Indeed, if we find that an organ normally serving the purpose of sense-perception begins to behave like an actual genital when its erogenous role is increased, we shall not regard it as improbable that toxic changes are also occurring in it — Sigmund Freud

1. The psychopharmacology of everyday life

Recently there have been a number of authorities who — from the inside of psychoanalysis itself — have suggested that the most forceful threat to psychoanalysis as a clinical practice is the present efflorescence and dominance of drug-based psychotherapies. Indeed, the astonishing public success of a physician such as Oliver Sacks — whose entire career would have been impossible without his illegal pharmaceutica experimentation upon uniformed patients in the guise of authentic Hippocratic care — can stand as a particularly chilling index of just such a crisis: the case study, a genre which Freud is often said to have invented, and to which he certainly gave the decisive impetus, has become in Sacks’ hands an unreflective celebration of the radiant sovereign power that legal access to, and distribution rights over, synthesized psychoactive substances can bequeath to the duly-authorised representatives of the pharmaco-medical institution. Sacks aside, John Forrester characterizes this shift thus: ‘the introduction of the psychotrophic drugs in the 1950s, a new generation of tranquilizers shortly after (Librium, Valium), the anti-depressants of the 1960s and 1970s, and the mood-altering drugs of the 1980s, has entailed a significant shift in the practice of psychiatry. Yes, the new psychiatry went hand in hand with a shift of theoretical focus from psychological and psychoanalytical theories to neurological and psychopharmacological concerns’. His analysis has been echoed by other major psychoanalytic theorist-practitioners, such as Bruce Fink, Elie Ragland and Elisabeth Roudinesco, all of whom naturally deplore this situation, even if their condemnations take different forms, and identify different causes.

Any recognition of this shift, however, should not ignore the continuities and complicities between the so-called psychoanalytic and psychopharmacological eras.
Forrester himself is concerned to show how psychoanalysis effectively functioned in the United States as, among other things, a kind of vanishing mediator in the ‘shift from asylum- to office-based psychiatry’. Or, as he more memorably puts it, ‘the real Freudian revolution was to bring psychiatrists out of the asylum’. It should probably be added that such a revolution would of course have been very different without the peculiarly ego-bolstering project of American psychoanalysis, against which someone like Jacques Lacan never ceased to polemicise. Nevertheless, despite the variety of historical, methodological, and theoretical complicities, there is at least one apparently irreducible, foundational difference: under the psychopharmacological dispensation, the physician only talks to the patient in order to ensure that the drugs are having some kind of beneficial effect – and thus no longer has to listen, insofar as there is no longer any unconscious to be discerned in the pathological symptoms and inaudible interruptions of the subject’s auto-verifications. Perhaps, as many have suggested, the ‘talking cure’ of the Viennese Witch-Doctor is thereby finally blown to quack heaven by the magic bullets of techno-pharmaceutical wizardry.5

Is, however, this difference between listening and dispensing really as irreducible as psychoanalysts’ and psychopharmacologists’ investments in their own respective projects compel them to assert? A number of possible procedures for reconfiguring this apparent discord can immediately be conceived. It might, for instance, be possible to demonstrate how various notions ultimately consonant with that of the ‘unconscious’ remain entirely acceptable, and are even explicitly welcomed, in the work of the psychopharmacologists themselves – even if, for whatever reasons, they cannot accept this very particular name. Or one could compare the actual procedures of both psychiatrists and psychoanalysts, in order to show that, whatever they may say about their own work, their conceptual differences are subtended by a fundamental similarity of practice. Or one might attempt to show that, philosophically speaking, all such differences are, finally, ‘co-supplementary’ – irresolvable, certainly, but nevertheless unthinkable and impracticable except when conceived in the hostile intimacy of their adversarial relationship.

My own procedure here will be somewhat different, and begins with the proposition that the dissension and confusion of the current situation tend to elide the fact that the coupled motifs of drug-treatment and addiction have always been central, not only to Freud himself, but consequently also to the discipline which he founded. Furthermore, this centrality has, for the most part, and for a number of reasons, most often been ignored, forgotten, repressed or foreclosed by writers in and on psychoanalysis, even before the explosion of modern drug treatments for mental (and addictive) disorders. Indeed, my main contention in this paper is that these motifs bear integrally on the very foundations, limits, status, and legitimacy of the Freudian and post-Freudian corpus, and in ways that are necessarily – if for very Freudian reasons – inconsistently accessible and almost unthematisable within that corpus itself. My argument will thus have recourse to details, events and structures that are at once empirical, biographical, historical, technological and philosophical, in order to demonstrate the critical role that drugs and addiction have played in the genesis of psychoanalysis, and thence to trace some of their subsequent effects. I will suggest that: (1) historically speaking, without drugs having being made a problem for Freud, psychoanalysis would not and could never have been invented; (2) as a result, a kind of fantasmatic ‘Other Scene’ of unspeakable ‘addiction’ provides the covert a priori motivation, material, and support for psychoanalysis; (3) to the extent that it remains
necessarily unanalysed, this non-place of addiction continues to affect, in an often illegible and subterranean form, the subsequent re-elaborations of psychoanalysis itself. Although this third point cannot be satisfactorily verified in a paper of this length, I will gesture towards certain moments in Freud’s later work where psychoanalysis is forced to encounter the problems posed to it by addiction. As I will argue, this is also the problem of the unofficial orifice ...

2. Freud on drugs

In order to demonstrate the extent of Freud’s drug-problem, I will begin with a discussion of some germane empirico-biographical details, and then proceed to an analysis of some of the more convoluted theoretical effects regulated by this problem.

It would, of course, be impossible to speak of Freud’s relation to drugs without mentioning his own notorious penchant for cigars. A keen smoker throughout his life, he also periodically tried to quit it up and was continually in anguish over the smoking addiction that he evidently couldn’t shake. As Peter Gay notes of Freud’s cigars: ‘He was fatally addicted to them; when in the early 1890s Fliess – after all, a nose and throat specialist – proscribed them to clear up Freud’s nasal catarrhs, Freud was in despair and pathetically pleaded for relief. He had begun smoking at twenty-four, at first cigarettes, but soon only cigars. He claimed that this “habit or vice”, as he called it, greatly enhanced his capacity for work and his ability to muster self-control’. Despite the manifold physical problems that this vice inflicted upon Freud, it didn’t at all prevent him from proselytizing for smoking: there is a story of him offering a cigarette to his 17 year old nephew Harry, which was refused; whereupon Freud avuncularly declared, ‘My boy, smoking is one of the greatest and cheapest enjoyments in life, and if you decide in advance not to smoke, I can only feel sorry for you’ (cited in LT, 170). Smoking even became a topic for scholarly reflection: at the first session of the Wednesday Psychological Society in the Autumn of 1902 – attended by Stekel, Kahane, Reitler, Adler, and Rank, among others – the assembled luminaries discussed the question of ‘the psychological impact of smoking’. Finally, of course, Freud developed jaw and throat cancer as a direct consequence of his habit, and, after a series of excruciatingly painful operations, was forced to wear a prosthesis for his last years. Interestingly enough, and despite the pain from his operations, Freud consistently refused to touch the opiates that would have provided him with relief. (The rest of the paper will attempt to provide a context for this notable refusal).

Most interpretations of Freud’s ‘addiction’ have, naturally enough, tended to elaborate themselves in Freudian terms. However, if, as Forrestier confirms, ‘we all know that Freud spent his working life sucking penises’, we also all know that sometimes a cigar is just a cigar (but what is a cigar?). If this cigar-addiction is undoubtedly the most familiar and pronounced example of substance-abuse in Freud’s life and work, he not only consistently enjoyed other drugs – notably alcohol and caffeine – but, during the period from about 1884 to 1895, he regularly ingested cocaine, a drug whose availability and popularity was on the rise in Europe at that time.

In fact, cocaine seems to have served quite a variety of interconnected functions in Freud’s life. Ronald Clark relates an anecdote from 1886, after Freud had gone to Paris to study with Charcot: ‘Once it was decided that he should translate Charcot’s two volumes of papers, Freud was quietly brought into a new social circle by way of the splendid Tuesday evening receptions held for the smart world of Paris at Charcot’s home on the Boulevard Saint-Germain. As he prepared for the first of these
ordeal, he was nervous enough to fortify himself with cocaine'. Writing to his fiancée, Martha, regarding his dressage on that first night, Freud jokingly bragged that 'I looked very fine and made a favorable impression on myself'. He not only drank beer and coffee along with everyone else, but, as he further confesses, 'smoked like a chimney, and felt very much at ease without the slightest mishap occurring ... These were my achievements (or rather the achievements of cocaine) which left me very satisfied' (cited in MC, 75).

Freud, indeed, was so struck by the supernatural powers of cocaine that he quickly found himself compelled to impose it on his friends and colleagues, prescribe it to his patients, and run a battery of rather unscientific tests on its possible uses, effects, and affects. He thus participated in cocaine-use (and drug-use more generally) in a number of characteristic ways: for aesthetic pleasure; as a personality-supplement; as an enhancer of physical and mental performance; as a dubious medical treatment for various physical ailments; as a crucial element in the formation and maintenance of social community — although, interestingly, he did not explicitly affirm its value as a speculative 'operator of infinity'. For the pre-psychoanalytic Freud, then, cocaine not only healed the sick and almost raised the dead, but it also provided surplus pleasure, social confidence, physical and mental strength without demanding anything in return.

Despite this familiar diversity of uses, what is specifically of interest here is Freud's attempt to link his professional status and reputation — hence his name — with the magical properties of this particular substance. Furthermore, the white magic of this foreign substance resided, for Freud, not only in its supposed uniquely beneficial effects on human physiology, but, more surprisingly, in its power to interrupt the deleterious compulsions to which other similar, but implicitly more dangerous drugs subject their users. For Freud would also recommend cocaine as the royal road to a successful cure for morphine-addiction, a recommendation that quickly (and unsurprisingly) ended in his abject failure and public humiliation. I will examine the details of this failure in the following section of my paper, but before doing so I want to re-mark a number of points that are of major import for any account of the relation of psychoanalysis to addiction.

(1) The period during which Freud is loudly singing the praises of cocaine is immediately prior to the development of psychoanalysis; as James Bakalar and Lester Grinspoon point out, 'Freud continued to prescribe cocaine until at least 1895, the year of his self-analysis, for topical application to the nasal mucous membranes, and he used it himself for sinusitis'. In less than a year, then, Freud abandons cocaine at the very moment that he is inventing a rather less substantial, if more significant, cure of his own. This apparently merely empirical supersession of one magical cure by another nonetheless had a deep and lasting effect on psychoanalytic theory.

(2) In spite of Freud's initial enthusiasm, psychoanalysis thereafter engages in no extended discussion of cocaine-use, or indeed of its fraught relationship to the question of addiction in general (as we shall see, and for a variety of reasons, Freud constantly elides or confuses the differences between the acceptable use, and the toxic ab-use, of this drug). Certainly, the question of drugs does not disappear altogether; as Forrester writes, 'Freud recognizes the fundamental service intoxicants render to human beings in their pursuit of happiness. And he classed them with humour and mystical states of consciousness as possessing a fundamental human dignity. We might conclude that intoxicants are as distinctive a part of human life as our gift for creative sexual perversion. There is, in addition, Freud's hilarious but
utterly serious observation that humans are better suited to fidelity to their intoxicants than they are to their sexual objects; a marriage to a Burgundy is always more constant and satisfying than a marriage to a Blonde’. Nevertheless, Freud would also, as aforementioned, later come to denounce the use of drugs in psychiatric treatments, claiming, somewhat contradictorily, that their effects – like those of hypnosis – were at once purely cosmetic, unreliable, and a toxic assault on the patient’s will.14

Furthermore, Freud’s acknowledgement of the genuine role played by intoxicants in an ‘aesthetics of profane illumination’15 is a long way from anything resembling addiction. Indeed, if psychoanalysis speaks of addiction at all, it is anxiously, uncomprehendingly, and in passing – and in order to exclude it from psychoanalysis’s legitimate field of operations.16 Certainly, Freud would consider that addicts share ‘the charm of cats and birds of prey in their inaccessibility, their apparent libidinal autonomy’,17 but it is precisely this very ‘charm’ that verifies that they are inappropriate candidates for psychoanalysis. As Freud writes of addicts in a 1916 letter to Ferenczi, ‘it is too easy for them to cling to the security of their drug’.18 This is a judgement that could only be repeated later by Lacan: ‘Addiction opens a field where none of the subject’s utterances are reliable, and he escapes analysis’.19 However, it is also necessary to add that this thoroughgoing exclusion of addiction from psychotherapeutic practice is founded on the prejudice that addiction’s aetiology is nevertheless, in principle, eminently explicable at the level of theory (even if this step is never de facto taken). In this regard, it is truly symptomatic that cocaine (and/or addiction) remains for the most part unmentioned in almost every account of the Freudian corpus and concepts, other than the biographical. And none of these biographies are quite sure what to do with it – typically, they note its importance and obvious continuing influence on Freud (without dealing with the details of such an ‘influence’ in any acceptable detail), and yet simultaneously try to limit its significance, as in, for example, Jones’ restriction of the ‘Cocaine Episode’ to 1884–1887.20

Into the bargain, the articles that Freud published on cocaine were not reprinted in the Standard Edition, notwithstanding the inclusion of any number of juvenile or occasional writings in these volumes.21

3) This exclusion of addiction links it, first, with the analogous problems posed for psychoanalysis by the liminal non-figures that are paranoids and psychotics,22 and, second, with any number of the famous speculative concepts later adumbrated by Freud: acting-out, melancholia, mania, repetition-compulsion, death-drive. But addiction thereby also communicates with other psychoanalytic categories, procedures, and practices that may at first seem utterly unrelated to any of these – for example, transference-love, or, perhaps rather more obscurely, the problem that the nose always posed for Freud. As I will want to ask, perhaps bizarrely: why is there no nasal phase in psychoanalysis?

But before I examine these points further, it is necessary to look more closely at the details of what Ernest Jones, perhaps a little too flippantly, names Freud’s ‘Cocaine Episode’.

3. The third scourge, or ‘an excellent thing for a long walk’

In 1884, a young and ambitious Sigmund Freud completed his medical studies and became an assistant at the Laboratory of Experimental Medicine at the University of Vienna. Freud, indeed, was notoriously ambitious: as Jones relates, ‘during the three hospital years Freud was constantly occupied with the endeavour to make a
name for himself by discovering something important in either clinical or pathological medicine' (LW, 86).

And it was in the course of what Freud himself sardonically called this 'chase after money, position, and reputation' that he first became interested in cocaine (cited in LT, 44). This interest was not especially unusual for the period. For despite the ubiquitous public hysteria today regarding cocaine's production, distribution and supposed abuse; its links to contemporary imperialism, organised crime, and military interventions; and the moral, medical and legal prohibitions and exhortations that ensure that cocaine will remain a banned and demonic substance for the foreseeable future, it was not subjected to any governmental regulation anywhere until the US Pure Food and Drug Act of 1906, which restricted the importation of coca leaf and required all medicines containing cocaine or opium to be properly labelled. So it was certainly not the Law of the State that got Freud into big trouble, indeed, it was barely a law at all. I have already flagged Freud's own personal use of the drug, but it was the public declarations that he made in its favour that precipitated a rather unpleasant response.

According to Ernest Jones, Freud first mentions cocaine in a letter of April 21, 1884, in which he writes,

I have been reading about cocaine, the essential constituent of coca leaves which some Indian tribes chew to enable them to resist privations and hardships ... I am procuring some myself and will try it with cases of heart disease and also of nervous exhaustion, particularly in the miserable condition after the withdrawal of morphiau (Dr. Fleischl). Perhaps others are working at it; perhaps nothing will come of it. But I shall certainly try it, and you know that when one perseveres sooner or later one succeeds. We do not need more than one such lucky hit for us to be able to think of setting up house (cited in LW, 88).

Impressed by Theodor Aschenbrandt's studies of the effects of cocaine on the human body, and by US reports of its efficacy in the treatment of morphine addiction, Freud proceeded to acquire a gram of cocaine, at an unexpected expense, from the Merck chemical factory. After running a number of extremely dubious 'experiments' (of which more below), he published a first essay on the substance, 'Über Coca', in the Centralblatt für die gesammte Therapie of July 1884 (LW, 90). In this text he lists a number of its benefits for health, as observed by himself and by other authorities, praises its varied effects (the abolition of fatigue, feelings of euphoria, suppression of appetite, its aphrodisiac properties, etc.), and outlines a number of its possible medical uses — as a physical and mental stimulant, a psychiatric drug (in the treatment of hysteria, hypochondria, melancholic inhibition, stupor, etc.), a treatment for digestive disorders, for cachexia (anemia, phthisis), and even for asthma and syphilis. Furthermore, as he writes in a passage that was scientifically and ethically suspect even then:

It seems probable, in the light of reports which I shall refer to later, that coca, if used protractedly but in moderation, is not detrimental to the body. Von Anrep treated animals for thirty days with moderate doses of cocaine and detected no detrimental effects on their bodily functions. It seems to me noteworthy — and I discovered this in myself and in other observers who were capable of judging such things — that a first dose or even repeated doses of coca produce no compulsive desire to use the stimulant further; on the contrary, one feels a certain unmotivated aversion to the substance (UC, 161).
But it was the following sections of Freud’s paper that ultimately caused the biggest problems: *Coca in the treatment of morphine and alcohol addiction*. Drawing on American research published in such reputable journals as the *Detroit Therapeutic Gazette* and *Louisville Medical News*, Freud claims that ‘there are some sixteen reports of cases in which the patient has been successfully cured of addiction; in only one instance is there a report of failure of coca to alleviate morphine addiction’ (UC, 170). He continues: ‘the treatment of morphine addiction with coca does not, therefore, result merely in the exchange of one kind of addiction for another – it does not turn the morphine addict into a *coquero*; the use of coca is only temporary’ (UC, 171). Furthermore, Freud would also recommend the use of injections in the administration of cocaine.

As a number of commentators would later point out, although Freud certainly recognised the *analgesic* and *aesthetic* properties of cocaine, he never really pursued its possible *anaesthetic* uses – for instance, in surgery. This is a crucial point. Freud completed his article, mentioned his interest in the drug to a friend, Leopold Königstein, then decided to visit his fiancée, Martha Bernays. By the time he’d got back from his trip, it was all over: an associate of his and Königstein’s, Carl Koller, had shown how cocaine could function as an effective anaesthetic in eye surgery. Freud was incredibly bitter about Koller’s triumph: he even later wrote, ‘it was my fiancée’s fault if I did not become famous in those early years’, but his disappointment did not stop him from taking cocaine himself for such things as stomach upsets, nose infections, exhaustion, or to make himself ‘feel more like a man’, and it didn’t stop him prescribing it for others. Unfortunately, he also recommended it to his friend Ernst von Fleischl-Marxow who had become addicted to morphine as a painkiller following the amputation of one of his thumbs; within a few days Ernst couldn’t stop whacking himself with coke, and eventually died as Europe’s first official cocaine addict.

Now Freud’s recommendation of cocaine *injections* is extremely important for a number of reasons: it was this hypodermic recommendation which got him into especial trouble when cocaine rapidly started getting a bad name as the ‘third scourge of humanity’ (after alcohol and morphine). This catch-cry was popularized by Albrecht Erlenmeyer, one of the most influential psychiatrists of the era, and was quickly taken up, not only by a number of other physicians working on morphine- and alcohol-abuse, but by the popular press as well. It thus marks the moment of the crystallisation and consolidation of a recognizably contemporary discourse of addiction; it is also the beginning of the enthusiastic social demonization of so-called addictive substances, that is, those whose supposed harm derives from nothing more than this very potentiality.

All up, then, the cocaine episode proved ‘the most sombre of [Freud’s] life’. His research had been exposed as outrageously unscientific, his most admired friend was addicted and paranoid (due, in part, to Freud’s intervention), his marriage plans had to be delayed, a rival had become world-famous for the development of cocaine anaesthesia in surgery, and the Viennese medical establishment heaped opprobrium upon Freud’s name and work. In one stroke, Freud had managed to fail scientifically, reputationally, economically, professionally, and personally...

And yet, as always, such public controversy had ambivalent effects. For if, as Ronald Clark points out, ‘when [Freud] set up practice in 1886 he at first tended to be remembered in some medical circles not as the doctor who had discovered the anesthetizing value of cocaine but as the man who had let loose the third scourge’
(MC, 62), it is also the case that 'the first patient who came to [Freud] on his own and not through the recommendations of a colleague had been attracted by the writings on cocaine' (BG, 34). It is also worth mentioning the interest taken by big drug companies in Freud's research, an interest which foreshadows the crucial links between multinational pharmaceutical companies and the medical institution today. For example, it was in response to Freud's and Fleischl-Marxow's writings on cocaine that the Parke Davis company put out a pamphlet 'Coca Erythroxylon and Its Derivatives', which declared 'If these [Freud and Fleischl-Marxow's] claims are substantiated ... [cocaine] will indeed be the most important therapeutic discovery of the age, the benefit of which to humanity will be incalculable' (cited in BG, 22), and the Merck chemical firm invited Freud to road-test their new alkaloid egnonin, derived from cocaine, and sent him one hundred complimentary grams.

At this point, however, even a kilo of cocaine would probably have been insufficient to make Freud feel the man he evidently believed he had wanted himself to have been.

4. Sticking your nose where it's not wanted

Not only does the cocaine catastrophe affect all registers of Freud's life and work in the 1880s and 1890s, but it also overlaps with and imposes itself on the development and structure of psychoanalysis itself. Strangely enough, the privileged conduit for this massively complicated and overdetermined transmission seems to be, of all things, the nose. There are three reasons of particular importance here.

First, the rather confused associations between the nose and the male genitals that remain a staple, not only of contemporary popular culture but of scientific discourse as well, and have apparently been so for centuries. For example, as William Acton, one of the most influential British medical practitioners in the third quarter of the nineteenth century and a major figure in the implementation of the notorious Contagious Disease Acts, writes in his Functions and Diseases of the Reproductive Organs (by which he means the penis), 'During my researches, I have occasionally been struck with the inaccuracy of the school-boy doggerel, 'Nosciture et labris quantum sit virginis antrum, Nosciture naso quanta sit hasta viro', and when I have noticed a man with a large organ, I have often looked to see if he had a prominent nose. I feel confident that the proverb involves a vulgar error.' If Acton's researches bizarrely meant that he would look first at the genitals and only secondly at the face of their nominal possessor, it was probably more common to see the one and not the other, and only then speculate knowingly on the basis of the visible facial evidence as to the relative masculinity and potency connoted by the unseen organ. What is also suggestive in such formulations is the semiotic confusion that the nose seems to provoke. In the terms of the philosopher C.S. Pierce's tripartite division of signs - between the index, the icon, and the symbol - the nose, in its own way, seems to be all three: as index, it points towards the unseen genitals with which it is causally linked; as icon, it supposedly resembles the aforementioned genitalia; as symbol, it connotes virility. So there are already a number of noteworthy aspects: the nose is acknowledged primarily in terms of visible size, and that only because of what it somewhat obscenely points to. Its function as an organ - what it can do - is thereby immediately subordinated to what it looks like.

Which brings me to my second point. For virility is not all a large nose comes to symbolize, and especially not in fin de siecle Vienna. The problem here is that if a large nose immediately connotes abundant masculinity, this is not such a good look:
(1) if you’re a woman; and (2) given its widespread association with a certain pariah race, the Jews. As Sandor Gilman puts it:

The association between the Jewish nose and the circumcised penis was made in the crudest and most revolting manner during the 1880s. In the streets of Berlin and Vienna, in penny-papers or on the newly installed ‘Litfassaulen’, or advertising columns, caricatures of Jews could be seen. These extraordinary caricatures stressed one central aspect of the physiognomy of the Jewish male, his nose, which represented that hidden sign of his sexual difference, his circumcised penis. For the Jews’ sign of sexual difference, their sexual selectiveness, as an indicator of their identity was, as Friedrich Nietzsche strikingly observed in Beyond Good and Evil, the focus of the Germans’ fear of the superficiality of their recently created national identity. This fear was represented in caricatures by the elongated nose (DR, 189).

Hence, of course, the title for this paper, ‘The Jew’s Two Noses’. This has been adapted from a phrase of Ben Hecht’s — who was, incidentally, one of the screenwriters for Gone with the Wind — and who published something called A Guide for the Bedevilled in 1945. It is basically an angry account of the abiding and virulent anti-semitism of American culture, motivated by America’s reluctance to declare war on the Nazis. At one moment Hecht rather enigmatically introduces into his text the weird lament, ‘Ah, this extra nose that the Jew carries! It is an organ out of which he gets little delight and much inconvenience’. In any case, this phrase can function to summarize a number of interconnected themes: the lineaments of social practices based on the primacy of vision, an implicit supposition that ‘the bigger the better-worst’, and an entire unconscious complex whereby the penis, the phallus, sexual hierarchy, popular physiognomy, racial difference, and social hegemony find themselves irremediably enmeshed.

And, finally, my third reason here: the abiding links between cocaine and the nose, a relation reflected in contemporary slang, e.g., ‘nose-candy’, or in the Hispanic perrico, ‘parrot’ (presumably because you shove it up your beak, and it makes you squawk like a parrot), and in the development of certain interesting contemporary surgical techniques (gold septums). This is also a fact which bears crucially on Freud’s own fraught relationship with these assorted rhinologies (remember, he recommended nasal, oral and subcutaneous application).

But what knotted these three aspects together for Freud was a friendship. At the time of his self-analysis in the 1890s, Freud’s best friend was a Jewish ear, nose and throat doctor named Wilhelm Fliess, whose own theories on the nose have most often been judged by subsequent commentators as the work of a demented quack. As Peter Gay puts it, ‘Fliess singled out the nose as the dominant organ, which spreads its influence over all human health and sickness. He was, moreover, enslaved to a scheme of biorhythmic cycles of 23 and 28 days, to which males and females were seen to be subject and which, he believed, would permit the physician to diagnose all sorts of conditions and ailments’ (LT, 46). For instance, the evidence for male periodicity included periodic nose bleeds; this evidence would ultimately, at least for Fliess, found a surgical practice capable of altering ‘the pathology of the genitalia by operating on the nose’ (DR, 189).

Indeed, both he and Freud were only too ready and willing to operate.
5. Pus in boots

If there is a canonical text for psychoanalytic dream interpretation, it is Freud's so-called 'specimen dream', otherwise known as the dream of 'Irma's injection', and in which the foundational Freudian principle that ‘a dream is the fulfilment of a wish’ is broached for the first time.\(^{33}\) It is not only, as Lacan says, psychoanalysis' 'dream of dreams', but constitutes, in Lisa Appignanesi and John Forrester's words, 'the primal scene of psychoanalysis'.\(^{34}\) Unfortunately, I do not have the time to do a detailed reading of the dream here, and will only list a few pertinent details.

Freud's own 'preamble' to the dream runs as follows:

During the summer of 1895 I had been giving psychoanalytic treatment to a young lady who was on very friendly terms with me and my family ... . This treatment had ended in a partial success; the patient was relieved of her hysterical anxiety but did not lose all her somatic symptoms. At that time I was not yet clear in my mind as to the criteria indicating that a hysterical case history was finally closed, and I proposed a solution to the patient which she seemed unwilling to accept ... One day I had a visit from a junior colleague, one of my oldest friends, who had been staying with my patient, Irma, and her family at their country resort. I asked him how he had found her and he answered: 'She's better, but not quite well.' ... The same evening I wrote out Irma's case history, with the idea of giving it to Dr M ... in order to justify myself. That night (or more probably the next morning) I had the following dream, which I noted down immediately after waking (ID, 180–181).

Before proceeding with an analysis of Freud's analysis of his own dream, it is necessary to emphasize a few points about the 'real' incident which it purportedly reconstitutes. As Appignanesi and Forrester retell it, returning to Irma her real name, Emma Eckstein\(^{35}\):

Emma started receiving treatment from Freud sometime in the early 1890s. We do not know what her symptoms were, but she became a special patient ... The crucial period of her treatment extended from 1895 to 1897, overlapping with Freud's espousal of the seduction theory and his discovery of the meaning of dreams.

In December 1894, Fliess visited Freud in Vienna, examined Emma and recommended that he operate on her nose, in order to alleviate certain of her symptoms, ones possibly connected, in the doctor's view, with masturbation. Fliess returned to Vienna in early February, operated on Emma and left. Freud reported on her post-operative progress on 4 March: the patient was not doing well. She had excessive secretion of pus, a bone chip had been expelled and a rather noxious smell emanated from her nose. Four days later, on 8 March, Freud gave Fliess the sudden upsetting news that Emma's condition had worsened.\(^{36}\)

Freud called in another ear, nose and throat specialist, Dr Rosanes, to take another look. To continue the story in Freud's own words, a letter to Fliess dated 8 March, 1895:

Rosanes cleaned the area surrounding the opening, removed some sticky blood clots, and suddenly pulled at something like a thread, kept on pulling. Before either of us had time to think, at least half a meter of gauze had been removed from the cavity. The next moment came a flood of blood. The patient turned white, her eyes bulged, and she had no pulse. Immediately thereafter, however, he again packed the cavity with fresh iodoform gauze and the hemorrhage
stopped. It lasted about half a minute, but this was enough to make the poor creature, whom by then we had lying flat, unrecognizable. In the meantime—that is, afterward—something else happened. At the moment the foreign body came out and everything became clear to me—and I immediately afterward was confronted by the sight of the patient—I felt sick ... I do not believe it was the blood that overwhelmed me—at that moment strong emotions were welling up in me. So we had done her an injustice; she was not at all abnormal, rather, a piece of iodoform gauze had gotten torn off as you were removing it and stayed in for fourteen days, preventing healing; at the end it tore off and provoked the bleeding.37

This suggests a number of points, some empirical, some speculative, which bear on the interrelations between noses, cocaine (among other drugs), injections, and the psychoanalytic text, all of which become irremediably commingled as a result of Freud’s own procedures.

Firstly, Irma’s ‘true’ identity was not known until the 1960s. However, in the section of Freud’s interpretation in which he deals with ‘propionic acid,’ he speaks of this acid as reminding him of a foul-smelling pineapple liqueur named ‘Ananas,’ and to which he provides an enigmatic footnote: ‘I must add that the sound of the word “Ananas” bears a remarkable resemblance to that of my patient Irma’s family name’ (ID, 187). Now, ‘Eckstein’ hardly resembles, ‘remarkably’ or otherwise, ‘Ananas,’ but, as Maria Torok points out, ‘the connection to this patient becomes obvious if we think of Emma’s nose operation. Ananas is quite similar to the drawling Viennese pronunciation of eine Nase (a nose)’.38 Furthermore, Freud himself remarks of the image of the scabby, curly structures in the throat that

the scabs on the turbinal bones recalled a worry about my own state of health. I was making frequent use of cocaine at that time to reduce some troublesome nasal swellings, and I had heard a few days earlier that one of my women patients who had followed my example had developed an extensive necrosis of the nasal mucous membrane. I had been the first to recommend the use of cocaine, in 1885, and this recommendation had brought serious reproaches down on me. The misuse of that drug had hastened the death of a dear friend of mine (ID, 187).

This admission or confession is hardly a simple one. In this re-presentation cocaine functions much like Plato’s pharmakon: though a certain remedy for his own nasal problems, it is yet the probable cause of another’s; a legitimate medical treatment he was first to identify (for which he therefore deserves the credit) — and which yet killed a friend and provoked ‘reproaches’ (for which he therefore must take responsibility), etc. The passage thus confusedly identifies cocaine as the divided cause of professional and sexual death-health. And there is another famous Freudian slip here: he had first endorsed cocaine in 1884, and not 1885 at all. This slip is all the more notable inasmuch, as Jones points out, ‘it was of course in 1884 when he recommended the use of cocaine, but it was in 1885 that he recommended the use of the (dangerous) injections’ (LW, 106).

Hence my second point; as Avital Ronell remarks, the dream constitutes ‘the story of Irma’s infection which Freud, however, calls Irma’s injection’.39 As the text of the dream itself has it, ‘injections of that sort ought not to be made so thoughtlessly’ (ID, 182). Or, again, as Freud phrases one of the latent wishes expressed in the dream: ‘Irmäs pains had been caused by Otto giving her an incautious injection of an unsuitable drug — a thing I should never have done’ (ID, 197). Once more: Freud’s sanctioning of subcutaneous injections had not only proved a central issue in the
cocaína scandal, but had also been principally responsible for the death of Fleischl (as he admits). 40 Freud himself directly associated the recurrent ‘threes’ in the dream to the threesome that Freud, Fliess, and Emma literally and manifestly formed, but it is also tempting to refer these triads to Freud’s preconscious recollections of cocaína as the third scourge which he had been held to have unleashed. 41 And yet these unfortunate occurrences now come to provide one of the principal supports for Freud’s central hypothesis that even the apparently self-recriminatory aspects of dreams are nevertheless self-dissimulating wish-fulfillments. Thus when he dreams ‘I thought to myself that after all I must be missing some organic trouble’, the truth of this dream-thought runs something like this: ‘the patient was not a hysterical at all; I simply overlooked some physical condition; my diagnostic failure was entirely due to my desire that my theories of hysteria be true; therefore, to the extent that I had missed some organic trouble precisely due to this desire, my theories are still true’. But in order to demonstrate the contradictory coherence of his own kettle-logic here, Freud must ‘confess’ to his cocaína error. It is thus symptomatic that he errs symptomatically in this ambivalently self-aggrandizing confession of error.

Third, at the time of the operation, Freud was himself still using and prescribing cocaína for topical application to the nasal mucous membranes. On a related minor note, the dream occurred after he had just taken up smoking again. Freud had been suffering from heart arrhythmia, migraines and nose infections, which Fliess had diagnosed as smoking-related, and had induced Freud to stop in 1894. 42 It is the details of this third point that, paradoxically, turn the sequence of biographical events into something more than a merely empirical situation. For this scene of appalling surgical malpractice – although absolutely ‘real’ (even if the details were until relatively recently masked by the analytic text which claimed to unveil them) – is consistently doubled by still another scene, even less legible because so blatantly manifest, and perhaps just as unpleasant. It concerns, above all, a fantasy of pedagogical reproduction.

In his letters to Fliess, Freud describes in graphic detail the effects of the botched operation on Emma: although dosed to the eyeballs on morfine, she is prostrate, in excruciating pain, and blood and pus are running constantly from her mutilated nose, which has the ‘fetid odour’ of rotting flesh. Throughout this trying time, a confused, even terrified Freud has been constantly dosing himself with cocaína: his own nose – like Emma’s – is spurring pus, but of a very different quality. 43 Indeed, he has been writing to Fliess for some time as to the beneficial quality of his own secretions: ‘In the last few days I have felt quite unbelievably well, as though everything had been erased ... Last time I wrote you, after a good period which immediately succeeded the reaction, that a few viciously bad days had followed during which a cocainizm of the left nostril had helped me to an amazing extent ... The next day I kept the nose under cocaína, which one should not really do; that is, I repeatedly painted it to prevent the renewed occurrence of swelling: during this time I discharged what in my experience is a copious amount of thick pus; and since then I have felt wonderful’. 44

At this point, everyone’s pussing. Fortunately, in Freud’s case it’s OK, it’s a promising sign of recovery and not at all of dissolution and decay. Furthermore, he’s still erect, standing, evidently a man, and therefore his nasal pus – given Freud and Fliess’s own theories of the time – is undoubtedly also spermatic fluid (which he is literally measuring out in cups), thick and rich. All thanks to the magic of cocaína. And he and Fliess are thus more than ready to teach the world the lesson of the nose
and its links to the genitalia, a lesson which is to be endlessly repeated, verified, and transmitted to the world through the only-too-physical, active surgical implantation of their autogenerative, in-corporeal seed in the welcoming nasal-uteruses of hysterical women. A true ‘double penetration’, then, in a number of senses of that phrase: appearing as both real and fantasmatic figures in Freud’s own text, Freud and Fliess aim to penetrate and impregnate the world through im-pustulating Emma’s nose, all the while efficiently penetrating and mingling indiscernibly with each other. A situation almost explicitly confessed to by Freud the following year, when he writes to Fliess of his desire to ‘blend our contributions to the point where our individual property is no longer recognizable’ (CL, 215).

Unfortunately, in Emma’s case, the friends’ attempts at procreation are miserably bungled. Her nose will not stop bleeding, ‘menstruating’, and hence there has been no conception: into the bargain, the pus-sperm of our odd couple is still leaking from her nose, having completely failed to take. Freud has stuffed everything up once more, and already again this failure is personal, professional, reputational, scientific, and so on.

He will have to keep dreaming if he is ever to make something of himself.

6. Conclusion: Snivilization and its discontents

Freud’s failure to make his reputation by way of cocaine was a crucial impetus in his turn from neurology to psychology, from explanations that presume that pathologies have a material, organic basis to explanations based on the primacy of ‘sex’. He made this transition between a neurological approach to a psychoanalytic one precisely because his dream drug had been judged by his culture to be addictive and mortificatory. Again, this is more than a merely empirical event: as I have shown, Freud can’t help but return to this event in the text that is the central document of psychoanalytic dream interpretation. Irma’s dream is the place where Freud invokes his failure to support the truth of his new solution. Yet Freud still can’t get his story straight: in his attempt to come clean, he confuses dates, persons, their orifices, treatments and pathologies in a way which bespeaks—in psychoanalytic terms—the continuing activity of an unconscious trauma.

On the other hand, it is also possible to read Freud’s cocaine troubles in a way that perturbs the contemporary discourses of addiction: ‘addiction’, for instance, is by no means a well-defined scientific concept, but names a structure that integrally conceals and confuses a number of non-scientific determinations (for example, cultural interdictions, professional and economic rivalry, obscene psycho-sexual desires, covert racism, and so on).

Because of the overdetermined ways in which the cocaine-event conditions Freud’s transition between very different ‘scientific’ domains, it is tempting to suggest that this event thereafter regulates an almost indiscernible but insistent series of interruptions of the psychoanalytic corpus. For the specific reasons which I have already outlined, we might expect that the psychoanalytic question of the nose continued to bear the traces of this inauguralatory event. As I have suggested, the supplementary nose is, certainly, the Jew’s circumcised penis, but also—and more confusingly in Freud’s case—his own nose, Fliess’s nose, Irma’s nose, the uterine tract, the phallus, Freud’s future social and professional reputation and, ultimately, the nose-phallus-uterus of civilization itself.

It is therefore probable that the foundational problematic I have been sketching will
return with the nose — and, indeed, this is precisely what happens in a number of major Freudian texts. But perhaps the most famous return to the nose is in the course of a long footnote to *Civilization and its Discontents*, where Freud writes:

The diminution of the olfactory stimuli seems itself to be a consequence of man’s raising himself from the ground, of his assumption of an upright gait; this made his genitals, which were previously concealed, visible and in need of protection, and so provoked feelings of shame in him.

Thus it is not simply that there is no nasal phase in psychoanalysis. If Freud, under the pressure of his drug-bust, sometimes seems to too-rapidly assimilate the nose to the oral cavity, the nose (identified here with the sense of smell) returns here at the very origin of civilization itself. But if ‘ontogeny recapitulates phylogeny’, why is there then no definite nasal phase in childhood? Precisely because the nose is the pre-history of the historical erection of the erection, the nose cannot become a phase because it designates the ambivalent residue of an immemorial transition. The nose constitutes the visible remains of the inhuman in humanity, when there was neither civilization nor shame.

But we can speculate that the nose also constitutes the visible remains of neurology in psychoanalysis, when there was neither addiction nor sexuality. This speculation further suggests a fundamental historic-cultural hypothesis for future research, and which implicates domains apparently very distant from the psychoanalytical: *sexuality is what arises when drugs become addictive*.

**Notes**


3. J. Forrester, ‘Lessons from the Freud Wars’, Unpublished manuscript. All further references to Forrester’s paper will be noted in the body of the text. I am grateful to David Bennett for bringing this text to my attention. I would also like to thank my referees for their generous and very helpful comments.


6. As Avital Ronell asks, ‘What if ‘drugs’ named a special mode of addiction, however, or the structure that is philosophically and metaphysically at the basis of our culture?’ *Crack Wars: Literature, Addiction, Mania* (Lincoln: University of Nebraska Press, 1992), p. 13. Hereafter referred to as ‘CW’.


9. I use the word *dressage* here (i.e. the training of horses in obedience and deportment), not simply for the opportunity of making a specious inter-lingual pun, but in order to flag the irreducible *disciplinary* aspects of all modern drug-taking, from the most apparently minor or innocent to the most flagrantly ‘transgressive’.

10. I am alluding here to that Romantic tradition Avital Ronell calls ‘hallucinogenre’ (*Crack Wars*, p. 11) in which drug visions provide the impetus for an ecstatic-fusional apprehension of the infinite eclosion-occlusion of Being -- invariably couched in a rhetoric of transcendence, intense affect (e.g., the ‘rush’), spectacular visions, spatial and temporal dislocation, the obliteration of quotidian subjectivity, and so on.

11. ‘Magic’ is Freud’s own word for cocaine’s efficacy. As he writes in a letter to Martha, dated June 2 1884, ‘Woe to you, my Princess, when I come. I will kiss you quite red and feed you till you are plump. And if you are forward you shall see who is the stronger, a gentle little girl who doesn’t eat enough or a big wild man who has cocaine in his body. In my last severe depression I took coca again and a small dose lifted me to the heights in a wonderful fashion. I am just now busy collecting the literature for a song of praise to this magical substance’, cited in E. Jones, *Sigmund Freud: Life and Work. Volume One: The Young Freud 1856–1900* (London: The Hogarth Press, 1956), p. 93. Hereafter referred to as ‘LW’. My emphasis.

12. As Ronell puts it, Freud ‘for the sake of some unplumbable purpose, staked his early career entirely on cocaine and on the essays devoted to cocaine. As a result ... Freud was publicly reprimanded and privately assailed’, Ronell, p. 52.


18. Cited in Louis Albrand, ‘Freud et le panégyrique de la cocaïne’, Spiriot, p. 43. In an essay mainly dedicated to the case of the little-known Brunswick siblings, Paul Roazen writes, ‘It turned out that a central reason for literary reticence about Ruth Brunswick was the extent to which, under Freud’s care, she had become addicted to drugs; at one point in Vienna she even put herself in a sanatorium to help overcome her dependency ... Addicts, like perverts, were in principle deemed to be outside the scope of neurosis, and therefore inaccessible to psychoanalytic influence’, ‘Freud’s Patients: First-Person Accounts’, in *Freud and the History of Psychoanalysis*, ed. by T. Gelfand and J. Kerr (London: The Analytic Press, 1992), pp. 297–298.


20. Indeed, the most recent biography of Freud in English simply rehashes the most minimal

21. Louis Alibrand’s attempt to theorize this situation remains, as I will try to show below, entirely insufficient to deal with the complexity of Freud’s relation to drugs: ‘We can easily understand why Freud became disinterested in cocaine; why, equally, he rarely alluded to it in the course of his illustrious career as a psychoanalyst, as he had repressed, in his unconscious, a particularly unpleasant episode of his life’, p. 42.


24. Very quickly, there came a number of attacks in the medical press. Indeed, for some time there had been a simmering controversy regarding the use of those newly synthesized substances, following Dr E. Levinstein’s publication of *Die Morphiumsucht nach Eigenen Beobachtungen* (translated into English in 1878 as *Morbid Craving for Morphia*): ‘Levinstein’s book was based on his own experiences in the institutional treatment of addiction in Berlin, and was instrumental in defining ‘morphinism’ as a separate condition or disease’, V. Berridge and G. Edwards, *Opium and the People: Opiate Use in Nineteenth-Century England* (New York: Allen Lane/St Martin’s Press, 1981), p. 142.


26. This association is more than simply folkloric. In Sandor Gilman’s words, ‘The idea that the nasal cavities were anatomically parallel to the genitalia grew out of the study of human embryology during the nineteenth century. As early as G. Valentin’s 1835 handbook of human development, the parallels in the development of soft-tissue areas and cavities of the fetus had been noted. By the time of the publication of the standard atlas of human embryological development by Wilhelm His in 1885, the assumption of such parallels was at the center of European embryology ... embryology also proved that the formation of the nasal passages and the incipient genitalia happened very early in the development of the fetus’, Gilman, *Disease and Representation: Images of Illness from Madness to AIDS* (Ithaca: Cornell University Press, 1988), p. 188. Hereafter referred to as ’DR’. A contemporary scientific variant of this scientific association focuses on the apparently profound physiological similarities between orgasms and sneezing.


Hollingdale (Harmondsworth: Penguin, 1968), p. 36. Finally, of course, we have the nose’s ambivalent treatment in psychoanalytic theory, of which more below. However, it is worth quoting Freud’s Hungarian disciple Sandor Ferenczi on this point: ‘smell may properly be considered the biological prototype of thought’, Thalassa: A Theory of Genitality, trans. by H.A. Bunker (London: Maresfield Library, 1989), p. 71. We could even provisionally gesture towards a possible historicisation of this fundamentally aesthetic question, as Susan Buck-Morss does in her elaboration of the bourgeois ‘phantasmagorisation’ of everyday urban life since the beginning of the nineteenth-century, ‘Aesthetics and Anaesthetics: Walter Benjamin’s Artwork Essay Reconsidered’, October 62, Fall 1992, p. 24. See also C. Classen and others, Aroma: The Cultural History of Smell (London: Routledge, 1994). This paper is intended as one chapter in an ongoing project on the role played by the nose and smell in culture more generally.

30. B. Hecht, A Guide for the Bedevilled (New York: Garden City Publishing Co., 1945), p. 21. The phrase occurs in the context of a discussion of Voltaire: ‘It is no pleasure to say of so fine a fellow as Voltaire that he is a fouler enemy of the Jews than the murderous German of today. It is like reporting of a great beauty who dazzles your eyes that she has not so pleasant an effect on your nose. Ah, this extra nose that the Jew carries! It is an organ out of which he gets little delight and much inconvenience. What he would embrace passionately as a man of the world, is sniffed at by this secondary proboscis and found to reek of aversion for the Jew. He may continue his embrace, despite this depressing odor, but it is the embrace of a lover whose heart must overlook more than it holds’, p. 21. Other sub-sections of the book include ‘The Love of Stinking’ and ‘Narcissus without a Face’, and, in the section ‘A Yale Scholar’ Hecht adds ‘Our scientists and scholars have been unusually busy of late measuring Jewish noses, occiputs and thigh bones ...’, p. 241. The title of the book is itself, of course, an allusion to Maimonides’ classical treatise, A Guide for the Perplexed.

31. As a historico-philosophical curio, Hegel’s section denouncing physiognomy and phrenology in Phenomenology of Spirit, trans. by A.V. Miller, foreword by J.N. Findlay (Oxford: Oxford University Press, 1977) is of some interest here, on at least two points. 1) ‘It may be said of the Jewish people that it is precisely because they stand before the portal of salvation that they are, and have been, the most reprobate and rejected: what that people should be in and for it self, this essential nature of its own self, is not explicitly present to it’, p. 206. 2) ‘The depth which Spirit brings forth from within – but only as far as its picture-thinking consciousness where it lets it remain – and the ignorance of this consciousness about what it really is saying, are the same conjunction of the high and the low which, in the living being, Nature naively expresses when it combines the organ of its highest fulfilment, the organ of generation, with the organ of urination’, p. 210. In Hegel’s speculative anthropology ‘the Jewish people’ are thus placed in a threshold position that is strictly analogous to the position of the penis – as at once the highest and lowest expressions of theologico-natural naïvety!


35. However, this attribution has been disputed (as has much else), by Jeffrey Masson. See The Assault on Truth: Freud’s suppression of the seduction theory (Harmondsworth: Penguin, 1985), p. 57.

36. Appignanesi and Forrester, p. 119.


40. Freud’s unconscious doubling of Fleischl and Fliess is obviously also of importance. As Ronell points out, ‘Freud was first, as usual; to draw attention to the jarring compatibility of the names of his most vital friends: Fluss, Fleischl, Fliess. Before there was Fleiss there was Fluss, and before Fluss (also ‘river’) dissolved into Fliess (also ‘flowing’, ‘secretion’), there was Fleischl (also ‘flesh’, ‘meat’), *Dictations*, p. 40.

41. Freud may indeed be alluding to this when he writes, ‘Certain other themes played a part in the dream, which were not so obviously connected with my expulation from Irma’s illness: my daughter’s illness and that of patient who bore the same name, the injurious effect of cocaine ... ’, *The Interpretation of Dreams*, p. 197. The covert numericity of Freud’s procedure here seems to consist of a kind of count-down, from three (Freud, Fliess, Emma), to two (Freud and Fliess, the only two who really matter), to one (Freud himself, the true double of Fliess’s double, hence in Fliess more than himself). It should go without saying that Freud’s numerology is, even by his own lights, utterly unsustainable. But see also Derrida’s remarks on the *square of women* who resist Freud’s dreams: ‘we must recall that everything here is concentrated and at the same time dissolved in a solution (Lösung), a chemical solution but also ... the solution of a problem (it’s the same word, Lösung), an analytic solution. An analytic solution untangles, resolves, even absolves; it undoes the symptomatic or etiological knot. The same word (solution, analytic resolution, Lösung) is valid for the drug and for the end of the analysis. And the reason Freud reproaches Irma in the course of the dream, the reason he reproaches Irma’s resistance, is that she has not accepted his solution’, *Resistances of Psychoanalysis*, trans. by P. Kamuf and others (Stanford: Stanford University Press, 1998), p. 7.

42. ‘Freud continued to prescribe cocaine until at least 1895, the year of his self-analysis, for topical application to the nasal mucous membranes, and he used it himself for sinusitis. He suffered not only from nasal infections but from migraine and, after an attack of influenza in 1889, heart arrhythmia ... Fliess induced him to give up smoking in 1894, and a short while afterward he suffered a severe cardiac condition with racing and irregular heart, tension, hot pain in the left arm, and respiratory difficulties. Fliess, who had previously diagnosed Freud’s heart troubles as being of nasal origin, now attributed them to nicotine poisoning. Although Freud doubted the diagnosis, he managed to stop smoking for 14 months, until he could no longer tolerate abstinence. By this time Fliess had again decided that the heart condition was of nasal origin, and this conclusion was apparently supported by the improvement that followed an operation and the use of cocaine nose drops. Jones believes that the heart troubles, the migraine, and the nasal infections were all neurotic, although slightly aggravated by the effects of nicotine’, Bakalar and Grinspoon, p. 35.

43. Freud also refers to his own nasal passing as ‘a private Etna’, *The Complete Letters*, p. 116.

44. Letter dated 24 January 1895, Freud, *The Complete Letters*, p. 106. And, in another letter dated 20 April 1895, following Emma’s recovery, ‘Today I can write because I have more hope; I pulled myself out of a miserable attack with a cocaine application’, p. 126. Freud was also concurrently taking another drug, strophanthus, for his physical complaints.

45. For a very different reading of this scene, see W. Koestenbaum, *Double Talk: The erotics of male literary collaboration* (New York: Routledge, 1989), esp. chapter one, ‘Privileging the Anus: Anna O. and the Collaborative Origin of Psychoanalysis’.

46. As it happens, Emma is so badly mutilated by the operation that she is rendered ‘barely recognizable’.

47. As Ronell remarks, ‘it all comes down to the discharge of the male organ contaminated with
properties of the female organ ... And it is Irma ... [who] will act as midwife and wet nurse to the dream of dreams, the story of the semen that did not follow', Dictations, p. 53. Ronell also notes that 'Emma' spelt backwards reads Amme, midwife!

48. In his speculations that Dora was a childhood masturbator, Freud remarks that: 'It is well known that gastric pains occur especially often in those who masturbate. According to a personal communication made to me by Wilhelm Fliess, it is precisely gastralgias of this character which can be interrupted by an application of cocaine to the 'gastric spot' discovered by him in the nose, and which can be cured by the cauterization of the same spot', S. Freud, Case Histories I: 'Dora' and 'Little Hans', trans. by A. and J. Strachey (Harmondsworth: Penguin, 1977), p. 115.


50. As one of the referees for this paper cannily pointed out in the report: 'If there were a "nasal phase" in infant development, perhaps it is the neonatal, when infants recognise their mother primarily by smell? The "nasal phase" of psychoanalysis would seem to be similarly primal'.

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