A REVIEW OF FREUD'S EARLY REMARKS ON ADDICTION: FROM AN IDEAL TO MASTURBATION

Rik Loose

'...why isn't everyone a drinker?'
de Mijolla and Shentoub

Introduction

It is a remarkable fact that there is no real substantial psychoanalytic theory of addiction, especially given that Freud had clinical experience of working with addicts.[1] This fact is even more remarkable when you know that one of Freud's first attempts to cure someone was his clinical intervention with his friend and colleague, Ernst von Fleischl-Marxov. Freud had hoped that cocaine could help his friend to get rid of an addiction to morphine. This attempt failed and eventually von Fleischl-Marxov died from a cocaine addiction.[2] Surely these clinical

---

[1] In Peter Gay's biography of Freud we can read the following: 'From 1912 on, Freud analysed Jones' attractive mistress Loe Kann, a morphine addict, whom everyone, including Freud, referred to as Jones' wife. Setting aside the sacred rule of confidentiality, he reported to Jones about her progress on the couch and the decreasing doses of morphine she was learning to live with'. P. Gay, *Freud: A life for Our Time*, London, Macmillan, 1988, pp.186-187. Also the famous analyst Ruth Mack Brunswick was addicted to morphine and a whole series of other drugs. Freud had understood that her addiction should be treated. She was in analysis with him, with interruptions, from 1922 to 1938. She worked as an analyst for most of her life and was very well respected by Freud and other analysts. Eventually she moved to America where she died in 1946 from medical complications as the result of an accidental fall which happened whilst she was under the influence of a combination of drugs.

[2] Freud's associate, von Fleischl-Marxov had become addicted to morphine which he used to lessen the chronic pain of an infection in his thumb. In this period Freud had become extremely interested in the 'magical' properties of cocaine. His desire to help his friend out of his agony, in combination with his enthusiasm for cocaine, led Freud, who assisted

encounters must have aroused Freud's interest in the problem of addiction and provoked questions regarding its metapsychology? Freud had a curious mind and his theory and metapsychology was always developed on the basis of his clinical work with patients. There are numerous references to addiction in his writings, ranging from his pre-analytical period to the end of his life, which are interesting and important but it is nonetheless strange that he never wrote an article dealing exclusively with addiction. Despite the many references, we can still speak of a relative silence in Freud's work with regards to this clinical problem. Freud has developed elaborate theories on neurosis, perversion and psychosis. Why is there no such elaborate theory on addiction in his work? Are there any deep-rooted psychological motives in Freud that contributed to this neglect? These questions have been taken up by some authors and we do not propose to deal with them here.[3] It is well known that Freud's

---

Breuer in the treatment of von Fleischl-Marxov, to giving him the drug thinking that it could be a harmless substitute for morphine. Unfortunately von Fleischl-Marxov developed an addiction to cocaine and he died in miserable circumstances. Apparently he subcutaneously injected the cocaine which resulted in 'undesirable side effects'. Peter Gay writes in a footnote to his biography of Freud that 'this is a complicated issue: Fleischl-Marxov injected himself with cocaine, and Freud did not at the time object to this procedure. Later Freud turned away from it, and denied that he had ever advocated it.' P. Gay, *Freud: A Time for Our Life*, o.c. p.45.

[3] In an article from 1995 Ali Magoudi argues that factors and events which contributed to Freud's cocaine episode, as Jones called it, resulted in a theoretical position which led to a tendency in Freud and psychoanalysts after him, to exclude addicts from psychoanalytic treatment. Magoudi highlights the blind spots in Freud's self analysis and theory in order to show how they functioned as obstacles to analysis of addicts and addictions. A. Magoudi, *Freud: de la cocaine au complexe d'Oedipe; Cliniques mediterranees*, nr 47-48, *Cliniques des toxicomanes*, Aix-en-Provence, Centre National du Livre et L'Universite de Provence, 1995, pp. 107-119. See further Peter Gay: 'We know that he admitted being addicted to cigars (...) Plainly there were depths to his mind that his self analysis had never reached, conflicts it had never been able to resolve. Freud's inability to give up smoking vividly underscores the truth in his observation of an all-too-human disposition he called knowing-and-not-knowing, a state of rational apprehension that does not result in appropriate action,' P.Gay, *Freud: A Life for Our Time*, o.c. p. 427. See also a section called *L'episode de la cocaine (1884-1885) et le probleme de la <toxicomanie> de Freud* in Didier Anzieu's book on Freud's self-analysis. D. Anzieu, *L'Auto-Analyse de Freud et la Decouverte*

relationship to drugs was ambiguous. When Freud came across cocaine in 1884 he was immediately fascinated with it, particularly its therapeutic properties and he used it himself for a period of about ten years. He wasn't really interested in alcohol and only occasionally drank some wine. Addiction problems in his practice and social environment irritated him. He was hopelessly addicted to smoking and nicotine. He smoked about twenty cigars a day. He needed cigars to work and lack of nicotine plunged him into a bad mood. When he was diagnosed as having cancer of the mouth he was informed that his smoking habit would kill him and on several occasions he was strongly advised by his physicians to stop smoking but he was unable to stop despite this medical advice.[4] From Freud's biographer Ernest Jones we know that for a long time Freud refused to take analgesics against the excruciating pain produced by the cancerous growth in his mouth. He likened taking drugs to the embracement of death. Freud's personal and professional ambiguities toward addiction perhaps contributed to the fact that there is no proper

---

de la Psychanalyse, Tome 1, Paris, P.U.F. 1975, pp. 71-78. There we can read among other things the following remarks (our translation): 'Whilst Freud elaborated bit by bit the psychoanalytic comprehension of most of the psychopathological manifestations, toxicomania remained an unexplored terrain for him, sign of a 'resistance' which is locked into a personal flaw' (P. 75). 'One encounters in fact in Freud certain characteristics which H. Rosenfeld (1960) showed in addicts: idealisation of the breast with which the subject proves the need to feel united or identified (Freud became partially conscious of this), the search for a means of artificially producing the hallucination of that ideal breast, the return of the good reconstituting drug as bad harmful substance (Freud came close to the recognition of this process with the discovery of ambivalence.), the disavowal of frustration and persecutary anxiety (Freud was not conscious of this anxiety nor of his defence against it), the identification with a sick object or death (here, in this case, grandfather Schlomo and then the younger brother Julius) (P. 78).

[4] Gay writes: 'Still, from 1923 on, Freud repeatedly developed benign or precancerous leukoplakias, which had to be treated or excised. Pichler was skilful and kind, but the thirty or more operations he performed - some not so minor - to say nothing of the scores of fittings, cleanings, and refittings of Freud's prothesis, were invasive and irksome procedures. Often they hurt him very much. The pleasure that continued smoking gave Freud, or, rather, his incurable need for it, must have been irresistible. After all, every cigar was another irritant, a little step toward another painful intervention.' P. Gay, *Ibid.* pp. 426-427.

theoretical development in relation to addiction in his work. One can therefore not depend on a coherent theoretical foundation in Freud in order to construct a psychoanalytic theory and clinic of addiction. Nevertheless an exploration of remarks on and references to addiction throughout Freud's work show that there is a lot of material to work with and on which to reflect. For this paper we propose to concentrate on his pre-analytical period in order to show that this was a very interesting period of Freud's work, especially in relation to addiction. We will not include his papers on cocaine here as, in our opinion, they are so central to the development of his work and important for an understanding of a psychoanalytic approach to addiction that they warrant a separate exploration.

Despite the lack of a substantial psychoanalytic theory on addiction an enormous amount of articles and books have been written about addiction from a psychoanalytic perspective. Excellent surveys and reviews of the literature have been written by Crowley (1939), Rosenfeld (1964), Yorke (1970), de Mijolla and Shentoub (1973), Limentani (1986) and Magoudi (1986).[5] This paper is to some degree based on the chapter by de Mijolla and Shentoub which deals with Freud's pre-analytical period. This work was chosen for its detailed description, its clarity and above all its wide range of references.

Freud's *Cocaine Papers* and remarks on addiction from his pre-analytical period already show an indication of the problem with the questions of diagnosis. What is addiction? What are the differences between normal and abnormal usage of drugs? Are there different kinds

---

[5] R. M. Crowley, Psychoanalytic literature on drug addiction and alcoholism, *Psychoanalytic Review*, 26, pp. 39-54. H. A. Rosenfeld (1964), '*The Psychopathology of Drug Addiction and Alcoholism: a Critical Review of the Psycho-Analytic Literature*' in *Psychotic states*, London, Hogarth Press, pp. 217-252, 1965. C. Yorke, '*A Critical Review of Some Psychoanalytical Literature on Drug Addiction*' in *Brit. J. Med. Psychol.*, 1970, 43, pp. 141-159. A. De Mijolla et S. Shentoub, *Pour une Psychanalyse de l'Alcoholisme*, Paris, pb Payot, 1973, pp. 15-100. A. Limentani, '*On the Psychodynamics of Drug Dependence*' in *Between Freud and Klein*, London, Free Association Books, 1986, pp. 48-65. A. Magoudi, '*Revue de la litterature psychanalytique sur les toxicomanies*' in *Approche Psychanalytique des Toxicomanes* (eds. C. Ferbos et A. Magoudi), Paris, Presse Universitaires de France, 1986, pp. 7-43.

of addictions and on what are these differences based? Should a diagnosis be based on different drugs and their effects? It is very difficult to define what precisely a drug is. A common definition of a drug is of a substance which when incorporated, is capable of producing alterations of the mind and the body. This definition makes sense at first, but on reflection it has no theoretical or even explanatory value. A lot of things that can be incorporated can be a drug or act like one. It is sometimes difficult to distinguish between what is a drug, a poison or a food. Drugs (including alcohol) taken in large amounts can become poisons, but in limited amounts they can function as remedies. If it is difficult to define what a drug is, then it is even more difficult to define what constitutes an addiction to drugs. A definition of addiction should be able to distinguish between normal use and abnormal abuse. These difficulties are compounded by the facts that the same drugs and similar quantities of drugs do not affect people in the same way. These different effects of drugs are more than likely related to psychological features of people and there is no doubt an extremely complex cause and effect dynamic between the former and the latter. If drugs affect people in different ways, then to distinguish between addictions on the basis of the kind of drug used might not be at all valid, unless a clear and unambiguous relationship exists between certain psychological features and particular sought after drug effects. Demonstrating the existence of such a relationship has proven to be extremely difficult. We certainly will not be able to answer all of these questions, but we would hope at least to be able to show that there is the foundation in Freud's pre-analytical period for the formulation of an answer to them.

From an ideal material object to the disappointment of fantasy

In 1888, the year after Freud wrote his last paper on cocaine, he published an article called *Hysteria*. He writes:

> As factors which produce outbreaks of acute hysterical illness may be adduced: trauma, intoxication (lead, alcohol),

> grief, emotion, exhausting illness - anything, in short, which is able to exercise a powerful effect of a detrimental kind.[6]

Alcohol and other intoxicants are here considered by Freud to be potentially dangerous substances or 'foreign agents' which can harm the psyche of the subject. Drugs are only one of a number of external factors which can cause hysteria. Five pages later he writes in the same article:

> To begin with, internal medication is to be disrecommended here and narcotic drugs are to be warned against. To prescribe a narcotic drug in an acute hysteria in nothing less than a serious technical mistake.[7]

Four years previously Freud thought he had found a narcotic drug which could function as an 'universal panacea' against human suffering. His investigations in relation to the drug cocaine led him to the conclusion that such a panacea is an illusion. Here he warns against using any kind of drug as a cure for hysteria. Nothing in this article refers directly to addiction. In a text from 1890 called *Psychical (or mental) Treatment* Freud deals with the question of hypnotic treatment. He writes that hypnosis should not be employed as a last resort measure, but can be employed to all nervous diseases and morbid habits such as alcoholism, morphine addiction and sexual aberrations.[8] In his text *Hypnosis* from 1891, Freud writes that hypnosis should only be used for ...

> ... purely functional, nervous disorders, for ailments of psychical origin and for toxic as well as other addictions and that in general it should be avoided for symptoms with an organic cause.[9]

---

[6] S. Freud. *Hysteria* (1888*b*), S.E., vol. I, London, The Hogarth Press, p. 50.
[7] ibid., p.55.
[8] S. Freud. *Psychical (or Mental) Treatment* (1905*a*), S.E., vol. VII, p. 299.
[9] S. Freud. *Hypnosis* (1891*d*), S.E., vol. I, p.106.

This is interesting as it seems to suggest that for Freud the addictions belong to those symptoms which do not have an organic cause. In a letter to Fliess from 1895 on Paranoia and known as draft H, Freud writes the following:

> The alcoholic will never admit to himself that he has become impotent through drink. However much alcohol he can tolerate, he cannot tolerate this insight. So his wife is to blame - delusions of jealousy and so on.[10]

Here we see a first association between alcoholism and sexuality in Freud's thinking. Another interesting aspect of this brief passage is the mechanism of denial in the alcoholic ('my sexual problem has nothing to do with drink.') and its associated mechanism of not taking responsibility by blaming others ('my sexual problem has nothing to do with me; my wife is to blame.'). It is important to note that Freud here refers to alcoholism in the context of paranoia. He will come back to the delusion of jealousy in the alcoholic in his text on Schreber. In a letter to Fliess from 1896, draft K, Freud refers to drinking (dipsomania) as a secondary symptom which can arise if the compulsions of obsessional neurosis are transferred to motor impulses against the obsession.[11] This remark is not unimportant as drinking is considered here by Freud as a (secondary) symptom related to obsessional neurosis. It is interesting that according to Freud this can only happen if something of the ideational aspect of the obsessional neurosis is translated into a motor impulse. He seems to suggest that these motor impulses are ritual actions, protective behaviours, brooding and so on. In other words drinking is something other than purely ideational, or as we could say drinking is not a symbolically structured formation of the unconscious. In *Further Remarks on the Neuro-Psychoses of Defence* from 1896, Freud considers dipsomania to be a numbing of the mind as a protective measure against obsessional

[10] S. Freud. *Draft H. Paranoia* (1895), *The complete letters of Sigmund Freud to Wilhelm Fliess*, (tranl. and ed. J.F. Masson), Cambridge, Harvard University Press, 1985, p.110.
[11] S. Freud. *Draft K. The Neuroses of Defence* (1896), op.cit., p. 166.

affects. Here again he places drinking amongst the secondary symptoms in obsessional neurosis where it functions as an anaesthetic.[12] In a letter to Fliess from 11 January 1897, Freud refers to a case of dipsomania about which he says that 'dipsomania arises through the intensification or, better, substitution of the one impulse for the associated sexual one'.[13] He also writes there that the same idea applies to the gambling mania of another patient. This is the first time Freud suggests that addictions like toxicomania or gambling can be substitutions of repressed sexual impulses. It is only thirty one years later in his paper on Dostoyevsky that Freud will come back to his idea of gambling as a substitute satisfaction for unsatisfied sexual impulses. In this paper he will link the addiction to gambling to masturbation. This is not the first time that Freud establishes a connection between addiction and masturbation. The first time Freud writes about masturbation in the context of addicition is towards the end of 1897, a year in which he made some of the most important discoveries in psychoanalysis on foot of his self-analysis, such as unconscious fantasies as falsification of the truth.

Important discoveries

In order to illustrate the importance of this crucial period in Freud's thinking it might be helpful to provide this year with a brief historical context.[14] During his 'cocaine period' (1884-1887) Freud had become interested in hysteria. He greatly admired the famous physician and expert on hysteria, Charcot, and visited him in Paris in 1885. In 1893, Freud breaks away from Charcot's thinking. In that year he writes an article called: *Some Points for a Comparative Study of Organic and Hysterical*

---

[12] S. Freud. *Further Remarks on the Neuro-psychoses of Defence* (1896*b*), S.E., vol. III, p.173.
[13] S. Freud. *The Complete Letters of Sigmund Freud to Wilhelm Fliess*, op.cit., p.222.
[14] Paul Verhaeghe's book, *Does the Woman Exist?*, has been of great help as a guide in our exploration of this brief historical context. P. Verhaeghe, *Does the Woman exist?* (translated by Marc Dury), London, Rebus Press, 1997, pp. 10-29.

Motor Paralysis.[15] In this article, Freud came to the conclusions that hysterical paralyses are not the same as organically caused paralyses and that hysterical symptoms of paralyses do not follow the laws of anatomy. In that same year, Freud and Breuer wrote their *Preliminary Communication* as an introduction to what later would become their famous *Studies on Hysteria*.[16] This is the moment the trauma theory is born. Hysterics have experienced some traumatic events and the representations of these events have a pathological effect because they cannot be abreacted. What cannot be abreacted? The affect or energy that is contained within these representations. Why can this not be abreacted? Because there is a 'splitting of consciousness', a dissociation between the group which forms the pathological representations of the traumatic events and the rest of the psyche which defends itself against these representations. The result of this split is that the affect or energy cannot be worn-away or abreacted via the ego or what perhaps should be called here the rest of the 'normal' conscious associations. What is this affect or energy? It is a quantity of something and Freud defines it, in 1894, in what is known as the Q-hypothesis:

> I refer to the concept that in mental functions something is to be distinguished - a quota of affect or sum of excitation - which possesses all the characteristics of a quantity (though we have no means of measuring it), which is capable of increase, diminution, displacement and abreaction, and which is spread over the memory-traces of ideas somewhat as an electric charge is spread over the surface of a body.[17]

---

[15] S. Freud. *Some Points for a Comparative Study of Organic and Hysterical Motor Paralyses* (1893c), S.E., vol. I, pp. 160-172.

[16] S. Freud. *On the Psychical Mechanism of Hysterical Phenomena: Preliminary Communication* (1893a), S.E., vol. II, pp. 3-17.

[17] S. Freud. *The Neuro-Psychoses of Defence. An Attempt at a Psychological Theory of Acquired Hysteria, of many Phobias and Obsessions and of certain Hallucinatory Psychoses* (1894a), S.E., vol. III, p. 60.

Freud's concept of quantity here is important. This quantity is something that cannot be measured but it can be changed and distributed. It is something that can be related to ideas or representations. It is clearly something that, according to Freud, can be harmful when it exists in isolated form or when it accumulates. Freud's psychotherapy of hysteria is an attempt to set this energy or quantity free from the clutches of the isolated/repressed group of representations by establishing a link between this group and the rest of the psyche and by allowing this energy to be worn-away via associations. Freud's idea of how this quantity functions is based on the constancy-principle from nineteenth century energetics. This will form a framework for much of his thinking (at least till 1920) and it forms the justification for his concept of the pleasure-principle, which, in simplified form, says that the accumulation of energy causes pain and its reduction leads to pleasure. Freud was confronted with the problem of quantity for the first time in his work on cocaine, where he tried to understand the peculiar relationship between the effect of cocaine and a quantity of energy contained within the body.

In 1895, Freud's Q-hypothesis helps him to to establish the beginnings of a differential diagnosis. In an article on anxiety neurosis he explores the relationship between anxiety and sexuality in terms of the dynamic between the psyche, the soma and quantities of energy.[18] Normally a quantity of energy which originates from the soma reaches a certain treshold of intensity with the result that it can be 'picked up' and processed by the psyche in such a way that it is properly abreacted. This process can go wrong in three different ways which will lead to three different pathologies: 1) There is a conflict in the psyche with the result that the energy, after having been processed, cannot be adequately abreacted and is therefore sent back to the soma where it leads to conversion symptoms; 2) there is a 'psychical insufficiency' through which accumulated somatic energy cannot be psychically processed; it remains, therefore, somatic and subsequently becomes harmful; 3) there is an

---

[18] S. Freud. *On the Grounds for Detaching a Particular Syndrome from Neurasthenia under the Description 'Anxiety Neurosis'* (1895b), S.E., vol. III, pp. 90-115.

'inadequate disburdening' of the somatic impulse, through for instance masturbation, with the result that a proper abreaction of the energy has become impossible and again becomes harmful. The first possibility indicates the mechanism at work in the psychoneuroses, whilst the second and third possibilities refer to anxiety neurosis and neurasthenia respectively, which belong to the category of the actual neuroses. This third possibility in particular is interesting for us here because Freud, as we said, would establish a connection between masturbation and addiction for the first time towards the end of 1897. But before we continue this exploration of Freud's references to addiction with this comment about masturbation in relation to addiction, we need to complete our exploration of the historical context of that crucial year in Freud's pre-analytical period.

We can infer from what Freud writes about quantity of energy in his article on anxiety neurosis that this quantity exists in somatic form and in a psychic form. The latter is the result of a psychic processing of the somatic form and is called sexual libido. The originally somatic or material form of energy is turned into a psychic or non-material kind of energy. Libido is the result of the transformation of somatic energy into a form of psychic excitation which becomes attached to psychosexual representations. Freud subsequently discovers that this quantum of psychic energy can be displaced over these representations. Displacement will later become one of the mechanisms of the primary process of the unconscious. But before this Freud was beginning to realise that this displacement of energy often concerns a wish or a psychosexual desire about which hysterics don't want to know anything and against which they vigorously defend themselves with symptoms. Paul Verhaeghe considers this discovery of Freud to be the true point of departure for psychoanalysis. He writes:

> From that point on, hysteria was no longer determined by some mysterious trauma, but by an inarticulable desire that kept on being displaced. On 27 October 1897, Freud generalised this point and made it the most fundamental

characteristic of hysteria: 'Longing is the main character-trait of hysteria, just as a current anaesthesia (even though only potential) is its main symptom.'[19]

Here we find an important argument for considering 1897 as a crucial year for Freud. In order to be able to put this argument into its proper context we will need to go back a couple of years. In *Studies on Hysteria* (1895) Freud argues that certain psychological experiences cannot be adequately abreacted, mainly because the patient represses certain painful ideas. The result of this repression is that this group of ideas is cut-off from the rest of the psyche and abreaction of the painful affect or energy via the rest of the psyche has become impossible. This strangulated affect becomes pathological. The unconscious group of ideas forms, as it were, a disturbing 'foreign body' within the psyche against which the patients need to defend themselves and which becomes the object of therapeutic effort. Is there no connection at all between this repressed group of ideas and the rest of the psyche? There are connections. Patients suffer symptoms and these symptoms are determined by this unconscious group of ideas or representations. Freud says that an unconscious representation is wrongly related to a conscious representation and he calls this displacement a 'false connection'.[20] In other words, symptoms are false connections between unconscious and conscious representations. The patient has no knowledge of this connection because of the displacement that has taken place. Freud mentions another connection between the unconscious and the rest of the psyche. He writes: 'The psychical material in such cases of hysteria presents itself as a structure in several dimensions which is stratified in at least three different ways'.[21] This is how Freud begins his discussion of the threefold order arrangement of mnemic material in hysteria.[22] There is a traumatic nucleus in which 'the pathogenic idea has found its purest manifestation'. Around this nucleus

---

[19] P. Verhaeghe, op.cit., pp. 15-16.
[20] S. Freud. *Studies on Hysteria* (1895d), S.E.., vol. II, p. 67, footnote.
[21] ibid., p. 288.
[22] ibid., pp. 288-289.

we find the different layers of mnemic material. The first layer is of a chronological order. The most recent memories lead to earlier ones and eventually the train of associations will end up with the most traumatic ones with which the series began. Similar memories constitute themes and these themes form a second kind of arrangement; they are concentrically arranged around the pathological nucleus. Each stratum is characterised by a similar kind of resistance against penetration of the traumatic nucleus and the closer you get to it, the higher the resistance. Freud indicates that the third kind of arrangement is the most important one but also the most problematic one to comprehend. It is an arrangement according to thought-content and the connections are made by logical links which take irregular and twisting paths to the nucleus and back to the surface. He writes:

> It contains nodal points at which two or more threads meet and thereafter proceed as one; and as a rule several threads which run independently, or which are connected at various points by side-paths, debouch into the nucleus. To put this in other words, it is very remarkable how often a symptom is determined in several ways, is 'overdetermined'.[23]

What Freud's discussion of hysteria shows here is that the unconscious and symptoms are structured and that this structure is situated in relation to a point which remains outside it or, rather, is excluded from within it. This nucleus is the point to where all threads of associations ultimately lead, but it is also the point where they cease to exist. As if nothing can be said anymore beyond this border around the nucleus. In *The Interpretation of Dreams* Freud calls this point 'the navel of the dream'. It is the point where all associations in relation to the dream elements come to a halt. Here language has no say. It is something at the core of our being which is excluded from the Symbolic and it is what Lacan called the Real which he conceptualised as that which cannot be grasped by the signifier.

---

[23] ibid., p. 289.

Freud's hope was to find a way of trying to get his patients to articulate something of this nucleus. He wanted his patients to penetrate this point in order to wear away, via chains of associations, the strangulated and therefore disturbing 'quantity of energy' or affect imprisoned in this nucleus. This hope was not crushed despite his therapeutic failures. Freud's patients did not seem to want to give up their traumatic memories and when they did appear to have articulated some of the original trauma, they began to produce other disturbing memories. In other words, the cathartic method with its ideal of a complete and final solution did not work and Freud finds himself confronted with a constant displacement of traumas, affects and memories. This is not to say that abreaction as a phenomenon does not exist. It is in fact used by modern therapeutic interventions, such as scream-therapy, gestalt-therapy and even some drug-based therapies, as their *raison d'etre* and therapeutic aim.

The therapeutic failures which resulted from the cathartic method did not change Freud's hope for a complete therapeutic solution to the hysterical and neurotic problems of his patients. It did however change something else! He abandoned his dependence on the trauma or seduction theory by introducing the theory of fantasy and infantile sexuality. This aspect of Freud's work is so well known and so thoroughly documented that a few words should suffice.

Before 1897 Freud believed that hysteria or neurosis was caused by a scene of sexual seduction in childhood which he considered to be traumatic for the infant. The infant could not comprehend this scene and the trauma remained an inactive part of the psyche of the child until a second scene experienced in or around puberty activated this dormant part of the psyche with a deferred effect. Slowly, but surely, Freud begins to realise that the hysterical symptoms contain an element of pleasure. This made him think that the first traumatic scenes perhaps might have been somewhat pleasurable for the infant. Freud has stumbled upon elements of infantile sexuality. The infant must have experienced a conflict between the pain of trauma and something pleasurable. This is the moment when the cathartic method of abreaction begins to disappear because the contradictory forces of conflict invalidate the idea of an

unproblematic purging of a 'toxic' quantity of energy. Or as Paul Verhaeghe writes:

> The failure of hysterical defence was not due to a failure of the process of discharging the memory of an external trauma. Hysterical defence fails because it has to make a compromise between a desire and the repression of this desire.[24]

In a letter to Fliess from 6 April 1897, Freud mentions for the first time that hysteria is caused by fantasies which are made up of things that children have heard at a very early age and were only understood later in life.[25] Freud's letter to Fliess from 2 May 1897 is a very important one. Here Freud indicates that the cause of hysteria is to be sought in fantasies which are related to infantile impulses and whose origins might also stem from masturbatory activity.

> In the first place, I have gained a sure inkling of the structure of hysteria. Everything goes back to the reproduction of scenes. Some can be obtained directly, others always by way of fantasies set up in front of them. The fantasies stem from things that have been heard, but understood subsequently, and all their material is of course genuine. They are protective structures, sublimations of the facts, embellishments of them, and at the same time serve for self-relief. Their accidental origin is perhaps from masturbation fantasies. A second important piece of insight tells me that the psychic structures which, in hysteria, are affected by repression are not in reality memories - since no one indulges in memory activity without a motive - but impulses that derive from primal scenes.[26]

---

[24] P. Verhaeghe, op.cit., p. 25.
[25] S. Freud. *The Complete Letters of Sigmund Freud to Wilhelm Fliess*, op.cit., p. 234.
[26] ibid., p. 239.

Freud's remarks here about self-relief and masturbation are not unimportant because they clearly hint at the possible connection between an 'artificial' production of pleasure and something unpleasant or dangerous against which this pleasure forms a protection. The interesting aspect of this connection is that masturbatory sexual pleasure can be used against frightening sexual impulses. This is crucial for the development of a psychoanalytic theory of addiction and we will come back to it with Freud's remark about masturbation and addiction later in that year.

From here on Freud will elaborate his idea that something painful or traumatic needs to be processed psychically by for instance fantasies. The letter to Fliess from 7 July 1897 is interesting not only because Freud feels on the verge of something new, but also because he appears to be making progress in his own self-analysis. His understanding of his own neurosis seems to coincide with his idea that memories and fantasies can be falsifications of the past (and the latter also of the future.).[27] The letter from 21 September 1897 is a crucial one. This is generally considered to be the letter in which Freud abandons the trauma theory. He writes to Fliess that in the unconscious 'there are no indications of reality' and he suggests that in the unconscious it is perhaps not possible to distinguish between truth and fiction.[28] Freud does not believe in his 'neurotica' anymore. In the very same letter, Freud writes in brackets the following remark: '...there would remain the solution that the sexual fantasy invariably seizes upon the theme of the parents'.[29] Indeed it is four letters later (15 October) that Freud writes to Fliess (and again in the context of his self-analysis) about the Oedipus Complex as 'a universal event in early childhood'.[30] In another famous letter to Fliess, from 14 November 1897, Freud writes that fantasies and the repression of these fantasies have something to do with 'sexual zones'.[31] This is Freud's first elaboration of a theory on infantile

---

[27] ibid., p. 255.
[28] ibid., p. 264.
[29] ibid., pp. 264-265.
[30] ibid., p. 272.
[31] ibid., pp. 279-281.

sexuality, a theory which he so far had only hinted at. Almost hidden in the letter, Freud makes a throw-away remark which should arouse our interest. He writes:

> ... and the final outcome is consequently that a quota of libido is not able, as is ordinarily the case, to force its way through to action or translation into psychic terms, but is obliged to proceed in a regressive direction (as happens in dreams).

In other words, a certain quantity of energy for some reason cannot be psychically processed and, therefore, it becomes disturbing. Something is excluded from language and has a traumatic effect. In the year 1898 Freud mainly concentrates on his analyses of dreams and, in doing so, he is very much relying on linguistic analyses. In his first letter from the next year (3 January 1899) Freud comes back to fantasies and infantile sexuality but this time he includes the linguistic connection between them. He writes:

> In the first place, a small bit of my self-analysis has forced its way through and confirmed that fantasies are products of later periods and are projected back from what was then the present into earliest childhood; the manner in which this occurs also emerged - once again by verbal link. To the question 'What happened in earliest childhood?' the answer is, 'Nothing, but the germ of a sexual impulse existed.' (...). In the second place, I have grasped the meaning of a new psychic element which I conceive to be of general significance and a preliminary stage of symptoms (even before fantasy).[32]

The new psychic element is the unsymbolised aspect of the sexual impulse and Freud considers it to be a first stage in the formation of symptoms.

---

[32] ibid., p. 338.

Nothing needs to have happened. These impulses (in unprocessed form) are enough in themselves to cause trauma. It is only sometime later that these impulses are retroactively understood with the help of fantasies which take shape with what Freud calls 'verbal links" and which are what we can call elements of language. It is in this latter stage that the formation of symptoms takes place on the basis of these elements of language. For Freud, symptoms are therefore structured like a language and contain the 'germ of a sexual impulse'. This 'germ' is something that is only retroactively and falsely understood later on. In other words all symptoms ultimately relate to a disturbing element of pleasure (or satisfaction).

These last couple of years have been very fruitful for Freud. He has discovered fantasy, infantile sexuality, the structuring effect of the Oedipus Complex and the importance of language for our understanding of the psyche. Above all, he has discovered that human suffering is not caused in the first place by a clearly locatable external trauma but by a disturbing element within the psychic economy of the subject which exists like an unprocessed remainder. Neurotics are no longer innocent victims of an external cause; something disturbs them from within. Let us now return to the end of that important year of 1897 when Freud remarked on the connection between masturbation and addiction.

Masturbation and addiction: From disappointment to the quest for something more

On 22 December 1897, he writes the following to Fliess:

> The insight has dawned on me that masturbation is the one major habit, 'the primary addiction', and it is only as a substitute and replacement for it that the other addictions - to alcohol, morphine, tobacco, and the like come into existence. The role played by this addiction in hysteria is enormous; and it is perhaps there that my major, still outstanding obstacle is to be found, wholly or in part. And

> here, of course doubt arises about whether an addiction of this kind is curable, or whether analysis and therapy must come to a halt at this point and content themselves with transforming hysteria in neurasthenia.[33]

In this passage, Freud relates the addictions to drugs, alcohol and other substances to neurasthenia via the 'primary' addiction to masturbation. We wrote before that, according to Freud, the 'inadequate disburdening' of the somatic impulse through masturbation can lead to a lack of proper abreaction of the somatic energy and ultimately will result in a harmful effect. What is an inadequate disburdening and what is a lack of proper abreaction? The former meant for Freud (at that time) that the absence of 'normal' sexual activity could result in an inadequate release of sexual tension or energy. The latter meant that, therefore, a certain amount of this energy could not be properly processed and worn away by the psyche as a result of which this somatic energy became harmful or toxic and caused neurasthenia. If the other addictions are substitutes for masturbation then it seems that Freud considered addiction to be related to an actual neurosis. This must surely be the beginning of the possibility of a differential diagnosis for addiction because Freud had earlier on related some of the addictions to other neuroses and mental problems. That here perhaps he encounters the limitations of his technique is of crucial importance and something that needs to be explored and questioned separately. Freud's final comparatively extensive remarks before the turn of the century on addiction and again masturbation stem from an article from 1898 called *Sexuality in the Aetiology of the Neuroses*. Here he is predominantly concerned with the related questions of how to break addictive habits and what it is that causes them. He writes:

> To break the patient of the habit of masturbating is only one of the new therapeutic tasks which are imposed on the physician who takes the sexual aetiology of the neurosis into

[33] ibid., p. 187.

> account; and it seems that precisely this task, like the cure of any other addiction, can only be carried out in an institution under medical supervision. Left to himself, the masturbator is accustomed, whenever something happens that depresses him, to return to his convenient form of satisfaction. Medical treatment, in this instance, can have no other aim then to lead the neurasthenic, who has now recovered his strength, back to normal sexual intercourse. For sexual need, when once it has been aroused and has been satisfied for any length of time, can no longer be silenced; it can only be displaced along another path. Incidentally, the same thing applies to all treatments for breaking an addiction. Their success will only be an apparent one, so long as the physician contents himself with withdrawing the narcotic substance from his patients, without troubling about the source from which their imperative need for it springs. 'Habit' is a mere form of words, without any explanatory value. Not everyone who has occasion to take morphia, cocaine, chloralhydrate, and so on, for a period, acquires in this way an 'addiction' to them. Closer enquiry usually shows that these narcotics are meant to serve - directly or indirectly - as a substitute for a lack of sexual satisfaction; and whenever normal sexual life can no longer be re-established, we can count with certainty on the patient's relapse.[34]

It strikes us as funny when Freud proposes to treat masturbators (like other addicts) in an institutional setting under medical supervision. We are less concerned today with masturbation but we are in a moral panic about addiction. Whatever image an institution full of masturbators under medical supervision conjures up for you, do not let yourself be distracted by it and do not ignore what is really at stake here.

---

[34] S. Freud. *Sexuality in the Aetiology of the Neuroses* (1898), S.E., vol. III, pp. 275-276.

Masturbation and addiction have in common the fact that both activities are able to produce a pleasure which is completely independent of others. The encounter with others always implies an element of risk, of anxiety and above all of unpredictability. To be part of human culture and to take part in the social bond always implies the paying of a price. This price is total pleasure which is lost when castration cuts the child out of the unity with the mother and replaces it with an ordinary or limited kind of pleasure. Addiction creates the illusion that this total pleasure is attainable again and masturbation creates the illusion for the other that the masturbator might have access to this pleasure. The masturbator knows only too well how limiting an orgasm is. This 'knowledge' of the masturbating subject is probably the reason why masturbation is less of a threat to culture than addiction and why these days we have treatment centres for addicts and not for masturbators. When do we find masturbators in treatment centres? When the limited effects of their activities do not suffice anymore and are supplanted with for-instance drugs or alcohol. When Freud makes the connection between masturbation and neurasthenia, he does not take his place in an age-long cultural tradition of frightening people away from such an un(re)productive activity, as masturbation by linking it with all kinds of imaginary diseases and ailments. When Freud posits that one of the causes of neurathenia can be masturbation, he is more concerned with an inherent problem in human sexuality. His concern is the possibility that some aspect of our sexuality cannot be symbolised or psychically processed and that this lack can lead to all kinds of disturbances such as neurasthenia or as he suggests in the above quote, depression. He writes that whenever something happens to the masturbator that depresses him, he might relapse into his convenient form of satisfaction. So perhaps the 'primary addiction' is related to depression or neurasthenia in a much more problematic way than we thought. Depression and neurasthenia can cause this 'primary addiction' rather than just the other way around. In other words, Freud is here opening up the possibility that addiction and masturbation as pleasure producing activities can be related to mental pain as the cause of these activities. This idea is substantiated by the rest

of the quote. He writes that 'habit' has no explanatory value and that not all people who take morphine or cocaine become addicts. In fact he relates the cause of addictions to a 'lack of sexual satisfaction' by positing addiction as a substitute satisfaction. He even goes so far as to suggest that abstention from drugs and alcohol in itself will never be sufficient to cure a patient but that one needs to look at the cause of the addiction which is situated within the subject. In this sense, Freud was already way ahead of most modern addiction treatment ideologies which proclaim that there are no causes of addictions and that this preoccupation with causes only diverts attention away from what should be the only and true therapeutic aim: abstention. The problem for Freud in 1898 is that the therapeutic solution he comes up with is a 'normal sexual relationship'. His blind hope for a complete solution in the form of a normal sexuality hides his inkling that something-is-up in the domain of human sexuality. With this blind hope of a normal sexuality, Freud is precisely at the same level as those modern treatment ideologies which proclaim abstinence as their aim and happiness as their object.

Address for correspondence:

Centre for Psychoanalytic Studies
LSB College
6-9 Balfe Street
Dublin 2