Appetite and Emotional Disorder
[1936]

IN THE PSYCHO-ANALYTIC and other psychological literature I find it generally agreed that disturbances of appetite are common in psychiatric illnesses, but perhaps the full importance of eating is not recognized. It is rare, for instance, to meet the word 'greed' in psychological writings, and yet greed is a word with a very definite meaning, joining together the psychical and the physical, love and hate, what is acceptable and what is not acceptable to the ego. The only psycho-analytic discussion I know in which the word greed enters inherently into the theme is Love, Hate and Reparation by Melanie Klein and Joan Riviere (lectures 1936, published 1937).

A discussion is overdue on the relationship of appetite to greed. I should like to put forward the suggestion that greed is never met with in the human being, even in an infant, in undisguised form, and that greediness, when it appears as a symptom, is always a secondary phenomenon, implying anxiety. Greed means to me something so primitive that it could not appear in human behaviour except disguised and as part of a symptom complex.

Careful history-taking has had a profound effect on my outlook, for it has made clear to me the clinical continuity of appetite disorders as they present themselves in earliest infancy, in childhood, in adolescence and in adult life. For some years now I have been teaching that history-taking reveals the fact that there is no sharp dividing line between the following conditions: anorexia nervosa of adolescence, the inhibitions of feeding of childhood, the appetite disorders in childhood that are related to certain critical times, and the feeding inhibitions of infancy, even of earliest infancy. Examples of crises would be: birth of new baby, loss of first nurse, removal from first home, first feeding with the two parents, attempts to induce self-feeding, introduction of solids or even simply of thickened feeds, anxious reaction to breast-bitting.

1 Read before the Medical Section, British Psychological Society, 1936.
These cases occur in one big grouping; at the one end of the scale are the feeding difficulties of infants, and at the other end are melancholia, drug addiction, hypochondria, and suicide. In other words, in illnesses of all kinds as well as in health we find that eating may be affected.  

Through analysis of older children and of adults very clear insight is gained into the many ways in which appetite becomes involved in defence against anxiety and depression. It can only be inferred, then, that the psychology of the small child and of the infant is not so simple as it would at first seem to be, and that a quite complex mental structure may be allowed even to the newborn infant.

First in the appreciation of oral function there is the recognition of oral instinct. 'I want to suck, eat, bite. I enjoy sucking, eating, biting. I feel satisfied after sucking, eating, biting.'

Next comes oral fantasy. 'When hungry I think of food, when I eat I think of taking food in. I think of what I like to keep inside, and I think of what I want to be rid of and I think of getting rid of it.'

Third comes a more sophisticated linking up of this theme of oral fantasy with the 'inner world'. There is a tremendous elaboration of the two parts of the fantasy I have just briefly outlined, namely ideas of what happens inside oneself and, along with this, ideas of what is the state of the inside of the source of supply, namely the mother's body. 'I also think of what happens at the source of supply. When very hungry I think of robbing and even of destroying the source of supply and I then feel bad about what I have inside me and I think of means of getting it out of me, as quickly as possible and as completely as possible.'

This sort of oral fantasy can be deduced from observations on the infants and little children who play with an object, as I hope to show.

It is this limitless elaboration that constitutes an 'inner world'. The word 'inner' in this term applies primarily to the belly, and secondarily to the head and limbs and any part of the body. The individual tends to place the happenings of fantasy inside and to identify them with the things going on inside the body.

This inner world is normally a live world of movement and feelings. It may be kept inactive when feared and in illness it may get over-controlled, or some of its elements may take control over the individual.

This part of oral fantasy seems to me to be but little acknowledged as such, and if I do rather press for its recognition the reason is that I do all the time need to understand it as a paediatrician. No case of collywobbles in a child, of vomiting or of diarrhoea, or of anorexia or constipation can be fully explained without reference to the child's conscious and unconscious fantasies about the inside of the body.

Even if we want to confine our attentions to physical disease within the body we still have to say that no study of a child's reaction to a physical illness could be complete without reference to the child's fantasies about his inside. It must seem very funny to a child when his doctor obviously knows less about his inside than he knows himself. Most doctors prefer to keep to the simple idea of pain without fantasy content, but the fact remains that children will often give an account of their inner world, when asked about their inner discomforts. One child says that there is a war going on inside between Spaniards and English who fight with swords. Another recounts a fantasy of little people sitting round a table in his stomach, waiting for the food to be passed down. A little boy of four said he could hear little men knocking their plates about after he had eaten. Another said that there was a row of children sitting on a fence inside mother, and a birth occurs when father goes in and knocks one off with a crowbar.

Occasionally an artist who can paint an ordinary picture will give us a piece of his inner world in terms of guts. The result is terrible to most people; they see bits and pieces everywhere, from which a butcher's shop is a relief. One can admire such an artist's courage, even if one feels bothered by his flight from fantasy to anatomy.

The following incident seems to me to illustrate the way in which acknowledgement of fantasy about the world inside the belly is made through the exercise of a sense of humour.

Case 1. A mother brought her son to hospital and in trying to tell me that he had a malformation of the penis (hypospadias) she said: 'The doctor said he looked as if he had been circumcised before he was born, and I was that scared, I can tell you.' The boy had an exceptionally dark skin, and I was asking her to tell me whether this darkness had come on recently or whether it was natural to him. Evidently she had always been disturbed by this pigmentation. She parried; it was due to the summer holiday (which was obviously false) and so on. At last she said, 'Oh, I remember, he was

1 Mothers will often say that their infants who are inhibited in their desire for food will nevertheless crave for medicines. I have been told this more than once of infants under one year old, and very many times of older infants and young children.

2 At this time it was not usual to look for the cause of psychological illness in the infant. My view was therefore somewhat original, and was disturbing to those analysts who saw only castration anxiety and the Oedipus conflict. In my later papers I have devoted myself to a development of the theme of the infant whose emotional development can be healthy or distorted at any age, even before the time of birth. At the present time (1936) there is a general acceptance among psycho-analysis of the view that there is a psychology of the newborn infant.

Although I was all the time influenced by Melanie Klein, in this particular field I was simply following the lead given me by careful history-taking in innumerable cases.

1 I was thinking of certain surrealist pictures, in some of which crude anatomical features appeared.
born like that; the doctor said that he looked quite sunburnt.' So I said, 'Well, he seems to have had quite a time in there, one way and another.'

Fantasies of pregnancy cover crude fantasies about the true inside, and afford relief from fears about destructive elements, so much so that it is sometimes hard for a child to give them up. But the fact is that the womb is not the inside. Boys adopt this defence as commonly as girls do. Mother becomes pregnant and then the swelling goes down and beholds a nice little human being emerges. So the idea is adopted.

Case 2. A little boy was brought to hospital for a belly pain. I often get asked to see children who have pains that have not yet been localized. This boy had not yet decided where to have the pain, but it had something to do with his inside. Actually he himself had not yet decided even to have pain, but he had something. This something was to do with mother's having just had a baby. He believed he had a baby inside. It must be a boy baby. He did not want to lose the baby, would prefer to keep it inside. It had something to do with love of daddy.

This kind of nascent fantasy is easily obtainable, but I do not think the child gains much by the fact of one's having reached to it. And of course in certain cases it would actually be harmful for a child to have his or her inner secrets forced. But the material is lying around for anyone to gather. Here is another case in which I took the trouble to let a child tell me about her fantasies in regard to her body.

Case 3. My assistant asks for my advice about a girl of seven called Heather, who since two has habitually scratched her genitals, so that they are constantly inflamed and sore. Recently she has only scratched at school, but teachers have complained. Cystitis and thread-worm infestation have been shown to be absent and no other physical disease can be found. Could it be psychological?

I assure my friend that it could be and agree to see the child and her rather forbidding mother. I have only a few minutes to spare but I must at least make some sort of diagnosis. I find a healthy and nice-looking girl, plump in spite of poor appetite, not unhappy, not restless, rather thoughtful.

I find she is well looked after at home. She is an only child and the parents are aggressively respectable, so that Heather is not allowed out in the street, and very seldom has anyone in to play with her. However, at school Heather has her own friends, and one must look further than these details, important though they are, for the cause of the compulsive genital-scratching.

I ask the mother to go out of the room, and find Heather eager to tell me of bad dreams which she can keep away by keeping her eyes open. She can sleep with her eyes open, she declares. It is clear that she has not only anxiety dreams, but visual hallucinations, partly awful, and partly beautiful. Her happiness, she says, is to find enough niceness in the things she sees to balance the badness. The chief thing is that she sees brown things coming out of holes. She is eager to give details of these grotesque and bad shapes and weird animals. Also there is a fairy with a fantastic name: 'She's nice, all's well when she's there, very tall; her real name's Heather.' She seemed almost surprised to realize her own real existence, being more at home in the fairy world.

The genitals feel to her to be full of these brown grotesques and she has to be always scratching them out.

I venture a question. 'How do they get inside you?'

'Well,' she says, 'I take them in with my food. You see, I'm very fond of liver and sausages and that's why they're brown mostly.'

It is not much of a guess to say that in unconscious fantasy she had eaten good and bad people, and bits of people, and that according to the love and hate involved she has been enriched and burdened respectively with intensely sweet or terrifyingly grotesque objects in her inner world. The fairy world in day-dreaming was enjoyed at a price which is the acknowledgement of the badness which, as she felt it, had to be scratched out of her genitals.

Her symptom is in effect an acknowledgement of badness, and it enables her to keep in touch with the beauty of her fairy world.

Having illustrated my meaning of oral fantasy and the special elaboration of fantasy about insides, I give some ordinary case histories, so as to show how frequently in paediatric practice appetite becomes involved.

I need no reminder that the value of all my observation depends on my ability to know the action and limits of physical disease (infection, malnutrition, etc.). On my ability to be sure that I am allowing for physical disease depends my right to become involved on the psychological side. In this connection I suggest that the study of psychology has been obscured by our lack of control over physical disease, and by our ignorance about diet, so that it was formerly very much more difficult to observe psychological factors than it is today. Medical knowledge and practice have brought about new conditions, and already we know that in less than half of the cases attending a children's hospital out-patient clinic is there any physical illness at all. One can hardly fall now, therefore, to observe emotional disorders and developmental anomalies of personality.

Also psycho-analysis has appeared on the scene, with its willingness to
explore and evaluate the unconscious. So gradually we have come to the study of the psychology of the developing infant and child.

Illustrative Cases

When I come to choose cases I am in trouble. By choosing cases I seem to indicate that appetite disturbance in psychological disorder is worth reporting as such, whereas the point I want to stress is that appetite disturbance is extremely common. It must be quite rare to get a history of an ill child, or even of a normal one for that matter, that does not reveal feeding symptoms.

Of course there is in every medical out-patient session a fairly high percentage of cases in which the child is brought openly on account of under- or over-eating, or because of a wide range of appetite vagaries. We are realizing more and more that many of these children are physically sound, and that nevertheless they may be ill in feelings. There are also the various vomiting types, from the less common hysterical vomiting to the very common bilious attack, sometimes organized (with the help of the doctor's preconceived notions) into cyclical vomiting with periodic prostration. Then there are all degrees of fat intolerance, from the common phobia of the skin on milk to coeliac disease, and so on.

My object at this point is to draw attention to the details of feeding that are so often of interest in cases brought for any reason whatever: behaviour disorders, inhibitions of intellectual attainment, failures in training to accepted standards, common anxious restlessness, phobias, anxiety states, depression phases, etc.

Naturally it is impossible for me to give illustrations of all these types of cases. The three following descriptions of children show respectively symptomatic greed, a change-over from an inhibition to a compulsion, and inhibition of greed.

Case 4. First, I take a girl who is now in early puberty. She has an older sister. The difficulty is a character difficulty. From early times she has been unable to allow her older sister any friend. The two sisters get on very well together, but their relationship has been, and still more will be, spoiled by this compulsion on the part of the younger to rob the elder sister of every boy or girl or adult who comes to mean anything to her.

When the sister was six to eight years old this tendency of the little toddler was quite amusing to all concerned, but gradually a situation has arisen in which there is a serious threat to a partnership which cannot, nevertheless, be overthrown without some damage to both parties.

It is not surprising that the greedy girl's greediness is not only for people. She also over-eats, clearly as a defence against anxiety, and at times gets quite unhealthily fat. Any attempt to diet her produces restlessness and temperamental acerbity, which contrasts acutely with what one feels is the child's normal self.

The sister has a complementary tendency to be ascetic. She is depressive in type, which brings her into contrast again with her boisterous eager sister, and she has phases of lack of zest for food with a tendency to leave part of everything offered.

Case 5. The next is a brief description of the case of a boy who changed over from being inhibited to being greedy. Tom, aged fifteen, is threatened with expulsion from a public school on account of unsatisfactory character. He seems at first contact to be an exceptionally decent sort, with a poise and rhythm which are in his favour. His intelligence quotient has been given as 120, and he seems intelligent in conversation. He has a younger brother and sister.

Tom changed in character when he went to public school at thirteen years. At prep school he had been popular, and fairly honest and straightforward.

When he went to public school he became definitely a nuisance. Here are extracts from the Housemaster's reports: 'At first usually untidy and unwashed; destructive of furniture, etc. (cutting holes in chairs). Inattentive in school and unable to concentrate. In trouble with various masters, and punishment has had no effect on him. The Headmaster feels he has exhausted the punishments within his range.' (This headmaster is not one who easily resorts to punishments, but the boy clearly does not respond either to understanding or to punishment in the usual ways.)

Cutting a long story short, Tom suffers from character difficulties which have developed since he left the prep school. The parents report that his face has changed since then, from extra frank to uncertain and deceptive, and also they have been worried by the fact that he has had an orgy at home of damaging his own room and its furniture with a knife. This room he has always loved.

The point that is of interest here is that with this character change there has also been a change over from inhibition of greed to greediness. At the time of the character changes he started to fill out bodily, after always having been spare, having acquired a more than healthy appetite, with some compulsion to eat in excess.

This present appetite might pass as normal but it is in marked contrast to his attitude towards food, which had been constant from early infancy to the end of the prep school period. He had been uninterested in food throughout, and no one could ever bribe him with food.

To get to the start of this feeding difficulty one has to go back to a difficulty at the breast at three months, followed by six months of difficult feeding.
with secondary constipation. At nine months the baby weighed only
nine pounds; from this time on he did fairly well, but kept a small desire
for food and a small body. So we may say this boy’s illness started at three
months.

A nurse who came when he was three years old describes how she found
him being fed by spoonfuls by each member of the family in turn, this
being the only method by which he could be got to take enough.

How familiar one becomes, in paediatrics, with this sort of picture of an
infantile feeding difficulty, augury of troubles ahead!

The importance of this case, though it is all too briefly described, lies in the
fact that it shows how inhibition of appetite served the boy well for 10-12
years, in his defence against anxiety. By means of his symptoms he has man-
aged to be a more or less lovable and social being, for he can almost do with-
out food. Without a belief in his own and other people’s goodness, however,
he cannot develop a full life, at least he cannot live and remain sae.

I now wish to draw attention to the extremely early age at which a human
being can attempt to solve the problem of suspicion by becoming suspicious
of food. The earliest months of infancy are exceedingly difficult to under-
stand, but it is clear that at nine and ten months this mechanism (that is, using
doubt about food to hide doubt about love) can be employed in full degree.

In the next case description I give the details as they appeared in the con-
sultation. At the end of my description an appetite disorder appears.

Case 6. Simon is brought to me at the age of eight years. With him comes
his brother Bill, a plump, healthy lad, whose condition puts into sharp con-
trast Simon’s small wiry physique. These are the only two children of a pro-
fessional man and his wife, a couple who enjoy themselves and each other
and the family and their position, and who are naturally worried by the one
son’s lack of physical development and also his other symptoms: lack of
appetite, high-strung nervous state, nightmares, and other important char-
acteristics which the mother gradually recalls in the course of my patient
history-taking.

Simon is undoubtedly highly intelligent, and at school is doing moder-
ately well; but he could read for six months before the school knew he could
read, and in other ways he does not do himself justice in his intellectual
attainments.

His power of concentration is small. At school they say his brain is over-
active, that he has a thousand thoughts at one moment. While he is learning
to ride a bicycle he is watching an aeroplane. He does things first and thinks
after, if at all.

He is honest, generous, affectionate, sensitive. His parents disagree on
one thing, whether to try to make him become normal by stern measures,
or to humour him and play for time.

In doing things he is slow, but should he want to be quick, then he
may be especially quick, since his nature is very much an alert one. For
instance, dressing is always a slow business unless for some reason he wants
to be the fastest at dressing in a group. Tidying up is incredibly slow. His
mother, who does not employ maids, would prefer always to clear up his
messes herself, but often she feels she must insist on his clearing up his toys
to some extent. He will get out twenty books to find one, but the idea of
putting nineteen back does not occur to him. He says, ‘Why should I?’ and
really does not seem to know.

He adores and admires his brother, but can be ordinarily jealous of him
—for instance if Bill is ill Simon will want more and more assistance over
everything, until the brother is better again.

His play seems at first sight to be rather normal, but it is not very imagi-
native. That is to say, play is all of ships and sailors and building, and his
reading is of general knowledge, of plants and animals, and of wonderful
achievements. In other words, in both play and reading there can be seen
some flight from fantasy to reality, though to a fairly romantic reality. The
mother seems to me to be rather scared of fantasy herself.

Direct evidence of fear of fantasy is not lacking — he was heard to say
in his prayers ‘Please God do not let me have nightmares’. Nightmares are
chiefly of animals, and in the day he is particularly fond of animals.
Through analytic work we know that anxieties about animals are often
about the biting animals, and in fact animals are introduced as a relief, for
in the earliest corresponding anxiety there is only a threatening mouth.
Animals can be tamed, but not mouths.

The boy’s lack of fear must be regarded, I think, as a symptom, espe-
cially as it has led him into danger. He had three bad accidents, to each of
which he contributed something. When tiny he put a stick in his eye, a little
later he became involved in the mechanism of a sewing machine, and at
another time he fell badly and had a scalp wound stitched.

The remarkable thing about him is that he has known what he wants to
be since one year old. At least, at one year he developed an ambition to fly.
Without fear he would fly from a table at this age, endangering life and
limb. He has always felt he could fly like a bird, and before he could swim
he dived from a height into water without fear. There has been no attempt
on the parents’ part to make him brave, indeed they have regarded his
bravery as a symptom from the time when he was one year old, and bird-
minded.

Recently he has been up in an aeroplane, and so the urge to fly has
become harnessed to the ambition to be an airman, and he is only just able to wait. In this way his symptom has metamorphosed into a vocation. I think this is a most unstable form of 'normality'.

The parents have had constant anxiety in connection with Simon's lack of certain ordinary and necessary fears, and realise that this relative lack of reality-sense makes his life a precarious one.

Theoretically we know that anxiety is not absent in this case. We could put it too simply and say he is afraid to be afraid. But there are complex mechanisms involved, and a clear statement of the psychological state would take more space than I can give here. It would be possible to say that he lives inside his own inner world, where control is magical, and he no more tries to die by flying off the table than ordinary people do when they fly in their dreams.

It is interesting to note that although at first I was told that he never showed fear at all, the mother remembered later that when he was six weeks to two months old he was so terrified of the crackling of paper that it was impossible to unwrap a parcel in the room where he lay. He screamed and simply could not bear it. The mother felt at the time that the intensity of his fear was abnormal, so that every precaution was taken to prevent recurrences of this trauma.

While I am describing early infancy, I will mention that he showed early likes and dislikes of people, and that this characteristic has stayed with him as a marked feature. As an example, while he liked most of those round him he hated a maid who came into the house when he was four months old and kept this up till she left when he was sixteen months old. There was nothing especially noticeable about her to account for this, and he has always just liked or disliked people, without justification from the observer's point of view. His separation of the world into 'liked' and 'disliked' has always been more subjective than objective.

Simon is supposed to be a happy boy like his brother but one soon sees that this happiness has an unreal quality. He is restless and he needs constant distraction and change. His being highly strung is made more obvious by the placidity of his brother Bill's temperament.

He was found at two years to be left-handed. This was allowed.

Simon talks a lot. It can almost be said that he talks all the time if he is not reading. Nail-biting started recently, also compulsive grunting noises which he makes while he is reading, sitting, eating, and so on. While reading aloud at school he may make these noises, or alternatively, may compulsively lift his hands up to his face.

One characteristic can best be described by examples. You are angry with Simon and say 'Go to bed early', and he says: 'Good, I'm tired', and goes up as if gratified. Or you say 'No chocolates today', and he says: 'That's good because I feel sick this morning', and again you have failed to convey to him the idea of punishment.

Another characteristic: Bill is asked to help, and he very likely goes and does what you ask him to do. Simon, on the other hand, sees in advance what you want, asks if he may do whatever is needed, but after half a minute has lost sight of the whole thing and is found doing something else.

A year ago he would not go to school. This amounted to an inhibition. When forced to go he promptly vomited. I think that the vomiting originally represented an unconscious need to be rid of bad things, but soon he was making use of vomiting to gain control over his mother. He could make himself sick quite easily. Mother could only threaten bed and watch results. She eventually took him to school and let him be sick there, after which he became able to go to school.

I now come to the appetite disturbance. The boy's most constant symptom has been an absence of ordinary desire for food. It may be said he has never been greedy. There is no food he really likes, nothing you could give him for a treat. He eats chocolates but forgets them and would always prefer playing about to eating. His brother's appetite is normal for his age and often huge. 'On a picnic Bill will eat till all's blue but Simon will eat one sandwich and only start a second with coaxing.' His interests are elsewhere.

From infancy the brothers have been in contrast, and from the mother's point of view 'this is curious since our Simon had such a good start, and the now more placid, generally normal Bill had a bad start'. Which brings me to the mother's main statement, that Simon was 'absolutely normal' till weaned at nine months. (Of course we know he was not absolutely normal; there was the anxiety aroused by the crackling paper, for instance.) Simon enjoyed the breast and developed physically and mentally, giving no trouble at all till weaned. He did not mind when for two months food was added and the breast contact was lessened, but when the breast was quite withdrawn he changed and he never recovered. This is a history with which everyone dealing with children is familiar. Weaning is one of several critical times of early childhood.

So Simon's condition could be called an inhibition of greed, secondary to weaning trauma, which was secondary to earlier infantile anxiety of psychotic intensity and quality.

A few odd notes may be added: when Simon was eighteen months old he and his mother went to stay at his aunt's house, not a happy home, badly run and unpractical. His own home was a happy one in which routine was reverenced. He reacted very badly to having to wait for meals (his first experience of this) and he started to stutter and to bite his nails. The stuttering ceased when he went home; the nail-biting persisted but it has never been so bad as it was during this holiday.
D. W. WINNICOTT: COLLECTED PAPERS

It ought to be mentioned that Simon was incredibly dirty and wet until seventeen months. He refused to use the pot as soon as he could clearly refuse things, and when old enough he would do it on the floor. His mother made no attempt to bring about a change through special measures. One day he himself said, 'Ah, dirty boy!' and after that he never made a mess.

Until recently Simon has been a messy eater. This is a symptom that often surprises people by clearing up for special occasions. Simon recently went away for a few weeks, ate like an ordinary child, spilt not a crumb, and did not even spot his tie. But home again he was as messy as ever. When told he could not go to a party because of his exceptional messiness he said: 'Oh, but I won't do it if I go to a party', but he does not see how illogical this sort of thing is from his mother's point of view.

Mother said 'People are coming to lunch on Sunday and you can sit over at the other table.' So he said: 'I won't make a mess on Sunday', and he didn't. 'But he was damnable,' the mother added, 'and I was glad when he became messy again, and more sweet-natured.'

He has a rather dull friend whom he despises and dislikes. When asked what he liked about going over to this friend he said: 'I had a jolly good tea.' As if to say: 'He doesn't matter, one could eat him up without remorse.' This illustrates the way that the main symptom, inhibition of greed, which had actually led to stunting of his physical frame, is a part of the boy's relation to the people of his external and internal world, the two being for him not always clearly distinguished.

In Simon's case once again can be seen the great importance of the inhibition of greed, here dating from weaning; and just as at the start the attitude towards food is an attitude towards a person, the mother, so later on the feeding symptoms vary according to the child's relation to various people.

Adult Examples

Although I give cases of children the same point could be illustrated by adult cases. Here is an example:

Case 7. A man and woman consult me because of marital difficulties. Among a mass of important detail I find the following: 'A man hates babies as someone else may hate cats, and may feel bad when one comes into the room.' He said this himself. His reaction to his wife's pregnancy was to become very antagonistic and he only became fond of his child, a boy, after several years. He would have found it easier to tolerate a girl. In this connection, in his own family there was one other child, a brother born when he was two or three years old. There is much evidence that he never dealt satisfactorily with this birth of a brother, and that for him, his own child's birth was a repetition of this event. This carries his illness (paranoid depression) back to the toddler years.

In his present attitude towards food this man shows what he was like as an infant. He is a vegetarian and feels that he is forced to eat meat by a wife who does not understand. He constantly makes his wife force him to eat what he feels he does not want; and he becomes furious, of course, if she becomes indifferent, and lets him go without. It is at meal times that he behaves oddly. The maid has forgotten to put a chair for him and so he stands, and eats a meal standing, making 'a dignified protest', without sense of humour, and this in front of his little boy.

There is confirmation from his mother's early description of him that this attitude in regard to food now is a returning of his earliest attitude to feeding.

This man's inhibition of greed, which has persisted from infancy, often breaks down into symptomatic greedy acts, which distress him as well as his wife. For instance, his son had severe measles and was put on to a milk diet. Special milk was set aside for him. My patient, the child's father, used to go secretly and drink the special milk, replacing it with ordinary milk. When his son was an infant, suffering from malnutrition, he used to go secretly and water the milk. He is always liable to secrete the best cake, the best sweet, the best of anything connected with food or drink, it being compulsive for him to have the best.

Missing is the normal greediness which is acceptable to the self, and which gives such relief of instinct tension.

THE HOSPITAL OUT-PATIENT CLINIC

In the following six case descriptions I shall give each very briefly, including only what seems necessary to convey an impression of the morning's pageant.

First I want to give an account of what a baby does as he sits on his mother's lap with the corner of the table between them and me.

A child of one year behaves in the following way. He sees the spatula and soon puts his hand to it, but he probably withdraws interest once or twice, before actually taking it, all the while looking at my face and at his mother's to gauge our attitudes. Sooner or later he takes it and mouths it. He now enjoys possession of it and at the same time he kicks and shows eager bodily activity. He is not yet ready to have it taken away from him. Soon he drops the spatula on the floor; at first this may seem like a chance happening, but as it is restored to him he eventually repeats the mistake, and at last he throws it down and obviously intends that it shall drop. He looks

1 In my clinic there was always available a metal bowl full of sterilized spatulas, shiny silvered objects set at a right-angle bend.
at it, and often the noise of its contact with the floor becomes a new source of joy for him. He will like to throw it down repeatedly if I give him the chance. He now wants to get down to be with it on the floor.

It is, on the whole, true to say that deviations from this mean of behaviour indicate deviations from normal emotional development, and often it is possible to correlate such deviations with the rest of the clinical picture. There are, of course, age differences. Children of over one year tend to short-circuit the incorporation process (mouth the spatula) and to become more and more interested in what can be done with the spatula in play.

Case 8. A mother brings her extremely healthy-looking baby for me to see as a routine measure, three months after the first consultation. The baby, Philip, is now eleven months old, and today he pays me his fourth visit. His difficult phase is past and he is now quite well physically and emotionally.

No spatula is placed out, so he takes the bowl, but his mother prevents this. The point is that he reaches for something immediately, remembering past visits.

I place a spatula for him, and as he takes it his mother says: 'He'll make more noise this time than last', and she is right. Mothers often tell me correctly what the baby will do, showing, if any should doubt it, that our picture gained in the out-patient department is not unrelated to life. Of course the spatula goes to the mouth and soon he uses it for banging the table or the bowl. So to the bowl with many bangs. All the time he is looking at me, and I cannot fail to see that I am involved. In some way he is expressing his attitude to me. Other mothers and babies are sitting in the room behind the mother some yards away, and the mood of the whole room is determined by the baby's mood. A mother over the way says: 'He's the village blacksmith.' He is pleased at such success and adds to his play an element of showing off. So he puts the spatula towards my mouth in a very sweet way, and is pleased that I play the game and pretend to eat it, not really getting in contact with it; he understands perfectly if I only show him I am playing his game. He offers it also to his mother, and then with a magnanimous gesture turns round and gives it magically to the audience over the way. So he returns to the bowl and the bangs go on.

After a while he communicates in his own way with one of the babies the other side of the room, choosing him from about eight grown-ups and children there. Everyone is now in hilarious mood, the clinic is going very well.

His mother now lets him down and he takes the spatula on the floor. Playing with it and gradually edging over towards the other small person with whom he has just communicated by noises.

You noticed how he is interested not only in his own mouth, but also in mine and in his mother's, and I think he feels he has fed all the people in the room. This he has done with the spatula, but he could not have done so if he had not just felt he had incorporated it, in the way I have described.

This is what is sometimes called 'possessing a good internalized breast' or just 'having confidence in a relationship with the good breast, based on experience'.

The point that I wish to make here is this: when in physical fact the baby takes the spatula to himself and plays with it and drops it, at the same time, physically, he incorporates it, possesses it, and gets rid of the idea of it.

What he does with the spatula (or with anything else) between the taking and the dropping is a film-strip of the little bit of his inner world that is related to me and his mother at that time, and from this can be guessed a good deal about his inner world experiences at other times and in relation to other people and things.

In classification of a series of cases one can use a scale: at the normal end of the scale there is play, which is a simple and enjoyable dramatization of inner world life; at the abnormal end of the scale there is play which contains a denial of the inner world, the play being in that case always compulsive, excited, anxiety-driven, and more sense-exploiting than happy.

Case 9. The next boy, David, is eighteen months old, and his behaviour has a special characteristic.

His mother brings him over and sits him on her lap by the table and he soon goes for the spatula I place within his reach. His mother knows what he will do, for this is part of what is wrong with him. She says: 'He'll throw it on the floor.' He takes the spatula and quickly throws it on the floor. He repeats this with everything available. The first stage of timid approach and the second of mouthing and of live play are both absent. This is a symptom with which we are all familiar, but it is pathological in degree in this case, and the mother is right in bringing him because of it. She lets him follow the object by getting down and he takes it up, drops it, and smiles in an artificial attempt at reassurance, meanwhile screwing himself into a position in which his forearms are pressed into his groins. While he does this he looks hopefully round, but the other parents in the room are anxious to distract their children from the sight which to them means something to do with masturbation. The little boy finds himself in company in which no one gives him the reassurance he so desperately needs. So here we have him on the floor, throwing away the spatula, screwing himself up in his own peculiar fashion and smiling in a way that indicates a desperate attempt to deny misery and a sense of rejection. Note the way in which this child creates an abnormal environment for himself.
He would take enough food if his mother gave it to him, but at this time he became suspicious of any new food, even from her.

While in this phase, in spite of my technique of approach, he cried during my examination of him. He turned from a spatula placed on the table within his reach to his mother, and did not get back to it. When I offered him a paper spool he did not grasp it, and his mother said: 'I knew he wouldn't take anything, not in his present state.'

This clinical picture stayed the same for a month, but at this present visit his mother is able to report the start of a return to normal in all respects. He is now sleeping well and has become more trusting. With me he is quite happy and when I offer him a paper spool he actually snatches it from me, looks very pleased, and proceeds to investigate it as he is carried away from my presence.

It will have been noticed how in the period of suspicion the boy's attitude to food was disturbed, and also his attitude to the proffered paper spool. His mother said, 'I knew he wouldn't take anything from anyone, not in his present state.' But when he recovered he snatched my offering and enjoyed investigating it, as would any other child.

Case 11. Here is a boy of two who has a feeding inhibition. He has never been ordinarily greedy. He never took to solids or to feeding himself. Also he lies awake a lot. His play is unimaginative, lacking in richness and fantasy, and he mostly uses daddy's hammer and nails, or he digs in the garden. At eighteen months he had a phase of mud-eating out of which his mother felt she had to train him. If I wish to describe a little child, I must show you something of his oral interests. With me he adopts a fairly neutral relationship. His attitude to the spatula gives the clue to his feelings. My notes are as follows: He sees the spatula, leaves it alone; touches it 'by mistake', as it were, while performing some hand-play; at this he turns right away; suddenly he returns to it and quizzes me to gauge my attitude and quickly turns away and smacks his thighs; he looks at the object and makes a rather loud sucking noise with his mouth; during a long interval he is eating the top rim of his vest, and then in relation to something he sees about me he cuddles right into his mother's bosom; he wriggles; now he takes the spatula in his hand in a quick movement and in a moment has banged it on the table and left it lying down (previously it was on end). As if alarmed by his act he leaves it as if finally but later he again touches it in an anxious way.

Here then is a picture of conflict involving oral instinct and fantasy. There is wide scope for work along these simple lines, and I understand
from Anna Freud that she has been making this kind of observation for some years. She has pointed out to me that there is an interesting failure of direct correlation between inhibition of grasping and mouthing and actual feeding inhibition, and with this I am in full agreement. The relation is an indirect one; and one which because of its unexpected features must hold much in store that has theoretical importance.

Thus an infant may put things to his mouth at home alone with mother and yet not do so when he comes to my spatula; my presence brings into the situation a link with the infant's relation to father which is perhaps at the time of the consultation in a difficult phase. This phase may be marked by symptoms such as vomiting or constipation, or some other dysfunction serious enough to cause the child to be brought to hospital.

The entry of father into the arena is illustrated by the following incident:

Case 12. A boy of fourteen months was being fed for the first time by daddy, who gave him fish. The mother reacted to this neurotically, feeling jealous for the moment, and said to her husband: 'Don't give him fish, it will make him ill.' That evening the child vomited, and following this had an interesting phobia which lasted for a few weeks. He developed a dislike of fish, and also of eggs and bananas.

By way of contrast see what the next boy does when he comes to see me.

Case 13. Lawrence is a first and only child and is two years and nine months old. He looks healthy. He had the breast for six months, then was weaned all in a day, but did well on milk from the bottle. He got easily on to solids and self-feeding, and he has always been nice and greedy. He has no feeding inhibition and so is plump and well-looking.

Lawrence on his mother's knee gets somehow on top of us and rather dominates the triangular relationship of the consultation, talking all the time in a loud voice, with a speech hesitation as part of the technique of domination. He reaches down for the spatula, takes it and makes it his own, then puts it in a bowl that is near and which contains many spatulas, pushes the bowl away and says 'Ta'; I put out a spatula on the table again and his interest quickly returns and he eagerly takes all out of the bowl and declares: 'I'm playing trains.' (His mother says this is rather like what goes on during the waking period during the night.) He now makes a procession of spatulas in pairs, makes what he calls a bridge, rearranges them in all sorts of different ways. The trains move, meet, join, separate, pass under tunnels, over bridges, and occasionally collide. The fantasy relates to the primal scene. It will be agreed that the details would have vital importance if one

were trying to understand the anxiety which disturbs the child's sleep, makes him stutter, and colours his play. He enjoys himself very much, and at home he can always be left to play by himself. I touch a spatula and he says: 'Don't touch, please', indicating the acute need for personal control of what instantly might become an end-of-the-world disaster. He must dominate to maintain control.

Here is no inhibition of appetite, but special anxieties have to be dealt with, anxieties about the relationship between the parents interpreted in terms of the boy's fantasy.

Lawrence's play with the spatulas reveals the quality of his fantasies. It is these same anxieties that are dealt with at the source by the inhibitions of greed that have appeared in so many of my other case descriptions. Inhibition means poverty of instinctual experience, poverty of inner world development, and consequent relative lack of normal anxiety about inner objects and relationships1.

SUMMARY

In the histories of all types of psychiatric case, there may be found appetite disorders, and these disorders may be clearly interwoven with the other symptoms.

Direct clinical contact with infants gives rich opportunity for observation and therapy, and for the application of principles learned through analysis of children and adults.

The theory of psychiatric illness must be modified to allow for the fact that in many cases the history of an abnormality reaches back to the first months or even the first weeks.

1 For further discussion of this type of observation see Chapter IV.