COPROPHAGIA AND ALLIED PHENOMENA

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THE PURPOSE of this paper is to bring together a certain array of clinical phenomena which do not seem to be sufficiently discussed. I shall call these phenomena derivatives of coprophagia. By this I mean picking or scratching of the anus or skin or mucous membranes anywhere on the body, picking in the mouth, ears, but especially the nose. I include eating body secretions or eating or smelling or playing with either feces, desquamated skin or any other product derived from the body. I would also include smearing feces, refusal to flush the toilet, and a wide variety of bowel habits, especially saving the stool to be evacuated only at certain times at the pleasure of the subject. There is a vast array of symptoms involving body parts, products or odors.

I shall discuss another set of related symptoms. This would include certain perceptions of or attitudes to time, particularly that of time going slowly, daydreaming, obsessive rumination, and certain types of obsessive thinking, including indecision and procrastination. There are also delay and difficulty in communication with the therapist.

Let us begin with the tremendous delay in getting this material from the patients. It is quite typical for a patient to be in his

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third year of analysis before he will admit to picking his nose and generally, but not always, eating the pickings. The patients enjoy these activities. The nose pickings are reported to be quite tasty, salty, to be exact. The patient suffers no guilt, but he *is* ashamed to tell you about it. We can safely make the assumption that every obsessional neurotic is a nose picker and/or anus picker and will take several years to communicate that information.

The problem of shame versus guilt in these patients is a most interesting one. Apart from the theoretical issues involved, we find that guilt brings material into the analysis, shame keeps it out. There is certainly a difference in ego and superego development involved between the capacity for guilt and the capacity for shame. Unfortunately space considerations do not permit development of this issue, important and interesting as it is.

The first patient is a nonpsychotic middle-aged professional man whose chief complaints were obsessional thinking, periods of depression, dissatisfaction with the progress of his professional career, unhappiness in his marriage, and homosexual fantasies and preoccupations. He experienced strong pleasure in odors, in flatulence, in sweat, and in constipation. He had a strong interest in and affection for his stool. He could not bear to flush the toilet, and would fondle and caress the stool in the bowl before, most reluctantly, permitting it to flush down. He had peculiar sensations in his mouth and had frequent fantasies and compulsive thoughts of eating his stool. On occasion he would have the urge to eat the stool of a dog in the street. He enjoyed being constipated and once had a seminal emission while constipated. After a bowel movement he would have an empty feeling and the urge to eat his feces. He would count money while having a bowel movement. He often caressed his buttocks or spit while urinating.

The patient liked to nap in my waiting room, and was resentful when I called him in early for his session in advance of the proper time. When he napped time stood still. He could not tolerate any waste of time and he wished he could stop time. He resented giving time to his clients. Any time he gave to someone else was time wasted. Time was as valuable to him as stool, and he did not like to give up either. He wanted time to stand still. Time could be used to escape reality—it was a form of fantasy. A nap

was pleasant because time stopped. He liked to sleep. "I would sell my soul for sleep." He could not tolerate free time. He had the same attitude to money. He paid his bills slowly and reluctantly and always managed to have his financial affairs in such a confused state that he was in possession of other people's money as well as his own. He was stingy, greedy, and occasionally dishonest. When he tried to curb his greed, he would get sensations in his anus. He had fantasies and daydreams of getting large amounts of money and also power over the affairs of his colleagues. He struggled against believing in magic and in the power of words to influence events. He would engage in long overly precise trains of thought in which he would define and redefine the exact meanings of words. At the same time his speech delivery was monotonous. There was a lack of emphasis in his speech, making it boring and soporific. He was stubborn, did not like to do what he was told or what was expected of him. He would leave his home in the morning with his shoelaces untied. He could not complete the writing of a scientific paper. "Giving a paper is the same as having the shit squeezed out of me." He was contrary, and kept people waiting. He enjoyed holding on to work as well as to his stools. He enjoyed seeing babies in diapers full of warm, fresh stool. He had many homosexual fantasies and masturbated often with his finger in his rectum. He repeatedly tried to perform fellatio upon himself, without success. He felt he was as good-looking as a woman, would imagine he was a woman, dressed as such, and would identify with women in their sexual experiences. In adolescence he had dressed himself in his mother's clothes.

In his communications he had his own variety of obsessive undoing. He might recite a long story of certain events which might logically permit both patient and therapist to draw some conclusions. At that point, just prior to going on with a conclusion or related material, he would say, "Be that as it may," and then go on. This expression demolished any attempt to establish a sequence of thought. It amounted to withdrawing everything he had just said. It was an undoing—a taking back of the stool immediately after presenting it. Similar expressions by other patients signifying undoing are, "In any event," or "Well, regardless." They take back that which has just been given.

The next patient was a nonpsychotic divorced man, in his thirties, who came for treatment because of one unsuccessful marriage, a current unhappy romance, and innumerable obsessive thoughts and compulsive actions. He had many enjoyable murderous fantasies such as being in Times Square with a machine gun and killing everyone in sight; of killing people by nailing them to the floor, by stabbing them in the head, and by other means. He also had fantasies of beating women.

He was a mixture of extreme orderliness and extreme slovenliness. He would not bathe for three months at a time, his underwear would be stained with feces, he would not shave for days, nor would he wear a tie. At the same time he had meticulous lists of all his possessions, his shirts, furniture, friends, money, etc. He arranged to have all his money in denominations of a certain figure and could not tolerate having an irregular amount of money in a savings bank. He could not buy common stocks because their values would fluctuate from day to day making it impossible to rely on the orderliness of the figures.

He was constipated and enormously preoccupied with his bowel movements and his rectum. He tried to keep his rectum clean. In order to do this he would push his stool back and forth several times before a bowel movement, and after the bowel movement would spend a great deal of time cleaning out his rectum with large amounts of cold cream and toilet paper. He carried cold cream with him wherever he went. He became a specialist in stools, their color, consistency, tendency to stick to underwear, etc. He regarded stool as bad, dirty stuff, "which I have to take out." At the same time he would often wonder whether he wanted to eat his feces.

He picked at his body and his skin. He ate his blackheads, his dried nasal secretion, dandruff, and skin; he would tear the skin off of his heels and soles and the skin of the inside of his ears which he would pick and eat, often without even being aware of what he was doing. It was when he was through eating the skin that he would suddenly be aware of what he was doing. He enjoyed this and it tasted "good." He would at times have the fantasy of slitting his nose open with a razor in order to get at the contents of his nose more readily. He could not bear to throw these things

away. "It's like throwing away a sirloin steak." These activities did not always depend on loneliness, but were accentuated by loneliness. He had the feeling, "I give to myself. If no one gives to me, I'll give to myself." At the same time he was grossly overweight, was a gourmet with normal food, and was a heavy eater. When he attempted to diet, as he finally did successfully, he cut down both on the body picking and ordinary food at the same time. He would pick his nose in lieu of a snack if he had a lonesome moment.

He said, "People are no good. I cannot believe in love." He had to be completely self-contained and self-sufficient. He had so arranged his apartment and its contents and fixtures that he would not have had to leave it for months. He was fascinated by Robinson Crusoe who took care of all his needs by himself. He said, "If I could provide my own food I wouldn't need anybody. If I could twist my hair I would even make cigars out of my own body." He smoked as many as fifty cigars a day. He had his apartment sealed in such a way that air conditioners, heaters, electric blankets, thermostatic controls were so conjointly regulated that he had a constant supply of nonfluctuating air and warmth continually about him.

He was a malcontent, wrote spiteful letters, made vitriolic remarks, had few friends, was a practical joker, was interested in criticizing authority, hating cops, as well as his mother and father. He had a habit of making sudden left-hand turns in traffic when he would be driving with his father in the front seat with him. This made the father repeatedly accuse him of trying to kill him in an automobile accident. His romances with girls were endless fights. His mother had rubbed his nose in his feces-stained drawers as a child to inculcate him with ideas of bodily cleanliness. He had sexual intercourse but preferred masturbation. The vagina was disgusting. He did not like his own pubic hair and repeatedly cut it off. Hair was dirty and revolting. One of his favorite stories was about a man who could eat feces with relish, but one day could not eat it because there was a hair on it. When lonesome he would resort either to daydreaming or to body picking and eating. The daydreams were of many kinds, generally of a heroic nature, not involved with anal preoccupations. He always felt he was bad, crazy, fat, and homely. He liked the idea of cheating insurance

companies. He thought with great glee how he could swindle the insurance companies by taking out an enormous amount of insurance and then committing suicide, forcing them to pay out the enormous sum of money.

The patient had certain mildly fetishistic attitudes to women's clothing, having sharp likes and dislikes, relating especially to tightness and looseness, the amount of the body that was exposed, dresses versus pants, whether the armpits showed, etc.

The tie between the nose and anus is illustrated by another patient, though in the form of reaction formations. This patient was a successful accountant, who suffered from massive obsessional and masochistic inclinations. He was extremely spiteful and cruel. The two parts of his body the cleanliness of which especially interested him were the nose and the anus. He would stuff cotton up his anus to make certain he would not soil his underwear and he would pick his nose to make certain that no crusts would ever fall out and touch his clothing.

Another male patient had the habit of saving all his bowel movements for the weekend. This removed the bowel function from the habitual disciplines of the week and transformed them into his own spontaneous actions. He picked and scratched at his skin, especially his scalp. Bearing on the issue of control of one's own bowel movements is the report by Bychowski (7) on a patient who derived pleasure from moving the fecal column up and down within the rectum.

Also related to this are some of the practices of certain fetishists and transvestites with their affinity for fetishes which produce a tight feeling, such as corsets and shoes. A nonpsychotic transvestite patient who was addicted to dressing himself in tight women's clothing, including corsets and shoes, had the following habit. He would manufacture an artificial penis and insert it into his rectum. Then, by means of rapid fluctuations in his intra-abdominal pressure, would force the object back and forth in his anus and rectum. While this undeniably had the meaning of homosexual penetration per rectum, it also had the meaning of playing with his stool *at the anus.* This was all done while his body was tightly encased in women's clothing. His great pleasure was *almost* to expel the object in his anus, yet at the same time keep it there indefinitely.

When it finally was expelled he would have strong regrets. In the course of such activity he would frequently soil himself. He wanted to remain soiled; he would attempt to defecate into his transvestite clothing and try to sleep while soiled, though he found himself unable to do so.

Abraham (1) has reported a case with similar features. A patient with foot and corset fetishism was both very interested in and disgusted with odors and also had fantasies of being bound and tortured and *prevented* from evacuating his bowels and bladder.

A middle-aged female patient was depressed and extremely obsessive. She had enormous difficulty in coming to any decision. The moment she did come to a decision she was immediately overcome with doubts and regret and would do her best to undo or revoke her decision. She was compulsive and obsessive in many areas. She had fantasies of certain kinds of torture, all relating to the problem of *not letting go.* One fantasy was that of being injected full of fluid by some torturer who would not permit her to let any of the contents go. She had to retain the fluid no matter how agonizing it was. Another fantasy was to imagine a pair of lovers who would excite themselves to an unbearable pitch, but would then separate and not permit themselves release. They would *never permit themselves to let go.* The retention of body contents is accomplished here in the fantasies, but *as though* imposed from without. This patient was unusually interested in odors and flatus. She believed that everybody had a secret odor and she would secretly pass flatus in public. In addition to her withholding both by fantasy and by indecision, she had another symptom, that of acquiring, and she would occasionally steal. This patient suffered from a psychotic depression, occasionally with retardation.

I now turn to another aspect of the symptomatology, that relating to time. I have already indicated some aspects of this element. The struggle over the control of the timing of the bowel movement may lead to certain pathological attitudes to time. Ferenczi (10) reported a case in which a "patient had curious attacks associated with a feeling of 'eternity,' during which she had to lie still, free from all excitation in an introverted state. This eternity

actually represented an indefinitely postponed bowel movement." We are familiar with depressives for whom time stands still or moves very slowly. These patients are invariably constipated and show mental retardation. Schilder (19) felt that the slowing of time was for the purpose of carrying out aggressions. Abraham (3) puts it in terms of displacement of anal interest onto time and notes the frequency with which obsessional patients "save time." Obsessives are in constant relation to time in their symptoms. They either daydream and pay no attention to time or they literally stop time or they resent time and time limits; sometimes they treat time as a commodity to be kept or given away.

An obsessional nonpsychotic patient had as his chief problem that of procrastination. He kept everyone waiting, his wife, his clients, and himself. As he approached a deadline he became enormously anxious, but it was nevertheless almost impossible for him to finish any one given piece of work. He was an attorney and when a decision favorable to a client of his would be handed down, he would delay indefinitely before notifying his client. If the decision was unfavorable, he would let him know at once. If he had free time, he would become restless, he could not tolerate time limits. He spent much time in daydreaming and in fantasy. He was very stubborn. He liked to do clean work and clean writing. He hated toilets, felt repelled by toilet odors, and delayed his bowel movements. Another patient communicated material in such a way that the analyst would not even notice the communication. Monotonous delivery was a way of telling and keeping a secret at the same time. This *not-noticed* quality led to a consideration of the patient's daydreams. The daydreams often served an intensely hostile, narcissistic purpose. He would daydream to spite his schoolteacher and to withdraw from unpleasant situations. In class he would appear as though he were paying attention, but actually he would be permitting himself to wander in pleasant reverie. If the teacher would in suspicion suddenly call on him, he would recite adequately. He would maintain a tiny bit of attention to the classroom proceedings.

One must not be misled by the content of daydreams; the content might be the least important aspect. The isolation and narcissistic withdrawal are the critical elements. Nose picking and

hair pulling often occur while daydreaming: narcissistic preoccupations go together. An interesting aspect of daydreams and obsessive reverie is the frequency with which they are forgotten. The patient succeeds in keeping his thoughts to himself; he has not let anything go. Other styles of thinking are related to daydreams, specifically rumination and circumstantiality. Circumstantiality is both sadistic and withholding.

Another patient had the frequent habit of having bowel movements ten minutes before the session was to take place. This had the effect of making him late for the appointments. Lateness was a chronic problem through a long analysis. When the timing of the bowel movements was interpreted as a resistance to free association, it resulted in the report of a dream at the subsequent session. The part of the dream which concerns us dealt with a private house at the end of a dirt road. His "private house" was his anus. By my interpretation I had demanded that he give me his associations when *I* wanted them, and not in the toilet in advance of the session. He responded as though I had been attempting to toilet-train him and he stated his anal defiance in the dream. The house on the dirt road was "private," i.e., none of my business.

There are connections between time, thoughts, and words. We may waste time, kill time, lose time. Time may move slowly or rapidly. Or, "I don't know where the time went." Time seems quite objectified. What do we do when we daydream? We isolate ourselves from objects and remain concerned only with our own thoughts which we keep secret. An obsessional patient, as a schoolboy, would have prolonged periods of daydreaming—especially when he should have been putting on his shoes in the morning prior to going to school.

Perhaps we might now review the connections which I have drawn between time and the stool. Words and thoughts are flatus and stool. Time limits are the command to defecate. The feeling of time slowing or stopping is the postponement of the bowel movement. Obsessive procrastination is the struggle against giving up the stool. Obsessive rumination is playing with the stool within the body. Free time is after the bowel movement, i.e., after the narcissistic defeat. Obsessively monotonous speech is a bowel movement without the assistance of the subject and without the sphinc-

ter action which segments the stool. Obsessive undoing is the return of the stool to the body. Coprophagia and smearing have the same meaning. Giving a train of thought in separate installments is a bowel movement in installments—spiteful—and misleading to the therapist.

Buxbaum (6) discusses hair pulling and hair eating in terms of the hair serving as an intermediate object. She reported two children, one of whom pulled and ate her own hair after touching her buttocks with it and a second patient who ate her own hair and also ate the dried mucus from her nose. Buxbaum sees this behavior as both an ambivalent relationship to one's own body as well as ambivalence to outside objects. She makes the interesting comment that she regards the hair pulling not only as an act of hatred but also as an act of love. The patient pulled her hair when she felt unloved. The patient expressed positive feelings by eating the hair. Eating destroys but also preserves. These children (aged six and three) used parts of their own body as intermediate objects. Although Buxbaum refers to these habits as "disgusting" and describes the touching of the buttocks, she does not discuss the anal aspects of this issue, a rather surprising omission.

A similar omission occurs in a report by Romm (17). She reports the case of a man who suffered the perversion of needing to cut his wife's hair and to shave his own body. His problem was discussed by Romm only in terms of the castration problem and the bisexuality. Romm gives a graphic description of her patient: he was slovenly, had compulsive habits, picked his nose and ate the secreta, scratched his scalp and face, picked off scabs and ate them. He smeared saliva and nasal secretion on his clothes. He was pathologically interested in the smell of flatus and feces. However, Romm omits discussion of this latter aspect of the problem.

Not all the workers in the field have neglected the relationship of the fetish to the stool. Payne (16) makes the point that the fetish may represent part objects, and in her reported case the fetish represented the *feces of the parents,* as the parts of the parents. The fetish is an external object and represents the desire of the patient to *have* an object. He is content with or capable of dealing only with fragments of objects. Her patient reported desire

to introject the parents. He had fantasies of eating the parents' feces and so obtaining control over them.

There are further reports in the literature in which the patients react to feces as part objects, but these deal with interest in *the feces of the parents.* The stool represents the parent in part-object fashion. In this situation the relationship to the stool is an object relationship—a fetishistic type of object relationship, but nevertheless an object relationship. The patients I described were concerned with *their own feces.* This issue refers to much more narcissistic needs of the subject and deals not only with coprophagia but also with the problem of soiling and other related derivatives of the reunion with the stool, including certain perversions.

Anal separation is closely connected with the child's narcissism and megalomania; unwise or premature intrusion in this area may have disastrous consequences. Various authors caution against too traumatic toilet training, emphasizing especially the renunciation of the infantile megalomania. Toilet training involves a double loss—loss of command as well as loss of the intimate tie to a body part. Karpman (13) suggests that feelings of inadequacy may be the permanent heritage of the destruction of this megalomania. The retention of the fecal mass had afforded both pleasure and power. Abraham (2), too, points to the omnipotence of the bowel function.

The narcissism of the transvestite equals that of the coprophagic. Saul (18) reports the case of a transvestite who would dress as a woman and then take himself out to dinner; he would then make love to himself. Dickes (8) makes the point that there are impaired object relations as well as pregenital problems in the fetishist. Autofellatio is related to all these syndromes. Hair pullers are notoriously narcissistic and have poor object relations. Spitz and Wolf (20) regard fecal play as a real object relationship, but others are not quite so definite that the stool is really an object. Abraham (4) takes the position that the relationship to the stool is the forerunner of object relations and that the close tie to the stool is the precursor of tenderness to objects. Bychowski (7), discussing the problem of autoerotic play with one's own feces, regards the stool as a pseudo object and the autoerotic play as a withdrawal

from dangerous reality. Anna Freud (11) described the case of a child who would soil and then use the stool as company when *lonesome*. This would occur during periods of depression in the mother of the child. She did not attempt to define the quality of the object relationship in this instance.

Fenichel (9) at first considered feces as object, but then withdrew a bit from that observation. To quote Fenichel, "The impulse to coprophagia which certainly has an erogenous source (representing an attempt to stimulate the erogenous zone of the mouth with the same pleasurable substance that previously stimulated the erogenous zone of the rectum) simultaneously represents an attempt to re-establish the threatened narcissistic equilibrium; that which has been eliminated must be reintrojected. A similar attempt at cutaneous reintrojection is represented by the impulse to smear." Bertram D. Lewin (15) also reported feces smearing as an attempt at cutaneous reintrojection of a lost object. To return to Fenichel, "They [the feces] represent a thing which first is one's own body but which is transformed into an external object, the model of anything that may be lost; and thus they especially represent 'possession,' that is, things that are external but *nevertheless have ego* quality." It seems to me that this definition of feces as model object nevertheless gives the stool special narcissistic value. Heimann (12) points to the narcissism of the anal stage and the lack of an object relationship to the stool. Arlow (5), on the other hand, in both personal and formal communications, held that the relationship to the stool is an object relationship, albeit a narcissistic one.

It would seem likely that there are two models for the evolution of object relations, one the separation from mother's breast, and the other would be the separation from the extruded stool. I have the impression that there has been no clear pairing of the mouth and anus as being involved in similar models and processes. Both of these models lead to the development of the sense of reality and recognition of objects, but there are certain vicissitudes and consequences which are *not* common to both.

We might begin by noting that the mouth is especially adapted to receiving while the anus is adapted to losing, and suggest that the mouth is the organ of optimism; the anus the organ

of pessimism. Both organs go through a process of separation, one from the breast and the other from the stool. The mouth, however, continues to receive throughout life, in eating, lovemaking, etc. The mouth experiences repeated consolations. We might regard these mouth experiences as repeated moments of restoration of the lost infantile narcissism. The anus, on the other hand, must forever go through the repetition of losing. Small wonder it is that while heaven is above and milky, hell is below and dark. Moods of depression are described as dark or black. The anus is the organ of loss, depression, and rage; whereas in the mouth there is repeatedly repair.

My impression would be that coprophagia and its displaced expressions represent *not* object relations or even transitional object relations, but rather narcissistic withdrawal and attempts to maintain the narcissism and megalomania of old (in the anal sphere). These actions are very closely tied to daydreaming, isolation, self-centeredness, and perversions, all of which have outstanding narcissistic characteristics.

The idea of the narcissistic union with the stool is also supported by Keiser (14), who, in a personal communication, described a male patient who would not bathe for long periods or clean his anus after defecation, and who smeared his semen over his own body to avoid a sense of body depletion. Saving his semen, his dirt, and his fecal soiling were all equated. To him it meant that he had not lost his feces and that his anus was not open.

If there is some degree of transitional relationship to the stool as object, it is not in the sense of Winnicott's (21) transitional object. This latter is an illusory fragment of a real external object, the mother. What I have been describing in coprophagia and related disorders is rather a transitional relationship to part of one's own body with the attempted illusion that it *has not been lost*. With Winnicott, the child has the illusion of control over mother. This is accomplished by means of an object. With the coprophagic there is the illusion that the stool has not really been lost—it is still part of the body, or at least immediately replaced within the body. This is a narcissistic position. At the center is the reunion with the stool. There is no need for external objects. This is not introjection. The coprophagic has a greater disturbance in

the sense of reality than the child with his piece of blanket or his teddy bear. Even the obsessive, who keeps his body and anus dirty, is engaged in a narcissistic union and reunion with his stool. The element of defiance of parental discipline is only part of the story. The dirt on his body is something he does not want to recognize as an external object: it is still part of his own body. This indicates a withdrawal from object relationship rather than a struggle with objects.

Summary

1. The clinical syndrome of coprophagia with nose picking and hair pulling and eating is described.

2. Its clinical relationship to obsessional neurosis and depression is noted.

3. The relationship to daydreaming and time disturbances is indicated.

4. The relationship to certain specific mechanisms such as undoing, rumination, and procrastination is indicated.

5. The narcissistic quality and impaired object relations of the syndrome are indicated, as well as the relationship to certain perversions.

6. The central factor of the attitude to the stool and the trauma of the narcissistic and megalomanic loss of control and body parts is indicated.

7. The attitude of the stool in the development of object relations is discussed.

8. A contrast is drawn between the transitional object of Winnicott and the attitude to the stool, which is part of the child, not part of the mother.

9. It is suggested that in coprophagia and its derivatives the stool is not an object, but is still a part of the child's body in its infantile and megalomanic sense.

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