Chapter 24. The case of Dr. Sigmund Freud

Through the centuries since Columbus, countless millions of smokers the world over have tried to stop smoking. Some have succeeded, many have failed. One of those who failed was Dr. Sigmund Freud. The account of his failure that follows is drawn from the three-volume biography of Freud by Dr. Ernest Jones, himself a psychoanalyst and one of Freud's closest associates.

In 1894, when Freud was thirty-eight, Dr. Jones reports, his best friend, Dr. Wilhelm Fleiss, informed Freud that his heart arrhythmia was due to smoking, and ordered him to stop. Freud tried to stop, or to cut down his cigar ration, but failed. "He was always a heavy smoker—twenty cigars a day were his usual allowance," Dr. Jones writes. "In the correspondence [between Freud and Fleiss] there are many references to this attempt to diminish or even abolish the habit, mainly on Fleiss's advice. But it was one respect in which even Fleiss's influence was ineffective."  

Freud did stop for a time at one point, but his subsequent depression and other withdrawal symptoms proved unbearable. He described these symptoms vividly:

Soon after giving up smoking there were tolerable days. Then there came suddenly a severe affection of the heart, worse than I ever had when smoking. ... And with it an oppression of mood in——which images of dying and farewell scenes replaced the more usual fantasies. . . . The organic disturbances have lessened in the last couple of days; the hypo-manic mood continues. . . . It is annoying for a doctor who has to be concerned all day long with neurosis not to know whether he is suffering from a justifiable or a hypochondriacal depression.  

Within seven weeks, Freud was smoking again.

On a later occasion, Freud stopped smoking for fourteen very long months. "Then he resumed," Dr. Jones reports, "the torture being beyond human power to bear."  

More than fifteen years later, at the age of fifty-five, Freud was still smoking twenty cigars a day——and still struggling against his addiction. In a letter to Dr. Jones he remarked on "the sudden intolerance of [my heart] for tobacco."  

Four years later he wrote to Dr. Karl Abraham that his passion for smoking hindered his psychoanalytic studies. Yet he kept on smoking.
In February 1923, at the age of sixty-seven, Freud noted sores on his right palate, and jaw that failed to heal. They were cancers. An operation was performed—the first of thirty-three operations for cancer of the jaw and oral cavity which he endured during the sixteen remaining years of his life. I am still out of work and cannot swallow," he wrote shortly after this first operation. "Smoking is accused as the etiology of this tissue rebellion." Yet he continued to smoke.

In addition to his series of cancers and cancer operations, all in the oral area, Freud now suffered attacks of "tobacco angina" whenever he smoked. He tried partially denicotinized cigars, but even these produced anginal pains and other heart symptoms. Yet he continued to smoke.

At seventy-three, Freud was ordered to retire to a sanitarium for his heart condition. He made an immediate recovery—not through any therapeutic miracle," he wrote, "but through an act of autonomy." This act of autonomy was, of course, a firm decision to stop smoking. And Freud did stop—for twenty-three days. Then he started smoking one cigar a day. Then two. Then three or four....

In 1936, at the age of seventy-nine, and in the midst of his endless series of mouth and jaw operations for cancer, Freud had more heart trouble. "It was evidently exacerbated by nicotine," Dr. Jones writes, "since it was relieved as soon as he stopped smoking." His jaw had by then been entirely removed and an artificial jaw substituted; he was in almost constant pain; often he could not speak and sometimes he could not chew or swallow. Yet at the age of eighty-one, Freud was still smoking what Dr. Jones, his close friend at this period, calls "an endless series of cigars."

Freud died of cancer in 1939, at the age of eighty-three. His efforts over a forty-five-year period to stop smoking, his repeated inability to stop, his suffering when he tried to stop, and the persistence of his craving and suffering even after fourteen continuous months of abstinence—a "torture... beyond human power to bear"—make him the tragic prototype of tobacco addiction.

All smokers who try to stop smoking do not, of course, stiffer the anguish Freud suffered. Even some chain cigarette smokers who have smoked two packs or more a day for many years are able to stop when they decide the time has come. In retrospect at least, some of these exsmokers report that "breaking the habit" was easy, or was difficult for only a few days or weeks. But Freud's case was far from unique. Indeed, we shall cite evidence below which suggests that the great majority of smokers are, like Freud, unable to stop smoking. Even those most highly motivated to stop, moreover, are among the failures. Sufferers from Buerger's disease are a startling case in point.

Buerger's disease is a condition in which the blood vessels, especially those supplying the legs, are constricted so that circulation is impaired whenever nicotine enters the bloodstream. If a patient with this condition continues to smoke, gangrene may eventually set in. First a few toes may have to be amputated, then the foot at the ankle, then the leg at the knee, and ultimately at the hip. Somewhere along this gruesome progression gangrene may also attack the other leg. Patients are strongly advised that if they will only stop smoking, it is virtually certain that the
otherwise inexorable march of gangrene up the legs will be curbed. Yet surgeons report that it is not at all uncommon to find a patient with Buerger's disease vigorously puffing away in his hospital bed following a second or third amputation operation. Much the same is true of patients who suffer a heart attack, or stroke, or the onset of high blood pressure. These patients have a life-and-death incentive to abstain— yet many go right on smoking.

Chest specialists similarly tell of men and women with progressive emphysema, whose breathing becomes increasingly difficult until eventually death occurs from respiratory failure. Even during the last months of their ordeal, when they must breathe oxygen intermittently instead of air, some of them go right on alternating cigarette smoke and oxygen. These and other lines of evidence have led Dr. Vincent P. Dole of the Rockefeller University, a leading authority on heroin addiction (see Part 1), to conclude: "Cigarette smoking is a true addiction. The confirmed smoker acts under a compulsion which is quite comparable to that of the heroin user." 

Confirmation of Dr. Dole's conclusion comes from Synanon, the therapeutic community for heroin addicts and others (see Chapter 10). Prior to May 1970, the New York Times reported in 1971, almost all Synanon residents were heavy cigarette smokers. Since Synanon supplied food, clothing, and all other necessities, including cigarettes, to its residents without charge, the cost to the community was high— almost $200,000 a year for cigarettes for 1,400 residents.

In May 1970, Charles E. Dederich, founder and head of Synanon, decided not only to stop supplying cigarettes without charge but also to ban smoking on Synanon property altogether. In addition to the saving in money, Dederich was motivated by the fact that an X-ray of his own chest showed cloudy areas in the lungs, and that some 200 young people under fifteen living in the seven Synanon centers were learning to smoke there.

A New York Times reporter visited Synanon in May 1971, on the first anniversary of the smoking ban.

"Once the decision was made," he stated, "smoking became the No. 1 crime for the community and was punishable by shaved heads or eventual expulsion." Dederich, himself an inveterate smoker, was among those who quit smoking.

It wasn't easy, for Dederich and for many of the others. "I couldn't have stopped without the help of my colleagues," Dederich was quoted as saying.

The most common reactions reported were depression, irritability, and weight gains ranging from seven to thirty pounds. After a year, the reporter stated, "most of the trauma of withdrawal is over. The majority say the thought of a cigarette is rare, although some admit to an "occasional urge" or fluctuating weight.

Those who felt that the urge had receded, however, were the successes— and not all of those who tried succeeded. "About 100 people left during the six-month period following the ban and chose possible readdiction to drugs outside Synanon to life without cigarettes," the Times added.
"With most drugs," one Synanon resident explained, "you get over the symptoms in a few days, a week at most. But with tobacco, we've noticed them for at least six months." Another, who had personally "kicked" both heroin and tobacco, made a comparison of the two even more startling that Dr. Dole's:

It was much easier to quit heroin than cigarettes. 12

Many ex-heroin addicts, it will be recalled, become alcoholics or suffer other distressing postaddiction misfortunes. No exhaustive study has been made of the problems of ex-cigarette smokers; but at the May 1971 meeting of the American Psychiatric Association, two psychiatrists from the Silver Hill Foundation in New Canaan, Connecticut—Drs. John S. Tamerin, director of research, and Charles P. Neumann, medical director presented some relevant data on "Casualties of the Anti-Smoking Campaign." 13

Drs. Tamerin and Neumann divided the casualties into major and minor. "Among the major casualties," they reported, "are cases of paranoid psychosis and violence following precipitous cessation of smoking." Such major casualties are probably rare.

Minor casualties include "the pansymptomatic individual with a history of repeated failure who again fails in an attempt to quit smoking, producing intensified feelings of worthlessness." As an example, Drs. Tamerin and Neumann presented the case of "an obviously neurotic nurse's aide" who participated in a Silver Hill Foundation group-therapy program designed to help cigarette smokers quit.

She was under much pressure from her family, to quit smoking but had been unsuccessful in repeated attempts to quit on her own, and prior involvement with other cessation programs had failed.... After several meetings in which others in the group announced they had stopped smoking, this woman claimed that she, too, had stopped completely. It was later discovered that she was still smoking, but concealing it within the group. She did, however, admit to extreme anxiety associated with attempting to quit and was given tranquilizers to assist her briefly during the withdrawal phase. She continued to be anxious and reported a voracious and indiscriminate appetite, even finding herself devouring leftovers from patients' plates. This unfortunate experience was clearly producing guilt and shame, and anger at a program that was supposed to be helping her. Eventually she did admit that she was sneaking cigarettes. It became apparent that she was not a candidate, at least at this time in her life, for the program, and it was suggested that she withdraw. Furthermore, in order to prevent the emergence of even more severe psychopathology, she was given brief supportive psychotherapy. In the therapy, a particular effort was made to help her feel that her continued smoking did not mean that she was deficient, inadequate, or inferior to those who had been able to quit. 14

Drs. Tamerin and Neumann comment at some length on what they call a new species created by the antismoking campaign—the hidden smoker.

Like their predecessors, the hidden drinkers, they have been pressured into a pattern of secrecy and deception. This syndrome is now being encountered among individuals who may acknowledge the validity of the data on smoking and disease and promise to stop—and do, for
Eventually the need to smoke returns. The individual, however, feels too guilty to reinitiate the habit at home. Consequently, he may smoke at work while denying at home that he smokes at all. This he may eventually reach such proportions that his coworkers, attending a social function in his home, are pressured into collusion with him. This pattern, of course, must be humiliating to the smoker himself and highly uncomfortable for the other people who are drawn into this new form of marital deception.

Equally unfortunate variants of this species are those individuals who work for organizations which have become heavily committed to and identified with the antismoking campaign. Such individuals may even be members of the higher echelon. However, if they are totally unable to stop smoking, they may be excluded from many organizational functions because of the group's concern about the negative public reaction. Such individuals are, of course, under enormous pressure to stop smoking and their inability to do so fills them with feelings of guilt, shame, and anger. Certain of these individuals may be able to curtail their smoking in public, but they are unable to stop completely and it is not unusual to hear reports of those who still sneak smokes in bathrooms and empty offices. One might suggest that an organizational attitude or policy which in any way fostered this type of behavior regression might benefit from constructive reexamination.

Among the other "frequently observed consequences of cessation," Drs. Tamerin and Neumann continue, are "compulsive overeating, an impairment of intellectual integrative capacity, social discomfort, anxiety, depression or even depersonalization."

Drs. Tamerin and Neumann do not, of course, suggest that antismoking campaigns be terminated in order to prevent such casualties.* Rather, they recommend "awareness of the psychodynamic and pharmacologic importance of cigarettes to smokers, and cautious use of 'hard sell' approaches which may induce guilt or shame."

* Dr. Daniel Horn, director of the National Clearinghouse for Smoking and Health, estimates that no more than 10 or 15 percent of smokers are better off continuing to smoke rather than risking the deleterious psychological consequences of quitting. 16

Approaches that "attempt to stimulate guilt via the implicit statement, 'See what you are doing to your family,' or shame via the implication 'There is something inferior or defective about you if you can't stop' may backfire," the two psychiatrists warn. "The unfortunate consequence of guilt- and shame-inducing approaches is that they may overwhelm the ego rather than informing, assisting, and strengthening it. The result of such approaches— reflected in some of the case material presented— is to leave the smoker afraid, ashamed, and guilt-ridden but weakened as he reaches for another cigarette to soothe those painful feelings." 17


4. Ibid., p. 311.


7. Ibid., p. 150.


12. Ibid.


14. Ibid.

15. Ibid.


17. Tamerin and Neumann, "Casualties of the Anti-Smoking Campaign."