to say what
they mean. Like everyone else, doctors can occasionally be
tongue
depressing, even when they are describing cases.

The tradition of medical mutilation of the English language
goes
back hundreds of years. Research into early
nineteenth-century Mis
souri death records has produced some curious medical
reports;
among the causes of death listed were:
• Went to bed feeling well, woke up dead.
• Died suddenly, nothing serious.
• Cause of death unknown; had never been fatally ill before.
• Don't know; died without the aid of a physician.
• Death caused by blow on the head with an ax. Contributory
cause, another man's wife.

Here is an off-the-charts lineup of more recent medical
fluffs
and flubs as actually dictated by doctors around the world.
To my 158
knowledge, each nugget in this varicose vein of anguished
English
has in no way been doctored. Fortunately for the rest of
us, unless
we happen to be one of the patients, these classics in the
annals of
curative history have been saved for posterity by medical
transcrip
tionists, who apparently love to have a little fun while
taking their
jobs seriously: • The left leg became numb at times and
she walked it off. • By the time he was admitted, his rapid heart had stopped, and he was feeling better. • Patient has chest pain if she lies on her left side for over a year. • Prior to the patient’s birth, she was informed at all times that her pregnancy was a normal one. • The patient states there is a burning pain in his penis which goes to his feet. • Both the patient and the nurse herself reported passing flatus. • His daughter was given a genealogical examination at the hospital. • On the second day the knee was better and on the third day it had completely disappeared. • She has had no rigors or shaking chills, but her husband states she was very hot in bed last night. • This patient has been under many psychiatrists in the past. • The patient has been depressed ever since she began seeing me in 1963. The pelvic examination will be done later on the floor.

160 More Oral Sadism and the Vegetarian Personality • The patient has never been pregnant and denies any reason for this. • She was divorced last April. No other serious illness. • The patient was admitted with abdominal pain from the emergency room. • He was found lying on the bathroom floor by his wife. • Patient was seen in consultation by Dr. Blank, who felt we should sit tight on the abdomen and I agreed. • Patient stated that if she would lie down, within 2–3 minutes something would come across her abdomen and knock her up. • Preoperative diagnosis: herniated dick. • I will be happy to go into her GI system; she seems ready and anxious. • Patient was released to outpatient department without dressing. • I have suggested that he loosen his pants before standing, and then, when he stands with the help of his wife, they should fall to the floor. • Patient had bilateral varicosities below her legs. • The patient is tearful and crying constantly. She also appears to be depressed. • Dr. Blank is watching his prostate. • Sister Anna Maria is a Catholic nun who is currently in between missionaries. • The patient was advised not to go around exposing himself to other people. • Rectal exam is deferred because patient is sitting upright. • The patient was somewhat agitated and had to be encouraged to feed and eat himself. • Discharge status: Alive but without permission. • The patient will need disposition, and therefore we will get Dr. Blank to dispose of him. • Coming from Detroit, Michigan, this man has no children. • Patient was admitted and suffered severe pain by Dr. Blank. • Healthy appearing decrepit 69-year-old white female, mentally alert but forgetful. • When you pin him down, he has some slowing of the stream. • Dr. Blank will dictate on the right breast later. • The infant was handed to the pediatrician, who
cried spontaneously. • The patient was found to have twelve children by Dr. Blank. • Many years ago the patient had frostbite of the right shoe. • The patient is a 74-year-old white female who was brought to the ER by paramedics acutely short of breath. • After his release from Coronary Care, Dr. Blank worked him over.

162 More Oral Sadism and the Vegetarian Personality

• The patient developed a puffy right eye, which was felt to be caused by an insect bite by an ophthalmologist.

• The patient refused an autopsy.

• The patient has no past history of suicides.

• The patient expired on the floor uneventfully.

• Patient left his white blood cells at another hospital.

• Apparently the mother resented the fact that she was born in her forties.

• Patient was becoming more demented with urinary frequency.

• Physician has been following the patient's breast for six years.

• This unfortunate 45-year-old woman has known me for about eight years.

• The patient is a 79-year-old widow who no longer lives with her husband.

• The patient's past medical history has been remarkably insignificant with only a 40-pound weight gain in the past three days.

• The right front side of her car was broadsided while the patient was in the passenger seat going through the intersection.

• The patient is a smoker so will be admitted to a smoking bed.

• The nursing home where the patient lives was noted to sputter, cough, and run a fever.

• The bugs that grew out of her urine were cultured in the ER and are not available. I WILL FIND THEM!!! • He had a
left-toe amputation one month ago. He also had a left-knee amputation last year. • The patient is a 71-year-old female who fractured her little finger while beating up a cake. • She slipped on the ice and apparently her legs went in separate directions in early December. • The patient left the hospital feeling much better except for her original complaints. • The operative field appeared in good condition, with no bleeding, and therefore the patient was terminated. • The patient experienced sudden onset of severe shortness of breath with a picture of acute pulmonary edema at home while having sex which gradually deteriorated in the emergency room. Bless the medical transcriptionists who have preserved these boners and boo-boos as a benefit to the health of all of us. May their tribe thrive and multiply! For more medical madness, have a look at A Bloopered Guide to Medical Terminology: Abdominal. Terrible. Anatomy. Part of a moleculey. Appendix. End of a book. Artery. The study of fine paintings. Atrophy. A prize. Bacteria. Inconveniently located room for serving food.

Barium. What you do when CPR fails.

Benign. What you do after you be eight.


 considerabe interest in capitated programs of mental health service delivery. Such programs deliver a defined package of services for a fixed dollar amount. However, this has generated significant concern among practitioners, who worry that capitated delivery models may not adequately address the needs of the severely mentally ill. Accordingly, there is now a move toward decapitation in the provision of mental health services. Getting Ahead by Getting a Head: The Decapitation Trend Unlike capitation, which sets limits on the dollar amounts allotted to treatment per patient, decapitation is a procedure resulting in the removal of the patient's head. While this may, on the face of it, appear to be a novel and radical form of cost containment, it finds
ample historical precedent in the traditions of psychosurgery and insulin-coma therapy. Indeed, before the popularization of talk therapy, trephining, or the drilling of holes into the skull, was a common treatment for mental illness, which allowed offending evil spirits to vacate the sufferer's brain. Later, psychopharmacology emerged as a nonsurgical form of decapitation, proving surprisingly effective in the cessation of untoward mental activity. 167 Although these early forms of decapitation found initial enthusiasm among practitioners, it quickly became apparent that they had limited cost-containment potential. Specifically, the side effects associated with psychosurgery, trephining, and pharmacologic intervention tended to increase rather than decrease subsequent medical utilization. Under a decapitated health care plan, patients are advised to keep their heads on straight or risk losing them altogether. Interestingly, this dovetails with some of the methods of brief psychoanalytic psychotherapy, which "hock away at the patient's head" (Habib, Dave, & Lew, 1993). In a prospective study of 8,000
patients enrolled in a large city health maintenance organization, actual decapitation needed to be performed only 16 times, with the vast majority of patients indicating that a single cautionary visit was ample treatment (Krueger, 1992). Relapse was nonexistent among the 16 treated individuals; none found the need to return to treatment.

Resistance to Decapitation Procedures

Ethical objections to decapitation still remain, particularly among nondirective practitioners who prefer client-centered forms of cranial displacement. In an intriguing and promising variant, clients are provided with their own medical tools and anesthesia following prolonged exposure to the music of Barry Manilow ("Suture-self, a self-help program of neurosurgery," Time, April 1, 1993). Results are roughly comparable to those of traditional decapitation, though some have claimed that nonspecific music effects, rather than the surgical procedure, are responsible for the observed decrease in subsequent medical utilization.

A more significant source of resistance to decapitation comes from the public, especially those in the hat trade. According to
some consumer advocates, widespread adoption of a decapitation scheme could result in the loss of millions of dollars to the hair care and cosmetic industries. Further, it could invalidate the painstakingly collected norms of the Wechsler Intelligence Scales. Traditional psychotherapists have also voiced concerns over decapitation, claiming that it would impair the functioning of some (though not all) of their patients. A very different source of criticism has come from the counseling profession, which faults "medical model" specialties for their "after-the-fact" approach to decapitation (Steenbarger, 1991). Differentiating primary, secondary, and tertiary models of decapitation, counselors have reported success with the proactive use of decapitation as a means of reducing the incidence of such resource-consuming problems as major depression, schizophrenia, and acne vulgaris. The Effectiveness of Decapitation At present, a number of multisite studies are comparing decapitation with other forms of treatment as a means of limiting health care related costs. In one study, subjects placed in a unique placebo
condition in which they were led to believe that their heads had been removed (although they actually remained intact) incurred significant declines in future health expenditures ("I went to a shrink and came out headless," National Enquirer, April 1, 1992). An unfortunate side effect, however, was the putatively decerebrated subjects' fixed delusion that they were now chairs of university departments.

More recently, Fisher (1993) criticized the above study for its lack of a truly active placebo condition. His study, featuring the use of virtual-reality helmets, apparently was more convincing in its placebo effect, causing patients to actively declare themselves as nominees for the United States Vice-Presidency. An unusually creative meta-analysis was conducted by Greenberg (1992), who followed the health care utilization of decapitated victims of automobile accidents, serial killers, and automatic seat belts. Greenberg argued that such "naturally occurring" decapitation could not be subjected to placebo effects and hence could serve as an accurate basis for determining cost containment. Consistent with his hypothesis, Greenberg found that the victims' use of medical and
mental health services were significantly curtailed following their ac
cidents. More recently, Greenberg and Steenbarger (1993) have been in
vestigating decapitation as a form of brief therapy, noting that it
possesses many of the central ingredients—limited duration, high
therapist activity, and focused desired outcome—of traditional short
term modalities. Decapitation Side Effects

A thorough literature review reveals that decapitation possesses a
favorable side effect profile when compared with such other medical
treatments as neuroleptics (Antoinette, 1991). Problems with identity
diffusion and self-esteem have been noted, as has a sense of loss of
stature. Anorexia is on the rise among the decapitated. Domectomy
recipients also frequently express concerns about dishevelled hair,
an apparent by-product of "phantom-head syndrome." Research is equivocal about whether the beheaded experience increases or
decreases in television addiction.

Although some proponents of the procedure acknowledge that "decapitation is not for everyone," most indicate that side effects
are short lived and they point to a host of unanticipated benefits for the headless. Narcissistic disorders and trichotillomania become relatively unknown. Similarly, rates of alcohol and tobacco abuse drop and there is a parallel decline in some of the sexual disorders (such as the uncontrollable urge for oral sex).

Nonetheless, the decision to decapitate is not to be taken lightly, as attempts to reverse the procedure have proved problematic. Although Shari Lewis and the Muppet Workshop have provided some intriguing glimpses of future prosthetic possibilities, the greatest success has been achieved with silicone implants. These create a very natural look and feel. However, implant recipients have suffered from a problem with shape constancy, a condition that has come to be known as "beanbag head."

Conclusions Capitated systems of health care delivery can be viewed as a transitional phase on the way to more promising decapitated alternatives. "Remove the head, free up the bed" has become the rallying cry for a number of health care economists who view decapitation as uniquely poised to halt the alarming rise in health care costs.
As studies establish the effectiveness and efficiency of decapitated systems, it is likely that attention will be given to the removal of other bodily parts as cost-containment incentives (Blacky, 1954), although replacement of traditional decapitation is unlikely, given the recent shortage of university department chairs and Vice Antoinette, Marie (1993). The comparative efficacy of decapitation vs. cake in quelling civil disorder: A review. The French Journal of Revolutionary Ideas, 3, 26–81.


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