

## THE CONTINUUM OF NORMALITY AND ABNORMALITY – AN INSIGHT INTO THE DIMENSIONALITY OF MENTAL HEALTH AND ILLNESS

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### Dear editor,

The relationship between normality and abnormality could be regarded in the following ways: (1) "normal" and "abnormal" are two distinct categories, (2) "normal" and "neurotic" could belong to one and "psychotic" to another category, and (3) there is a continuum stretching from "normal" followed by "neurotic" to "psychotic" and "abnormal" constituting the other pole of the dimension of (ab)normality (Gross 2005). The first view is deeply rooted in the long psychiatric tradition, the second one is a sort of compromise whereas the last one is in line with the psychometric tradition. The concept of discrete categories as opposed to dimensional conceptualisations might be closely related to several other dichotomies: qualitative vs. quantitative differences, clinical observation/ experience vs. the arsenal of research tools, psychopathology vs. personality psychology, clinical vs. Normal populations, and pathocentric vs. biopsychosocial model.

When talking about the dimensionality of mental health and illness, we usually and primarily refer to personality (dis)integration, environmental and genetic influences on personality, along with habits, traits, emotions, cognitions, and behavior of a particular person. These components and functions of human personality are regarded as measurable (by the means of objective tests, scales, questionnaires, etc.), especially in psychology, and can be expressed/ operationalized as dimensions (continua).

There are several arguments in favor of viewing mental health and illness as a continuum:

- Some personality tools used in the studies with the general population include items that measure neuroticism and/or psychoticism (higher scores could indicate a possibility for the existence of a neurotic or psychotic process). An example is the Eysenck's Personality Questionnaire (EPQ).
- Some psychiatric assessment tools include items or (sub)scales measuring personality traits and/or similar constructs that are usually investigated in the healthy population as well. Examples include the Brief Psychiatric Rating Scale – BPRS (assessing levels of anxiety, hostility, depressive mood, etc.) and the Brief Symptom Inventory – BSI (two of its subscales are Depression and Anxiety and relate to the dimension of neuroticism).
- The Minnesota Multiphasic Personality Interview-2 (MMPI-2), despite the fact that contains the word "personality" and the scale "Social Introversion" (which is one of the well-established personality traits) is used for psychopathological purposes. Furthermore, the Personality

Psychopathology-Five (PSY-5), derived from the MMPI and used in both clinical and healthy populations, includes extraversion (which is one of the basic and broadest personality traits), aggressiveness (another personality domain or facet), constraint (which is similar to conscientiousness which is one of the main and broadest personality traits), as well as neuroticism and psychoticism.

- Lots of pathological phenomena could be explained by or broken down into several dimensions assessed in healthy populations. For example, the feeling of superiority as part of delusions of grandiosity includes high levels of self-esteem and self-competence experienced e.g. during the manic episode. Self-esteem is one of the core "elements" of personality and is linked to self-competence and self-efficacy. All of these constructs are operationalized in the form of psychological instruments.
- The Mental Health Continuum – Short Form (MHC-SF) measuring emotional, psychological and social well-being is one of the psychological tools relying on the assumption that mental health is a dimensional variable.
- To a some extent, personality disorders overlap with the other mental disorders and their symptoms are usually less severe than in the case of the corresponding mental disorders (e.g. paranoid personality disorder compared to delusional disorders, schizoid personality disorders compared to schizophrenia, etc.). Thus, personality disorders could be placed somewhere in between normal and psychotic functioning, which may imply the existence of the continuum mentioned above.
- There is a high convergence between general factor of psychopathology (p) and general factor of personality – GFP (Oltmanns et al. 2018). Of course, they have been defined in the opposite direction however (mental illness vs. mental health, respectively).
- Severity of psychopathology could be predicted based on personality measures. For instance, there is evidence for negative associations of antisocial personality disorder with conscientiousness and agreeableness as personality domains (Decuyper et al. 2009) and the severity of positive symptoms positively correlated with neuroticism and negatively with agreeableness (Lysaker et al. 2003).

On the other hand, thinking in categories and behaving accordingly have been widely studied within cognitive and social psychology, especially in the domains of stereotypes which are relevant in the light of consistent efforts in social psychiatry toward their reduction. The lesson we have learned so far is that people tend to organize their knowledge and perceptions in categories, in order to make the process of retrieving and using them in a simpler and more straightforward way. However, we should keep in mind that we do not need to be confined by the categorial approach while trying to understand, study and treat complex problems, such as mental health and illness.

Additionally, there is a strong need for close collaboration among psychiatrists, clinical psychologists, and personality psychologist, both researchers and clinicians, on this difficult task of shedding light on the relationship between normality and abnormality.

**Acknowledgments:** None.

**Conflict of interest:** None to declare.

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