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# "You may quite well say that we are all ill": Freud on the continuity between normality and pathology

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## Abstract

The relation between normality and pathology has intrigued philosophers for centuries, but it has been recently revived by a number of researchers who have articulated and defended various versions of the continuity thesis (or CT, namely the idea that normal and pathological states are not categorically different). Despite a growing interest in the notion of continuity, CT is far from being the received view within philosophy of psychiatry, with many researchers still seeing normal and pathological states as being different in kind. In this article, I show that the core ideas underlying CT were already present in a sophisticated form in Freud's work. Indeed, Freud defends two interrelated theses that allow us to see him as an early defender of continuity. On the one hand, he is committed to the idea that healthy and mentally disordered subjects exhibit deep similarities in terms of mental functioning. On the other hand, he defends the possibility of describing with sufficient precision and generality what goes awry in pathological cases. The article is structured as follows: I first appeal to Freud's work to show that his account of psychopathology supports continuity; I then focus on two theoretical aspects of Freud's proposal that should be taken as *desiderata* for any refined account of mental disorders; and finally, I illustrate how the approach works in practice by analyzing one of Freud's clinical cases.

## Keywords

continuity, Freud, neurosis, psychoanalysis, psychopathology

## An early defense of continuity

In this section I draw mostly on primary sources to argue that Freud's account of mental disorders can be seen as a powerful defense of the idea that normal and pathological states are continuous. Specifically, I focus on two theses defended by Freud. I dub the first thesis *strong continuity*, and I characterize it as the idea that the same psychological mechanisms, forces, and structures are at work in healthy and mentally disordered subjects. I then introduce a second thesis, called *meaningful difference*, which appears to be in tension with the first. Through the discussion of a series of essays where Freud directly compares clinical and non-clinical populations, I show that it is possible to describe with sufficient precision and generality what goes awry in pathological cases. Although these theses have been already embraced and defended by some Freudian scholars (see Van Haute & Geyskens, 2012), they are still controversial within contemporary psychiatry and they are often overlooked by philosophers of psychoanalysis (as also stressed by Van Haute, 2005). The following discussion will thus serve the purpose of introducing Freud's view of continuity to researchers in philosophy and psychiatry who are not already familiar with his work.

### *Strong continuity*

The evidence for strong continuity is disseminated throughout Freud's writings at various stages of his career, from the early *Studies on Hysteria* (1895) to the late *Outline of Psychoanalysis* (1938/1949). This strong commitment to continuity arises primarily from the observation that the same psychical mechanisms, forces, and structures witnessed in patients can be detected—albeit more implicitly—in people that are normally regarded as "healthy." As Freud puts it: "Pathology, with its magnification and exaggeration, can make us aware of normal phenomena which we would otherwise have missed" (1933, p. 80). These similarities in mental functioning run deep and uncover a psychical apparatus that can be divided "geographically" into three mental provinces: id, ego, and super-ego.

To put it roughly, Freud describes the id as the most ancient part of the mind, one that lacks direct communication with the outside world and focuses on a realm of internal perception (e.g., bodily changes, feelings of pleasure and unpleasure). This mental province is also the seat of the instincts originating from our somatic organization and represents the demands of everything that is inherited and present at birth (see 1938/1949, p. 84). The main purpose of the id is thus to give mental expression to the instinctual needs coming from the body.[1] Notably, Freud describes it as a structure that lacks unified will or coherent organization: neither the laws of logic (e.g., law of non-contradiction) nor the notion of time have any significant influence on the id. In fact, contrasting impulses may coexist side by side without neutralizing each other, and they can be "virtually immortal and preserved for whole decades as though they had only recently occurred" (1933, p. 99). The ego develops out of the id and represents the mental agency responsible for our contact with the external world with all its resources, dangers, and demands. It is characterized as the seat of thought because it mediates between the instincts coming from the id and the actions affecting the external world. Freud describes this system as interpolating thought between desires and action, as synthesizing and unifying the pressures coming from different sources into a more or less coherent whole (1933, pp. 102–103). The ego's main concern lies therefore in self-preservation and protection against external and internal dangers: for this reason, it is also the seat of anxiety (reaction to danger), repression (flight from an internal threat), and disavowal (flight from an external threat). Finally, Freud characterizes the super-ego as a portion of the ego that develops throughout childhood and in particular via identification with the parents: more specifically, it works as a "special agency where parental influence is prolonged" (1938/1949, p. 15). In this sense, the super-ego represents the most recent and superficial part of our mental apparatus, because—as opposed to the id—it is something acquired through nurture and something that is not present from the very beginning of life (see 1933, p. 84). In terms of goals, the super-ego is thus the mental agency that observes, judges, and criticizes the ego, thereby representing our moral conscience as well as our self-ideals or expectations (see Figure 1 for a visual representation of Freud's mental agencies).

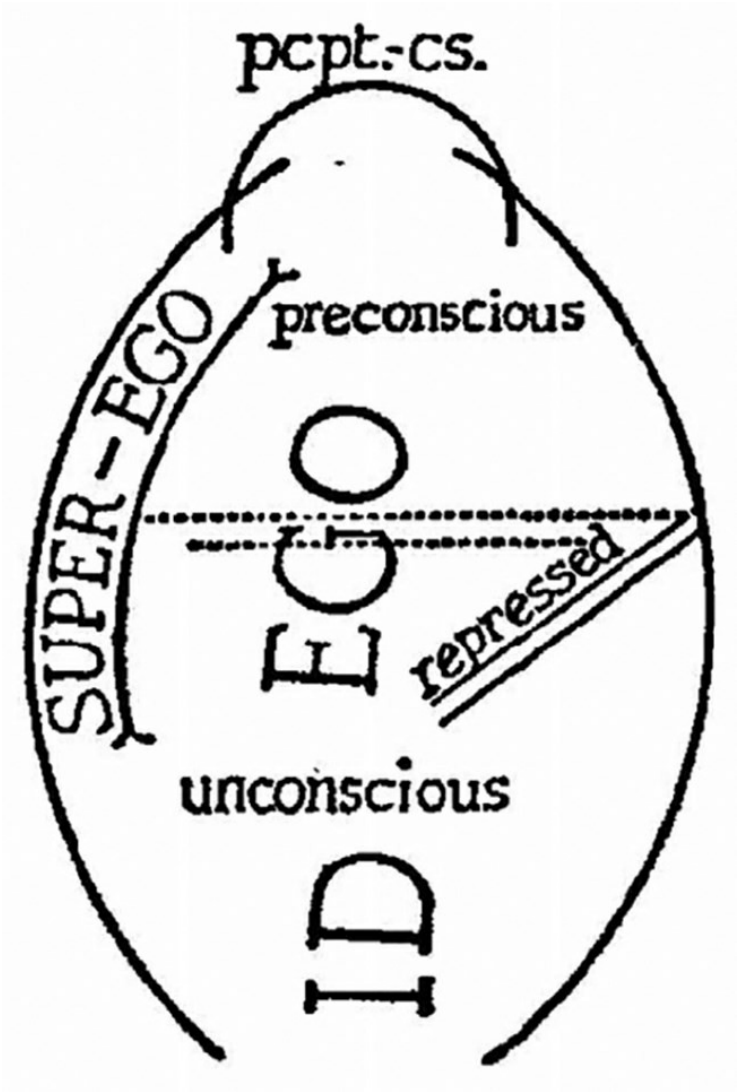

**Figure 1.**

The anatomy of the Mental Personality

Note. (This figure is taken from Freud, (1933). Reprinted from the *New Introductory Lectures on Psychoanalysis* (p. 105), by S. Freud, 2013, Martino Publishing. Reprint of the 1933 edition published by the Hogarth Press. Copyright (2013) by Martino Publishing.

This apparent simplification of the psychical realm should not obscure a crucial fact uncovered by Freud. The dynamics among these mental structures do not reflect a situation of harmony, but rather a state of permanent tension and conflict. Indeed, some forces—such as those represented by the id—are upward-driving and struggling to emerge, whereas others—such as those at work in the super-ego—are downward-driving and attempting to repress. In this battlefield, the ego plays the delicate role of a mediator: on the one hand, it takes over the instinctual demands of the id and attempts to lead them to satisfaction without neglecting reality; on the other hand, it strives towards the ideals placed on it by the super-ego while trying to avoid punishment. Making use of a series of metaphors, Freud first compares the ego to a constitutional monarch, "without whose sanction no law can be passed and who hesitates long before imposing a veto on any measure put forward by the Parliament" (1923/1989, p. 81). However, elsewhere, Freud describes the ego as a slave who "has to serve three harsh masters, and has to do the best to reconcile the claims and demands of all three" (i.e., the external world, super-ego, and id; 1933, p. 103). This process of mediation and defense inevitably turns out to be inadequate, as the ego is "fighting on two fronts": on the one side, it protects itself against the dangers of the external world, while on the other it puts up with demands from the internal world (1938/1949, p. 87). For our purposes, it is important to stress that this psychical apparatus is *shared* by people who are regarded as healthy as well as by people affected by mental disorders. Freud states the point explicitly: "It is not scientifically feasible to draw a line of demarcation between what is psychically normal and abnormal; so that the distinction, in spite of all its practical importance, possesses only a conventional value" (1938/1949, p. 81).

Two points in support of strong continuity are repeatedly brought up by Freud in his writings. First, he defends the idea that psychical continuity grounds the comparison between normal and abnormal cognition. Specifically, Freud claims that the commitment to psychical continuity serves as the main justification for inferring normal functioning from pathological cases. This is shared by many contemporary philosophers of psychiatry, who believe that focusing on pathology represents a good way to investigate the mind's normal functioning (see Graham, 2013; Murphy, 2006). Yet, the idea that we can learn something about the mind by studying how the mind breaks makes sense only under the assumption that normal and abnormal cognition are importantly continuous. Indeed, without such an assumption, nothing prevents us from thinking that pathological and healthy functioning would follow completely different rules and operate under different mechanisms. If this were the case, we would probably be able to discover something interesting about pathology without being able to infer any conclusion or gain any insight about how the mind normally works.

Notably, the commitment to continuity may be—and indeed has been—interpreted in a stronger and a weaker sense both by Freud himself and by later commentators of his work. According to the weaker interpretation, the study of pathology sheds some light on normal functioning but the two conditions are still seen as importantly separate, at least from a clinical perspective. This seems to be the view adopted by mainstream psychiatry, where diagnostic tools such as the DSM or standardized tests are specifically designed to pry apart normal and pathological conditions. According to the stronger interpretation, continuity implies a more radical revision of the very notions of normality and pathology: in other words—as stated above (Freud, 1938/1949, p. 81)—the distinction between them cannot be but conventional.[2] Freud makes the point more explicit through an analogy: if we throw a crystal to the ground, we notice that it does not break "haphazardly" but rather follows specific lines and limits that were implicit in its structure. Similarly, mentally disordered patients show mental "breaches" or "clefts" that can be interpreted as missing links, and make observable "through magnification and exaggeration" some patterns or phenomena that would be otherwise inaccessible (1933, p. 80). With the so-called "crystal principle," Freud inaugurates what has come to be known as *anthropological pathoanalysis* (Van Haute, 2014; Van Haute & Geyskens, 2012), that is, the idea that human existence has to be understood from the point of view of its psychopathological variations. This approach proves theoretically significant as it rejects the very idea of "normality" or "health" in contrast to which pathology should be determined. Rather, "according to Freud the fundamental tendencies which characterize what it means to be human do out of themselves lead to pathology, and *that which we call psychical health is nothing other than the precarious balance of these tendencies* [emphasis added]" (Van Haute, 2005, p. 365).

Freud fleshes out this principle in several other places, from the *Project for a Scientific Psychology* (posthumously published in 1950 but written during the early years of psychoanalysis; Freud & Bonaparte, 1954) to the late *Outline of Psychoanalysis* (1938/1949). In the *Project* (1950), Freud directly compares the compulsions experienced by patients suffering from hysteria with the "excessively intense ideas" that we all encounter in our everyday lives (Freud & Bonaparte, 1954, p. 405). These two sets of ideas are remarkably similar: for example, they are both hard to dismiss and they often arouse distressing affect in the people who experience them. However, while we tend to regard excessively intense ideas as "the product of powerful and reasonable motives," compulsions "strike us by their oddity" and seem to have special importance only for the person who is affected by them (p. 405). This passage shows that the comparison between healthy and mentally disordered populations is fruitful because it also helps to uncover important aspects of normal functioning. Freud defends the point even more strongly in the *Outline*, where he expects the study of neurosis to provide us with valuable contributions to our knowledge of healthy functioning. As he puts it, "it may be that we shall thus discover the 'weak points' in a normal organization" (1938/1949, p. 64).

Second, such continuity between mental health and pathology is ultimately based on quantitative factors such as the degree of mental energy accumulated or discharged, or the force of the instinctual demands repressed by the ego. Freud insists that the only meaningful distinction between mental health and pathology should be based on *quantitative factors*, such as the quota of affective tension that a subject can tolerate. This idea is, again, grounded in an underlying continuity between normal and abnormal cognition and arises from the observation that the patient's behavior does not radically differ from the one exhibited by healthy people. Already in the *Studies on Hysteria* (1895), Freud realized that we all bear in our consciousness a great number of ideas that have not been "affectively dealt with." Thus, even people who fall ill are able to tolerate this accumulation until "the amount is increased by summation to a point beyond the subject's tolerance" (p. 174). Notably, this breaking-point is highly individualized and depends on a host of factors that are internal as well as external in nature (e.g., personality, environmental influences, traumatic events). As Freud put it in a later essay: "Each individual has in all probability a limit beyond which his mental apparatus fails in its function of mastering the quantities of excitation which require to be disposed of" (1926, p. 128). This observation allows us to significantly refine the continuity claim and to show the internal complexity of Freud's account. On the one hand, there is no qualitative distinction between healthy and pathological mental functioning because the same pathogenic determinants are present in everyone. Freud makes the point explicit in the *Introductory Lectures on Psychoanalysis*: "'Being ill' is a practical concept. ... But if you take up a theoretical point of view and disregard this matter of quantity, you may quite well say that we are all ill—that is, neurotic—since the preconditions for the formation of symptoms can also be observed in normal people" (1916–17, p. 358).[3] On the other hand, we still need to explain why some people are more liable to develop a mental disorder with respect to others who share a similar psychological makeup and go through similar life experiences. Freud regards this question as a crucial one: "Why are some people not falling ill?" (1924a, p. 152); "What we need and cannot lay our finger on is some factor which will explain why some people are able to subject the affect of anxiety, in spite of its unique quality, to the ordinary workings of the mind, or why others are doomed to break down over this task" (1926, p. 130).

In order to address this issue, Freud introduces a different approach to the study of the mind: crucially, he realizes that it is not sufficient to give a *topographical* account of the mental provinces or to investigate the way in which the psychical forces come *dynamically* into conflict. What is missing is an *economic* account, one able to deal with mental events in terms of the intensity of forces running through them and thus having the resources to explain mental phenomena quantitatively. Once this approach has been adopted, we can regard two subjects as different in terms of the "relative strength of their [mental] forces" (Freud, 1937, p. 230). For example, in one person the repressed forces (i.e., those coming from the id) may be too strong and hard to keep at bay, while in another the repressing forces (i.e., those coming from the superego) may be too weak to resist effectively against the attack (see Freud, 1924b, 1938/1949). In these cases, we may even witness a similar symptomatic manifestation (e.g., hysterical paralysis) arising for different economic motives: in the first case, the strength of the psychological forces would be primarily responsible; in the second case, the degree of control exercised by the ego would play a more important role. In the next section, I take a deeper look at the crucial role played by the economic approach in Freud's account.

## *Meaningful difference*

As I mentioned above, Freud's account combines a strong commitment to mental continuity with the attempt to describe as precisely as possible what goes awry in pathological cases. In other words, healthy and mentally disordered subjects exhibit important similarities as well as meaningful differences. The evidence for the latter thesis comes mostly from a series of essays where Freud directly compares clinical and non-clinical populations, discussing resemblances and differences between the two groups.

One of the earliest sources in this sense is the article "Obsessive Actions and Religious Practices" (1907), focusing on the resemblance between the obsessive actions of neurotics and the religious observances of believers. Freud immediately warns us against regarding the similarity as a superficial one: indeed, the beliefs and actions of neurotics appear deeply continuous with those exhibited by religious people. For example, both groups tend to make small adjustments to everyday actions (e.g., eating habits and prohibitions) and they both subject themselves to a range of restrictions and arrangements that often take the form of a *ceremonial*. Freud describes a ceremonial as a sum of conditions placed upon something forbidden so as to make it permissible (1907, p. 124). In this sense, celebrating a wedding according to certain rules before having sex and washing one's hands a certain number of times before going to bed count as ceremonials. Moreover, there are distinguishing psychological traits that accompany the performance of a ceremonial: mostly a sense of conscientiousness and anxiety about "doing things right," but also an important relationship between actions (or inactions) and guilt. Due to these striking similarities, Freud suggests regarding neurosis as a sort of "individual religiosity" and religion as a kind of "universal obsessional neurosis" (1907, p. 128). However, he also points out some important differences between people with obsessional neuroses and religious people: for instance, the former tend to regard their ceremonials as an eminently private and solitary enterprise, while the latter take great pains to display them as public and collective rituals. Again, people with neuroses exhibit a high degree of individual variability and idiosyncrasies in performing their rituals, whereas religious people tend to repeat an impersonal series of stereotyped or codified gestures. Notably, the key difference between the two groups seems to lie in the degree of intersubjective agreement upon certain beliefs and actions. Whereas people with neuroses' ceremonials appear "senseless" to others, religious rituals are embedded in a network of socio-cultural practices and symbolic meanings (1907, p. 120). Similarly, in the *Project for a Scientific Psychology* (Freud & Bonaparte, 1954), Freud distinguishes compulsions from excessively intense ideas by appealing to different degrees of intersubjective recognition:

> Excessively intense ideas also occur normally. … We are not surprised at them, if we know their genetic development (education, experiences) and their motives. We are in the habit of regarding these excessively intense ideas as the product of powerful and reasonable motives. In hysterics, on the contrary, excessively intense ideas strike us by their oddity. They are ideas which produce no effects in other people and whose importance we cannot appreciate. They appear to us as intruders and usurpers and accordingly as ridiculous. (p. 405)

Another discussion along similar lines can be found in the article "Mourning and Melancholia" (1917), where Freud explores the emotion of normal grief in order to shed light on pathological melancholia (today known as depression). Once again, the idea is to offer a comparative account of grief and depression showing what the two conditions have in common as well as what makes them importantly different. On Freud's view, both conditions arise from similar external influences and they are both reactions to a significant loss that can be interpreted literally (e.g., death of a loved one) or ideally (e.g., loss of love). At first glance, grief and depression appear remarkably similar: they are both characterized by "painful dejection," "abrogation of interest in the outside world," and general inhibition to undertake any activity, even those that were once deemed pleasurable by the individual (1917, p. 244). However, depression exhibits a distinguishing feature that most cases of normal grief lack, namely an attitude of self-reproach and low self-esteem that Freud describes as "delusional belittling" (1917, p. 246). This important difference suggests that depression and grief may have a similar origin but a different outcome: in other words, they may be the very same process undergoing a normal development in the one case and a pathological one in the other. Freud characterized the common underlying mechanism as follows: the function of reality-testing carried out by the ego reveals the absence of the loved object, causing the sudden withdrawal of all the mental energy previously attached to it. This free-floating energy then generates a more or less prolonged phase of struggle against reality, where various forms of wish-psychosis may ensue (e.g., dreams about the loved one, phenomena of hyper-familiarity, hallucinations). At this point, a bifurcation occurs: some individuals undergo a normal development and end up deferring to reality after some time; others experience a pathological development where the ego finally identifies with the lost love-object and therefore feels itself "at loss, wounded, hurt, neglected, out of favor, disappointed" (1917, p. 251). Depression, like psychosis, is thus characterized as a progressive weakening of the ego, whose energy becomes absorbed in dealing with the loss of a love-object and finally becomes "drained" and "utterly depleted" (p. 253).

Notably, these reflections on meaningful difference disclose a complex scenario in which ideas of normality and pathology interact with the social context along with its pressures and requirements. On the one hand, the case of religious rituals clearly illustrates how intersubjective agreement on what counts as "normal" (or even "healthy") may play a key role in classifying a given action as more or less pathological. On the other hand, in some cases intersubjective agreement contributes to normalize thoughts or behaviors that are, in fact, collective pathologies (e.g., genocides, see Simmel, 1946), as well as to wrongfully pathologize individuals and groups (e.g., sexual and gender minorities). In still other cases, the social context may draw the boundaries between normal and pathological: whether someone counts as a sports addict, a binge-watcher, or a workaholic may vary dramatically depending on factors such as access to resources, group culture, socio-economic status, and so forth. This also applies to the case of mourning and melancholia, as Freud's own thoughts on the matter appear to have been deeply influenced by his changing perspectives on loss and grief during war and peace time (see Homans, 1989).[4] –

In a later essay entitled "The Loss of Reality in Neurosis and Psychosis" (1924b), Freud even characterizes normal psychological functioning as a form of reality distortion and in particular as a compromise between neurosis and psychosis. In the neurotic case, a conflict between the ego and the id resolves in a flight from reality where the ego gains the upper hand and succeeds in keeping the id at bay. However, since the repression is only partially successful, the repressed content ends up coming back as a symptom: for example, in hysteria a body part unconsciously connected with the repressed content becomes paralyzed or painful. In the case of someone suffering from psychosis, the conflict between the ego and the id resolves in favor of the id and the ego becomes partially suppressed. Thus, due to the ego's constitutive connection with the external world, psychosis inherently presents itself as a more or less severe loss of contact with reality. In sum, Freud characterizes repression as a normal psychological process that becomes pathological only under particular circumstances. Normal repression simply consists of avoiding thinking about something that causes one to feel unpleasure by directing thoughts elsewhere. For example, I feel anxious about the talk I am going to give in a few days and I actively try not to think about it. Pathological repression takes place when we do not completely succeed in "forgetting" the distressing idea and we

are reminded of it by "fresh perceptions" (Freud & Bonaparte, 1954, p. 409). For example, I see a PowerPoint icon on my desktop and I suddenly think about the talk. However, this is not sufficient to transform the initial idea from merely distressing to pathogenic; some process of displacement has to occur, where we unconsciously associate the initial idea to a new one that ends up replacing it while attracting its whole quota of affect and anxiety. In our example, this would happen if I were to unconsciously develop a phobia or obsession towards something only loosely related to my talk: for example, the blazer that I am supposed to wear that day or the train that is supposed to get me to the venue. According to Freud, normal functioning could thus be seen as a compromise between these two extreme solutions. As he puts it: "A reaction which combines features of both these is the one we call normal or 'healthy'; it denies reality as little as neurosis but then, like a psychosis, is concerned with effecting a change in it" (Freud 1924b, p. 185). Once again, Freud combines a strong idea of psychical continuity with the effort to distinguish non-problematic cases from others that are harmful for the subjects who experience them.

## A refined account of mental disorder

In this section I discuss some theoretical aspects of Freud's account in more detail in order to lay down the building blocks of a refined model of mental disorders. More specifically, I focus on two ideas that prove helpful in the construction of such a model. I will first flesh out the economic approach introduced above and explore the idea that mental functioning can be successfully described by appealing to quantitative factors. Next, I focus on etiology and argue that most mental disorders are caused by two different kinds of pathogenic determinants: *dispositions* (i.e., constitutional factors) and *experiences* (i.e., accidental or contingent factors). This allows us to move towards a complex view of psychopathology where disorders arise from the interaction between multiple factors and symptoms are almost invariably overdetermined.

### *An economic approach to mental functioning*

As I mention earlier, throughout his career Freud developed the idea that mental functioning can be described by appealing to quantitative factors. This notion can be traced back to one of his earliest works, where he still presents it as a working hypothesis:

> 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 discharge. (1894, p. 60)

Later in the essay, Freud characterizes this quantity by analogy with an electric charge that spreads over ideas or memory-traces and works similarly to the flows and fluids described by physicists (1894, p. 60). A year later, Freud reiterates the same point: "It is impossible any longer to avoid introducing the idea of quantities (even though non-measurable ones)" (1895, p. 86). The analogy with electricity also undergoes a significant development and starts to be applied to pathological phenomena: "If the tension is excessively high, there is danger of a break occurring at *weak points* [emphasis added] in the insulation" (p. 203). This passage is particularly interesting for our purposes because we can see an early reference to the idea that every mental apparatus exhibits a series of vulnerabilities (i.e., "weak points") in its organization.

The assumption about the existence of quantitative factors within the mind becomes increasingly important in Freud's theory, to the point that he feels the need to add an economic approach to the tenets of metapsychology. Such an approach sees psychical events not only in terms of their location (*topographical*) or forces (*dynamic*) but also in terms of their intensity, strength, and magnitude (see also Kitcher, 1995). In Freud's work, the economic point of view becomes particularly important when it comes to comparing healthy and pathological cases: indeed, the two are often seen as topographically and dynamically similar but economically different. For example, dreams are psychotic forms of wish fulfillment that can be distinguished from hallucinatory experiences only in virtue of their short duration and of the higher degree of control that the subject exercises upon them (see 1938/1949, p. 49). Notably, Freud also saw the introduction of an economic viewpoint as a way to bring psychology closer to the physical sciences, where quantities are successful means to capture and measure a great variety of natural phenomena. If introducing notions such as energy, instincts, or cathexis comes at the price of a certain indeterminacy, Freud is ready to point out that a similar degree of approximation affects many other disciplines. As he puts it in "An Outline of Psychoanalysis": "The basic concepts and principles of the new science (instinct, nervous energy, etc.) remain for a considerable time no less indeterminate than those of the older sciences (force, mass, attraction, etc.)" (1938/1949, pp. 30–31). Therefore, the introduction of the economic approach should be seen as an attempt to carry out a thoroughly materialistic enterprise, where the physical and the psychical realms are subsumed under similar laws (see Makari, 2008, for a similar point).

From a theoretical viewpoint, the adoption of an economic approach proves helpful in the investigation of normal functioning and pathology. When describing normal functioning, Freud repeatedly appeals to notions such as "quotas of affect" (1895, p. 205) or "sums of excitation" (1915, p. 123) that can increase, decrease, spread over ideas or memories, be displaced, or be discharged. Such a quantitative approach not only defends the idea that "in mental life, some kind of energy is at work" (1938/1949, p. 37), but also grounds a particular view of affect, instincts, and control. Freud describes affect in terms of *libido*, a quota of displaceable energy that attaches itself to psychical contents (e.g., ideas, memories) and can join forces both with erotic and destructive impulses (despite being per se neutral in quality). The general principle governing libido is to avoid accumulation and facilitate discharge: in this sense, we can imagine some sort of "mental metabolism" where energy can be stored and released in response to a range of different stimuli (see Freud, 1923/1989, pp. 61–62). Every mental structure becomes involved in this process in a way that reflects its peculiar aims and functions. For example, the id exhibits a certain "looseness in displacement" because it regards discharge itself as more important than particular actions or goals. Conversely, the ego is "more particular about object-choice and path of discharge" because of its connection to the ideals promoted by the super-ego as well as to the stimuli coming from the external world (1923/1989, p. 64). On Freud's view, affect plays a crucial role within thought: indeed, "our ego always entertains purposive cathexes, and often many at the same time" (Freud & Bonaparte, 1954, p. 434). Instincts are also characterized quantitatively as "excitations" or "wishful impulses" arising from the relationship between the internal and external worlds; they are

"psychical representatives of organic forces" (1915, p. 122). Notably, instincts are described as being qualitatively similar to one another but as varying with respect to the amount of excitation that they carry. That said, some of the instincts find their satisfaction via an alteration of the internal source (e.g., thirst) while others require a modification of the external world (e.g., getting rid of an enemy by attacking). Finally, control arises progressively as a way of mastering stimuli coming from different sources. On the one hand, external stimuli and threats require immediate responses in terms of actions, for example, flight from a predator. On the other hand, internal stimuli trigger a set of more or less complex activities that aim at changing the world in order to afford satisfaction, for example, courting a potential partner. The development of control also requires a distinction between primary and secondary processes: the former are animated by drives and primarily seek discharge (pleasure principle); the latter correspond to a regulatory mechanism that makes satisfaction dependent on the resources and constraints available in the environment (reality principle). In what follows, I show that the relative strength of affective processes and instincts as well as the degree of control that a subject exercises on them play a crucial role in distinguishing between healthy and pathological manifestations.

As I repeatedly stress, Freud insists on rejecting any kind of qualitative distinction between mental health and pathology: "Neuroses have no psychic content of their own which is not also to be found in healthy states" (1910, p. 50). On his view, mental disorders arise from acute affects or increases in excitation that fail to find proper discharge in physical and psychical activities. In other words, psychopathology originates from a subject's inability to master a certain amount of excitation crossing over a threshold, or from the failure to sublimate and convert a quota of affect to a different use (1916–17, pp. 374–375). Notably, this threshold point is highly individualized although it is possible to individuate general mechanisms at work in specific disorders. For example, when talking about anxiety Freud makes clear that we all experience this affective state but that neurotics are affected by it "much more" and "so much more strongly" than others (p. 393). He then proceeds to distinguish between realistic anxiety as the reaction to a perceived danger that puts the subject into a state of preparedness, and neurotic anxiety as a general and free-floating apprehensiveness ready to attach itself to any idea. Yet, this distinction is also presented as a quantitative one: "The neurotic will differ from the normal person in that his reactions to the dangers in question will be unduly strong" (1926, p. 127). Similar examples are provided in Freud's account of compulsions and phobias, characterized economically as "excessively intense ideas" arising with a "special frequency" (Freud & Bonaparte, 1954, p. 405) or as ideas that appear strange because of their "intensity" as opposed to their content (1916–17, p. 399). Elsewhere, Freud discusses a more subtle economic distinction between healthy and hysterical subjects, one that concerns a difference in degrees of attention. More specifically, patients would fall prey to an extremely focused—albeit involuntary—attention towards certain aspects of their body or of the environment. Whereas healthy subjects who focus attentively on one perception lose the capacity to experience other perceptions only temporarily, for subjects suffering from hysteria, "every idea takes possession of the whole of their limited mental activity" (1895, p. 230). This remark suggests that some mental disorders could be regarded as continuous—or merely economically different—with phenomena such as focusing or attending to something. This would also help to explain pathological manifestations such as fixation on certain objects (e.g., phobias and compulsions), people (e.g., erotomania, Capgras delusion), or events (e.g., delusion of thought insertion, delusion of reference).

In sum, the adoption of an economic approach to mental functioning allows Freud to hold on to the continuity thesis, while at the same time identifying two different ways in which normal processes can go awry. In some cases, there are mechanisms that undergo a special development and thus become pathogenic (e.g., repression). In other cases, purely economic factors are sufficient for crossing the threshold between healthy and pathological manifestations (e.g., ideas arising with a special intensity or frequency).

### *Two kinds of pathogenic determinants: Dispositions and experiences*

From an etiological viewpoint, psychoanalysis offers a complex and multi-factorial account of how mental disorders arise, and by doing so it distinguishes itself from competing views of mental illness as "organic inferiority" (Adler, 1917) or "degeneracy" (Janet, 1894). Freud repeatedly rejects overly reductionist explanations and insists that different etiological factors have to be active at the same time for a mental disorder to develop. As he sarcastically puts it:

> The ideal solution, which medical men no doubt still yearn for, would be to discover some *bacillus* [emphasis added] which could be isolated and bred in a pure culture and which, when injected to anyone, would invariably produce the same illness. Or, to put it rather less extravagantly, to demonstrate the existence of certain *chemical substances* [emphasis added] the administration of which would bring about or cure particular neuroses. (1926, p. 136)

Yet, Freud's skepticism against a purely organic explanation of mental illness should not be interpreted as a wholesale rejection of the role played by biological factors. Indeed, in his account, two different kinds of pathogenic determinants are present: *dispositions* or constitutional factors on the one hand, and *experiences* or accidental factors on the other. The former are described as those elements that "a person brings along with him into his life," whereas the latter are those that "life brings to him" (Freud, 1913, p. 317). Among the dispositional factors, Freud enlists purely somatic elements (e.g., a high degree of nervous excitability) as well as early childhood experiences or facts related to sexual development. Accidental factors instead include psychological experiences that occurred later in life and significant conflicts between mental agencies (e.g., ego and id). The very idea that accidental factors would play an important role in the development of psychopathology has been introduced by Freud and Breuer in their "Preliminary Communication": "[Our results] are valuable theoretically because they have taught us that external events determine the pathology of hysteria to an extent far greater than is known and recognized" (1893, pp. 3–4). A few years later, Freud insisted that mental disorders should not be treated on a par with cases of "mental degeneracy" but that they could often be seen as motivated responses to traumatic life events (1895, p. 1).

However, Freud also recognizes that external events normally tap into some sort of susceptibility or predisposition exhibited by the patients, one that can be uncovered only by carefully analyzing their habits, personality traits, and life history. The discussion of clinical cases such as Elizabeth von R. (1895, pp. 135–181) offers a nice illustration of this enterprise (see below).

Therefore, the novelty of Freud's account consists in the idea that mental disorders never have a uniquely identifiable cause but should rather be seen as constellations of pathogenic elements. Notably, the particular combination of factors cannot be established in advance and is subject to a high degree of interpersonal variation. As he puts it: "You must know that the same factors always come into operation in the causation and mechanism of every possible form of neurosis; but the chief importance in the construction of the symptoms falls now upon one and now upon the others of those factors" (1916–17, p. 381). Freud thus offers an etiological picture where two general kinds of pathogenic determinants (i.e., dispositions and experiences) are present but also in which every individual exhibits a particular combination of them.[5] But how does this model work exactly?

Freud fleshes it out more thoroughly in a series of essays focused on etiology, dispositions, and onset of neurosis. As early as 1894, he had already acknowledged the importance of childhood experiences for etiology: indeed, clinical observations often showed that patients could trace back the origin of symptoms to one or more events that occurred during their early years. Yet, in the article "Further Remarks on the Neuro-Psychoses of Defense" (1896), he significantly refines his position by introducing two crucial observations. First, he notices that certain classes of people are more prone to developing mental illness with respect to others and that environmental factors are often responsible for this difference. For example, he points out that women are more frequently subject to sexual abuse during childhood (p. 166) and often experience life situations characterized by extreme monotony or frustration such as sick-nursing or house chores (see the clinical cases discussed in Freud, 1895). Second, Freud realizes that the way in which the patients relive or remember their experiences is often far more important than the content of the experiences themselves. This remark allows us to characterize the notion of trauma in a way that goes beyond the reconstruction of what happened in someone's past and focuses instead on the way in which a person has appraised specific experiences or events. As Freud rightfully points out, someone else could have gone through the same experiences while "remaining unaffected" (1896, p. 167). This point is crucial because it introduces the idea that a subject's personality as well as her attitude towards life events could act as powerful pathogenic determinants.

In later works Freud continues to develop the idea that pathogenic determinants interact in a complex way, with dispositional elements often going hand in hand with accidental ones. The article "Types of Onset of Neurosis" (1912) represents one of his few attempts at rigorous classification and discusses a list of possible triggers of mental illness ("precipitating causes"). Starting from observation and clinical experience, Freud notices that some patients fall ill because of frustration: in many of these cases, a love object is withdrawn and no substitute takes its place, causing libidinal energy to "dam up" due to the lack of discharge (1912, p. 232). Most patients treated by Freud at the beginning of his career could be subsumed under this category. Indeed, women suffering from hysteria often exhibited a combination of "mental liveliness" and "monotonous life" that made them particularly prone to accumulate a surplus of mental energy unable to find discharge (see, e.g., Anna O. in Freud & Breuer, 1895, pp. 22–47. Other patients suffer excessively because of the demands of reality that exacerbate the conflict between the impulses coming from the id, the repressing forces expressed by the super-ego, and the ego's mediating role. The negative consequences of such a conflict are exemplified by another early case discussed by Freud, in which the patient is described as "overly hard on herself" and as exhibiting a particular kind of moral oversensitivity with strong self-deprecation tendencies. In particular, she could not accept the existence of "a whole multitude of indifferent, small things lying between what is good and what is evil—things about which no one need reproach himself" (see Emmy von N., Freud, 1895, p. 65). In the sense described above, the demands of reality had too strong of an effect on this patient, who took every small event as an occasion for feeling guilty or morally reprehensible. Finally, Freud introduces a third category of patient, namely those whose onset is triggered only by a change in economic factors—for example, a sudden libido increase. As I discuss above, this "crossing of a threshold" plays an important role in drawing the distinction between health and pathology. As Freud puts it: "There is no qualitative difference between determinants of health and those of neurosis … on the contrary, healthy people have to contend with the same task of mastering their libido—they have simply succeeded better in them" (1912, p. 237).

Despite the attempt at categorization, the boundaries between these groups of patients do not appear to be clear-cut and the three types of onset often blend into one another. For example, a patient could experience a relative degree of frustration because of her inability to cope with the demands of reality, and this increase of tension could then economically determine her crossing of a threshold into illness. The interplay among different types of factors helps us to clarify the idea of a *pathogenic constellation*, where there is no simple relation between organic dispositions, life events, and symptom formation. Indeed, most pathological manifestations emerge through summation: various kinds of dispositions seem necessary but not sufficient for mental disorders to develop, as there must be other "reasons" to bring them about (e.g., traumatic events, mental solitude, or isolation). As a consequence, Freud outlines a model in which symptoms are almost invariably overdetermined: we cannot speak of a unique "cause of illness" (1912, p. 237) or of a specific "pathogenic excitant" as we would do for an infectious disease (1938/1949, p. 63). The idea of overdetermination is nicely illustrated in the following passage, in which Freud attempts to trace back the different pathogenic determinants to their origin:

> The logical chain corresponds not only to a zigzag, twisted line, but rather to a ramifying system of lines and more particularly to a converging one. It contains nodal points at which two or more threads meet and therefore 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. (1895, p. 290)

## A Freudian case study: Elizabeth von R

In this final section I illustrate how Freud's account of mental disorder works in practice by examining one of the clinical cases discussed in the *Studies on Hysteria* (1895): Elizabeth von R. (pp. 135–181). Before delving deeper into the analysis of this case, it is worth stressing that Freud regarded the accurate reconstruction of a patient's history as a crucial element for therapy as well as for the theoretical development of psychiatry. Here he puts the point neatly:

> I have not always been a psychotherapist. Like other neuropathologists, I was trained to employ local diagnoses and electro-prognosis, and it still strikes myself as strange that the case histories I write should read like short stories and that, as one might say, they lack the serious stamp of science. I must console myself with the reflection that *the nature of the subject is evidently responsible for this* [emphasis added], rather than any preference of my own. The fact is that local diagnosis and electrical reactions lead nowhere in the study of hysteria, whereas a *detailed description of mental processes* [emphasis added] such as we are accustomed to find in the works of imaginative writers enables me, with the use of a few psychological formulas, to obtain at least some kind of insight into the course of that affection. (pp. 160–161)

In this passage, Freud expresses again the need for a new level of description for mental disorders, one able to capture the complexity of the patient's experience without being at odds with what happens at the neurobiological level. Despite all their idiosyncrasies and imprecision, Freud believes that case histories could offer some help in this direction and thus carefully collects them throughout his career (see, e.g., 1909, 1911, 1916–17).

The case of Elizabeth von R. works as a paradigmatic example to illustrate the theoretical aspects outlined earlier in the paper. Indeed, Freud offers here a fine-grained etiological explanation taking both dispositional and accidental factors into account (1895, pp. 160–161); he also makes his commitment to continuity explicit while drawing significant differences between normal and pathological cases (pp. 164–165, 174); and finally explains the emergence of mental illness by appealing to economic factors (pp. 157, 174). The analysis of Elizabeth's case starts with a short description of the patient's symptomatology along with her character traits and family environment. When Freud first meets her, Elizabeth is a 24-year-old woman suffering from a persistent pain in her legs and exhibiting an interesting form of "painful fatigue": these symptoms prevent her from walking normally and cause her a great deal of distress (p. 135). Freud describes Elizabeth as highly intelligent and ambitious: during her childhood, she had a close affective and intellectual relationship with her father, who used to treat her "like a son and a friend with whom he could exchange thoughts" (p. 140). As she grew up, her discontent with being a woman grew stronger as she realized that she was not willing to sacrifice her freedom of judgment and her inclinations for marriage. As a consequence, both her sisters ended up getting married while Elizabeth devoted most of her adult life taking care of her sick parents as well as attending to various kinds of family business. Following the death of her father—whom she sick-nursed until the end—Elizabeth started displaying the symptoms described above in a mild form. A few years later, the sudden death of her sister due to a complication during pregnancy marked the definitive onset of Elizabeth's disease. Up to this point, Freud admits that it is very difficult to see a direct connection between the patient's symptoms and her life-history, since the latter seems characterized by "commonplace emotional upheavals" that elicit "human sympathy" but blatantly fail to explain her disorder (p. 144). However, Elizabeth also seems to fit the general description of the "Typus Hystericus" provided by Freud: an overflowing productivity of the mind, coming from her intelligence and ambition, inevitably clashes against the monotony of her family life and duties, that is, sick-nursing or house chores (p. 240). Notably, this first part of the analysis already uncovers pathogenic determinants of different kinds. On the one hand, there are dispositional factors such as Elizabeth's personality and her family's history of nervous illness (p. 140); on the other, there are accidental factors such as the fact that she had to bear the responsibility of sick-nursing within the family. At this point, Freud also noticed that some accidental factors were more recurring than others: for example, "sick-nursing plays such a significant part in the prehistory of cases of hysteria" (p. 161). Indeed, this condition—often falling on women—invariably correlates with a situation of personal neglect; constant worry; and a lack of sleep, exercise, and proper diet (p. 175). Crucially, sick-nursing also brings about the habit of suppressing one's own emotions and diverting one's thoughts away from anything that does not immediately relate to the person who is being assisted (pp. 161–162).

Starting from these observations, Freud formulates a hypothesis about Elizabeth's cause of illness: the symptoms may originate from a conflict between an incompatible idea fended off from consciousness and her sense of duty towards her family. By exploring this intuition, Freud succeeds in tracing back the beginning of the patient's leg pain to two important events: once, at a party, she spent the whole night with a man to whom she was attracted, just to return home and find her father's conditions worsened. Years later, she got to spend some time with her sister's husband and became fond of him to the point that she started to desire "a husband like him" (1895, p. 154). These two episodes are importantly similar because they display the conflict between Elizabeth's desire to be in a relationship with a man and her sense of duty and guilt towards her family. In both cases, the latter feelings prevail and cause the erotic impulses to be repressed: Elizabeth cannot bring herself to be involved with the man she met at the party because she decides to take care of her father. Later, she cannot admit to herself that she has fallen in love with her brother-in-law because she does not want to hurt her sister. Finally, the conflict becomes unbearable when Elizabeth finds herself at her dead sister's bedside and cannot help thinking: "Now he is free again and I can be his wife" (p. 156). Such an incompatible thought is immediately fended off from the patient's consciousness and thus ceases to enter in association with other ideas. As Freud puts it: "Her love for her brother- in-law was present in her consciousness like a foreign body, without having entered into relationship with the rest of her ideational life" (p. 166).

The psychoanalytic approach to Elizabeth's case allows us to draw a number of conclusions about the etiology and development of her symptoms. Indeed, Freud identifies both a motive and a mechanism for the patient's hysterical disorder: the former can be described as Elizabeth's need to defend herself against an incompatible idea (i.e., "I am in love with my brother-in-law"), whereas the latter consisted in converting a quota of psychical affect into a physical manifestation (i.e., leg pain and paralysis). Moreover, the symptoms themselves seem to bear a strong resemblance to the repressed idea, as Elizabeth repeatedly describes herself as "helpless" and unable to "take a single step forward" (1895, pp. 152, 176). Finally, this case shows that mental disorders often arise by summation of partial traumas and that specific symptoms come about after a certain threshold has been crossed. Indeed, as Freud points out, Elizabeth had been able to bear incompatible ideas in her consciousness for some time without serious consequences. Yet, there seems to be a limit to the degree of affective tension that a person can tolerate as well as to the pressure brought about by a new conflict between ideas. Once again, "what we are concerned with is clearly a quantitative [economic] factor" (p. 174). However, since this observation applies to those suffering from hysteria as well as to healthy subjects, the discussion of Elizabeth's case also offers more evidence in support of continuity: "The view which I have just been putting forward does no more than bring the behavior of hysterical people nearer to that of healthy ones" (p. 174).

## Conclusion

In this article, I defend an early version of the continuity thesis in philosophy of psychiatry by showing that Freud's account of mental disorder could be seen as an exemplar of such an approach. Generally speaking, Freud rejects the idea that the difference between healthy and pathological subjects could be described as categorical or clear-cut (see 1933, 1938/1949) but at the same time he is committed to highlighting some important differences between the two groups (see 1907, 1917, 1924a, 1924b). More specifically, he outlines a view where mental disorders are characterized as constellations of elements that are not pathological in themselves, but become so in virtue of their intensity, accumulation, or interaction (see 1912, 1916–17). Throughout the paper, I focus on two theoretical aspects of Freud's approach that I deem valuable for the elaboration of a refined version of the continuity thesis. First, I discussed the idea that mental functioning (and malfunctioning) can be described by appealing to quantitative or economic factors. For example, an incompatible idea can be tolerated by a person until it reaches a certain degree of intensity or frequency that causes them to cross a threshold and develop pathological manifestations. Second, I explored Freud's suggestions about etiology and I argued that most mental disorders are caused by two different kinds of pathogenic determinants: dispositions (e.g., heredity or personality traits) and experiences (e.g., traumatic events). This brings about a complex view that goes beyond the opposition between internal and external factors and regards psychopathology as emerging from the interaction between different determinants. Finally, I offered an example of how the approach proposed by Freud works in practice by discussing the paradigmatic case of Elizabeth von R. (1895, pp. 135–181). This patient's history proves particularly useful in highlighting the advantages outlined above. The appearance of Elizabeth's symptoms is explained by appealing to different kinds of pathogenic determinants (e.g., character traits and life events) as well as to economic considerations (e.g., accumulation of unbearable ideas).

## Notes

1. This perspective on the origin of the *id* may appear overly simplistic to readers who are acquainted with Freud's complex characterization of wishes and drives (see Freud, 1900, 1905, in particular), and with the psychoanalytical debates surrounding these concepts. Given that a thorough discussion of these issues would be beyond the scope of this paper, I introduce the id—as well as the ego and super-ego—following Freud's *New Introductory Lectures on Psychoanalysis* (1933).

2. Interestingly, Freud himself appeared to oscillate between the stronger and weaker interpretation throughout his career. Some interpreters—such as Van Haute (2005)—suggest that the apparent retraction from the stronger view in Freud's later works could be due to his wish to make psychoanalysis more acceptable to the established sciences (p. 370).

3. This quote clearly exemplifies Freud's commitment to the stronger interpretation of the continuity claim outlined above. Van Haute and Geyskens (2012) argue that Freud's later shift toward the weaker interpretation may be traced back to the introduction of the Oedipus complex as a normative and explanatory element within psychoanalysis. Starting with the so-called Rat Man case (Freud, 1909), neuroses progressively came to be seen as developmental disorders or as defensive reactions against the anxiety that stems from the Oedipal crisis. This is clearly at odds with the anthropological and pathoanalytic approach that sees neuroses as exaggerated variations of normal human existence. For a detailed discussion of this internal tension within Freud's thought, especially in relation to the controversial idea of a "normal" sexual development, see also Van Haute and Westerink (2017).

4. I would like to thank an anonymous reviewer for these suggestions.

5. See Van Haute (2014) for a similar characterization of Freud's pathological constellations. In particular Freud's idea of the "hereditary disposition" should not be understood as a genetic determination in the contemporary scientific sense, but rather as a complex field of problematics—a question or questions rather then [sic] an answer or answers—which we all share as human beings and that determines our existence. Its intensity or, maybe better, its urgency is not only subject to individual variation, but can also change in the course of our lives. (Sec. 3, Para. 5)

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