

Normality—Toward a Meaningful Construct

By PAUL C. HORTON

The condition of alienation, of being asleep, of being unconscious, of being out of one's mind, is the condition of the normal man.—R. D. Laing

THE TERM "NORMAL" has become, if it has not already been, a liability to the special language of adult psychiatry. Despite the shaky foundation supporting the use of this term, it is frequently leaned upon as though it designated one of the pillars of psychiatric thought. This paper explores the need for and the neglect of the scientific underpinnings which the widespread employment of the term would seem to presume, and it reports research showing that mental health professionals use the term in a way which allows them to assess and label specific behaviors. This usage is unfortunate in that the term "normal" does not designate a valid construct, nor is there a relevant scientifically meaningful body of psychiatric knowledge from which to proceed in developing an empirically sound construct. It is suggested that much detour research is in order. The appropriate direction of that research is explored.

THE PROS AND CONS OF RESEARCHING NORMALITY

In recent years, subsequent to Offer and Sabshin's interesting text,¹ there has been a circumscribed, insurgent interest in the psychiatric literature regarding the status of the concept, normality. This interest is "insurgent" because the message of the normality seekers is that the psychiatric establishment has been going down a primrose lane in its thinking about what is "normal" and that "For the next decade the greatest need . . . involves the collection of empirical data regarding multiple populations studied by multiple techniques."² This interest is "circumscribed" in that the normality research is the product of only a handful of workers. The alleged traditional psychiatric approach ("normality" as the absence of disease³) is attacked as being scientifically, heuristically, and philosophically unpalatable. Defining something by what it is *not* illustrates, in this case, a methodology which Kaplan refers to as the "Drunkard's Search: The drunkard who dropped his door key at his door searches for it at the street corner, 'because', he explains, 'it's lighter there'.³

Normality is, in Kaplan's opinion, a "topic of neglect."³ Sabshin asserts:² "...there are very few psychiatric or psychoanalytic studies of normative adult behavior." These opinions are relevant in view of Taft's conclusion that "The main attributes of the ability to judge others seem to lie in three areas: possessing *appropriate judgmental norms*, judging ability and motivation. Where J is similar in background to S, he has the advantage of being able to use appropriate norms for making his judgment."⁴ (Italics, mine.)

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The normality insurgents argue that a scientifically meaningful normality construct can provide a baseline by reference to which diagnostic and therapeutic efficacy can be assessed. Typical of these pleas is that of Hollingshead and Redlich:

Unfortunately, psychiatry lacks a standard of what is normal and what is abnormal. A standard measure of normality and abnormality would enable researchers to determine the presence or absence of mental illness in a population. It also might enable them to estimate the proneness of some persons to mental illness. In sum, the lack of criteria for dividing the sick from the well presents great obstacles to investigators who desire to make studies of incidence or prevalence of mental illness.”⁵

Taft's findings suggest that a normality construct is a necessary condition for the valid assessment of diagnostic and therapeutic efficacy and the determination of population base rates. It is further reasoned that validation of *other* theoretical constructs will be facilitated by reference to a standard of normality. And, finally, it is claimed that there is some configuration of traits, of behavioral patterns which can be objectively identified and to which the term “normal” can be felicitously affixed. This latter claim is especially relevant to the proponents of community psychiatry. An expeditious formula for determining the relative normality of an applicant or client would be of tremendous dispositional utility in the booming community mental health business.

From the patient's viewpoint as well, the concept of normal is quite important. Stanton and Schwartz point out: “This concept of ‘normal’, and the implied promise of everything that a patient may imagine as included in it, is the dominant conscious organizing factor in what a patient does in the hospital.”⁶ In addition, the majority of *outpatients* I have evaluated or treated, have raised questions about their own “normality” or about the sort of “normality” they might find in the course of the treatment.

In spite of the cogent arguments in favor of the generation of a scientifically valid construct, there are several reasons why such a construct has not been widely pursued. Sabshin has spoken of the “resistance”⁷ he has encountered in trying to demonstrate the need for a meaningful concept. Kaplan has implied with his “Drunkard’s Search” analogy that a kind of mistaken expeditiousness underlies its neglect. I have encountered another serious objection to the pursuit of “normality.” This objection is a “resistance” of sorts but occurs at a cognitive level. This is what one might call the “intuitive” objection. The argument goes something like this: “Based on my clinical experience, I know what ‘normal’ is and therefore, researching normality is a waste of time.” A more general way of stating this position is to say that one can have true convictions which one cannot prove for practical or theoretical reasons, and that failure to offer proof for these convictions does not mean that the convictions are unsound.

It is logically correct, of course, that failure to objectively validate a conviction does not render the conviction invalid, and if one combines this premise

with a rare skill such as that spoken of by Socrates in *The Republic*, one is perhaps justified in being neglectful of scrutinizing his impressions and convictions: "My own case of the internal sign is hardly worth mentioning for rarely, if ever, has such a monitor been given to any other man."⁸ However, there is evidence to indicate that the majority of us must be more circumspect about our "intuitive" knowledge. (See also reference 9.) Taft demonstrates the danger in adopting the "intuitive" principle as a modus operandi in judging others: "Luft compared the ability of clinicians (psychiatrists, psychologists, and social workers), graduate students, and physical science students on a series of tests in which they were required to predict the responses of individuals to objective and projective test items. The physical scientists were superior to all the other J's on the tasks taken as a whole."⁹ It is no wonder that Holsopple and Phelan call for a de-emphasis of pathological stereotypes and a devotion of more time "to building up stable internal norms of the personality patterns to be found among well-functioning people."¹⁰ One might conclude that the other side of the normality conviction coin is that the strength of a conviction does not render the conviction apriori true.

PSYCHIATRIC CONCEPTIONS OF NORMALITY

The lack of an objective data-base for a truly meaningful normality construct has not prevented psychiatrists from speculating about its meaning. Normality as the absence of disease has been described as the "traditional" psychiatric approach.² Many psychoanalysts think of normality as an ideal state, a kind of mental utopia or as an end-product of successful psychoanalysis. Still other psychiatrists are seen to conceptualize normal as the simplistic average.² The latter notion may carry a distinctly negative loading. Laing says for example: "What we call 'normal' is a product of repression, denial, splitting, projection, introjection and other forms of destructive action on experience . . . It is radically estranged from the structure of being."¹¹

The word "normal" is derived from the Latin word "normalis" which means "according to rule."¹² This seems paradoxical in that there are so many and diverse rules governing its usage that it often appears as though there were no rules at all. Stromgren has observed: "Psychiatry has . . . often been accused of *indulging* in terms and concepts, frequently even in terms without concepts."¹³ His remark seems especially apropos to the psychiatric use of "normal."

As one peruses these stylized notions, one is struck by two ubiquitous features. Firstly, as has been frequently lamented, the various notions of normality are value-ridden. In many cases the notions are little more than personal biases. Such qualities as "adequate self-knowledge," and "adequate life goals"¹⁴ exemplify these funded opinions. The second striking feature is that they are so vague and general that their application would seem to be unfeasible. The employment of these often conflicting and personalized notions by community psychiatrists would certainly lead to much stylized counter-transference abuse.

It is interesting that although the psychiatric literature on normality

abounds with literary conceptions, there is little or no evidence that these notions are capable of being employed when psychiatrists are confronted with specific behaviors or situations. It is claimed, however, that many psychiatrists have "funded meanings" or "tacit conceptualizations"³ of normality. If psychiatrists carry with them "funded meanings" of normality for which there is no reasonably objective data-base, it seems crucial for this to be known. Excess conceptual baggage, especially of the opinionated sort, should be discarded by us in the same way that physicists have done away with such notions as "ether," for which no objective validity could be shown. In keeping with this, research carried on at the University of Michigan Hospital addressed itself to whether or not psychiatric residents at all stages of training through the fifth year have ideas about normality which are *capable of being employed in a very specific way*.

SUBJECTS AND METHODS

In the fall of 1967, forty-seven University of Michigan psychiatric residents, ranging in training from first to fifth years, were asked to evaluate how they thought a "typical normal person" would respond in a variety of situations contrived to engender anxiety, hostility, generosity, satisfaction and candor as described in a 48 item questionnaire. An example of one of the items follows: a typical normal person is called a "stupid idiot" by his boss in front of the entire office staff. The boss calls him this over a mistake that the boss himself has made.

How angry would the typical normal person become?

not	annoyed	mildly	much	murders
at	but	angry	anger	the
all	decides	-voices	--quits	boss
	to forget	his	his job	
	the whole	anger		
	thing			

How angry would you be?

not	you would	mild	much	you
at	be annoyed	anger	anger	would
all	but would	-would	-you	murder
	forget the	voice	would	the
	whole	your	quit	boss
	thing	anger	your job	

Thirty-one (66%) of the residents returned completed questionnaires. Ten of 11 came from first year residents; nine of 14 from second year residents; seven of ten from third year residents; four of nine from fourth year residents; and one of three from fifth year residents. Fifty-seven Ypsilanti State Hospital "schizophrenics" were also surveyed as a comparison group.

FINDINGS AND DISCUSSION

A distribution of the responses of the residents and schizophrenics on the nine point rating scale of the first part of the above item is shown in Fig. 1.

The resident's responses ranged from "annoyed but decides to forget the whole thing" through "much anger-quits his job." This variance was characteristic of virtually all of the item response distributions.

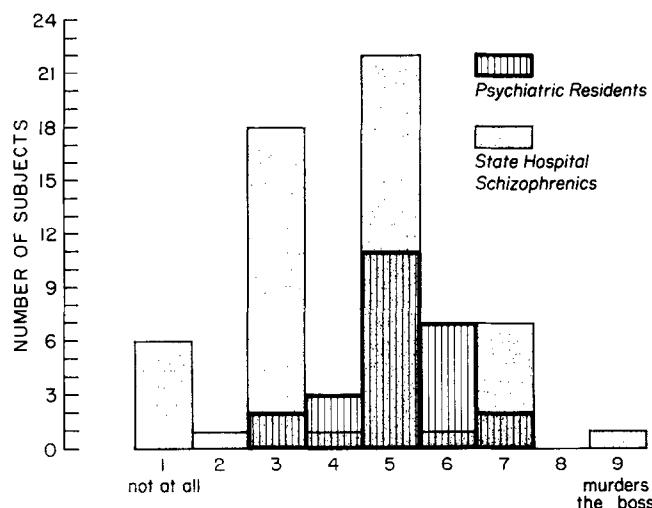


Fig. 1.—Distribution of responses to item No. 30 of questionnaire. The horizontal represents points on the rating scale.

The last item read as follows:

How do you define a "typical normal person?"

I	I	I	I	I	I	I	I	I
as "average"	as slightly better than average	much better than average	much better than average but less than perfect	as "perfect"				

In this item it was assumed that the absence-of disease perspective of normality is actually a subcategory of the normality-as-ideal perspective. A distribution of the responses of the residents and schizophrenics appears in Fig. 2.

There are three significant findings of this study: (1) The majority (66%) of residents asked to participate in this study demonstrated that they had an idea of "normal" which they were willing to employ and which allowed them to categorize behavior in very specific situations; (2) The residents showed remarkable inter-resident variability (as the above graph illustrates) in their ideas about the "typical normal person"; (3) The majority of the residents consciously defined their notions of normality as being a hybrid of the normality-as-average and normality-as-ideal perspectives. This latter finding is important in that the current stylized literary notions of normality do not include a hybrid notion. It is interesting that pilot research at the University of Michigan into the in-practice rule of sort (as contrasted with literary rules of sort or self-reports about how one sorts out normal behavior) has yielded results suggesting that the rule of sort is extraordinarily complex. Preliminary data indicate that the rule of sort for an individual psychiatrist

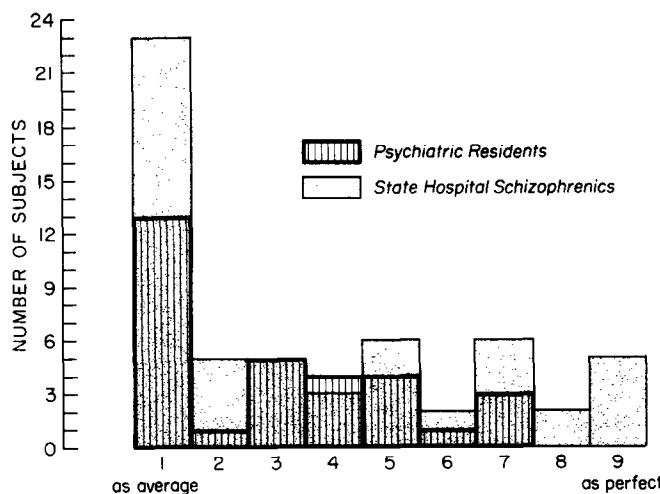


Fig. 2.—Distribution of responses to item No. 48 on questionnaire illustrating the subjects range of ideas about "normality."

is actually a complex of rules working concurrently. Furthermore, these rules interact with the sort of behavior in question, thus adding a new dimension of complexity. To caricaturize the situation, the stylized notions of normality in vogue in the literature probably bear about as much semblance to how and what the individual psychiatrist thinks about normality as a Hollywood movie does to real life.

The meaning of the failure of 16 psychiatric residents to return completed questionnaires cannot be stated with certainty. No harassments or inducements were employed in attempting to obtain a 100 per cent return. Several of the nonresponders stated that they did not regard "typical normal person" as a meaningful category. The remaining nonresponders offered no reason for failing to fill out the somewhat lengthy questionnaire.

THE PRESENT DATA-BASE AND RESEARCH STRATEGIES

Unfortunately, research in the name of "normality" has yet to be productive of potentially integratable data. Consider the following data about the "normal" woman (normal as average) gathered by Michigan State University's consumer marketing program:¹⁵ She walks about 8 miles a day to do errands; she has trouble sleeping and 40 per cent of her insomnia is caused by "worry," 30 per cent of her worries are about things she can not do anything about, and 20 per cent are relatively unimportant; when she dreams she likes to remember the social function at which she met her husband and when he proposed to her. Compare these data with what Offer has to say about "normal" adolescents: "During the freshman year, among the small groups that dated actively, kissing and necking were the prominent way of expressing affection . . . Less than 10% had sexual intercourse by the end of the junior year. No subject admitted participating in overt homosexual behavior. Lastly, we would like to add that 80% of the subjects confided in us that

they approved of premarital sexual intercourse, but only after high school. The main conscious reason that the teenagers gave for not engaging in sexual intercourse in high school was fear that the girl would get pregnant."¹⁶ Offer's data and the Michigan State University data have in common the stamp of marketing research. If one were marketing sex, Offer's data might be helpful. It is difficult, however, to understand the relationship between the percentage of teenagers who *admit* to homosexual relations and the generation of a construct of "normal" adolescent sexual behavior. There are three reasons why this appears to be a futile approach. The first is that the normative values of Offer's parameters are too culture, class and time bound. Even if we knew what teenagers *do* sexually, as contrasted with knowing what they *say* they do, extensive normative research would have to be undertaken every few months or years in order to keep the norms up to date. Contrast the temporal stability of the normative values of intelligence test parameters with the probable temporal stability of the normative values of Offer's parameters. A scrupulous effort has been made in the construction of intelligence tests to minimize and eliminate, where possible, faddish elements. Offer, however, seems to be derogating the normality construct to a kind of "who-says-they-do-what-when" status.

A second defect of the Offer approach resides in the method with which data is collected. "Conscious" reasons given by teenagers (or any age-grouping for that matter) regarding their sexual behavior may be far from real reasons. The L, F, and K scales on the Minnesota Multiphasic Personality Inventory were devised out of the realization that what people say about what they do or think may be quite different from what they actually do or think. The L and K scales were devised to detect gross and subtle dissimulation, respectively. The F scale is elevated "whenever a subject does not answer with discrimination because of inability to read and understand well enough . . ." or when direct carelessness, or carelessness with intent to confuse the data" is involved.¹⁷ Scientifically speaking, it is not enough for a researcher to say "I just had the feeling they were telling the truth." Besides the possibility of deliberate falsification, this stance ignores the whole province of defense-psychology. From an armchair perspective, one wonders, for example, if it is even remotely plausible for a virtual stranger, representing the establishment, who "cannot gratify longings for understanding and help"¹⁶ to query teenagers about "overt homosexual behavior" with the expectation that they will be able and willing to be candid. Ordinarily, the admission of painfully guilt-ridden acts is predicated upon the formation of a *therapeutic* alliance. Even when a therapeutic alliance has been formed, however, defenses such as denial, projection, and rationalization may have to be worked through before the therapist obtains a valid perspective about what has happened to the patient. The stereoscopic therapeutic technique wherein spouses are treated by therapists who compare notes can provide a startling awakening to the psychiatrist who assumes that he is "getting the picture" from his single source of information. The Offer approach appears to be productive of a hodge-podge collection of data of dubious veracity.

The third defect of the Offer study is that the parameters researched hold no promise for the establishment of *laws* of normal behavior. To attempt to create a normality construct by asking what percentage of high school juniors date actively or pet heavily, etc., is rather like trying to invent the law of gravity by cataloging the colors of various objects which fall to the earth. Cul-de-sac research and ephemeral norms are byproducts of the injudicious selection of parameters.

Besides the ill-selection of parameters there is much left to be desired in the logic and reasoning of some of the present research strategies. Shakow,¹⁸ for example, commits both logical and assumptive errors. His approach is conceptually sophisticated in that he perceives that the definition of a normal person may be predicated upon the identification of characteristics which make one *ineligible* for class membership.* From his study of schizophrenics he concludes, for example, that "The normal person habituates easily and is relatively free from perseveration. He demonstrates an appropriate balance between stability and flexibility, being neither too rigid nor too loose." Let us heed Stamp's advice and ". . . lay bare the bones of the argument."²⁰ Shakow has found inflexibility to be a characteristic of schizophrenic behavior. He concludes from this that the "normal" must be, in some sense, flexible. This conclusion is invalid. This is like saying, "Since communists are atheists, noncommunists must believe in God." Let us examine what seems to be the step-wise progression of Shakow's reasoning in order to determine where he has erred. Shakow begins with these assumptions: (1) if schizophrenic then abnormal; (2) if schizophrenic then inflexible. He concludes from these premises: if inflexible then abnormal. Surely, he could not have concluded the reverse, that abnormality implies inflexibility, on the basis of studying only one subcategory of abnormality. His conclusion that inflexibility implies abnormality is, however, invalid. His error is rendered transparent by substituting less abstruse terms: (1) if communist then atheist; (2) if communist then human. Therefore, if human then atheist. The next step in the argument is syllogistically valid but begins with a fallaciously arrived at premise: (1) if inflexible then abnormal; (2) if inflexible then not flexible (3) if abnormal then not normal. Therefore, if normal then flexible. His conclusion based, in part, on a premise which was arrived at by specious reasoning, is therefore, unacceptable. Shakow makes still another error in reasoning. He promises to construct ". . . a theory which provides reasons why schizophrenic disturbances do not occur in normal mental functioning." Later, however, he states: ". . . individual and group variability are so great, particularly in schizophrenics, that there are bound to be occasional overlaps between schizophrenic and normal performances." This issue of category overlap is pivotal. If one is going to make "direct inferences" about "normal" from the study of "extreme abnormality" one must be able to clearly identify the category into which a particular behavior falls.

Offer and Offer²¹ commit the fallacy of "begging the question" by

*See reference 19 for an explication of disjunctive classes.

screening "abnormals" out of a study of "modal adolescents." They assume what they are attempting to arrive at through empirical means. "Modal adolescent" in this study is at least a misnomer. It is interesting in this connection that Masterson and Washburne²² found only 41 of 101 adolescents surveyed to be relatively healthy. Given Offer and Offer's criteria, the "modal adolescent" may well be the "abnormal" adolescent.

The research of Kysar²³ et al also "begs the question" in the selection of subjects. Kysar et al. "randomly" choose freshman college students from "the total population of freshmen admitted to an urban university in September, 1968." They refer to their S's as "'normal' late adolescents." They seem to be implying that "normal" late adolescence entails being a college freshman. There are those who would argue that "normal" late adolescence entails being a G.I. in S.E. Asia or an unemployed ghetto resident. The interaction between the statistical approach which "randomly" selected subjects implies, and the utopian approach which the choice of a highly select group of Ss implies, compounds the ambiguity which plagues the use of the label, "normal."

The final error which I will call attention to is a result of the failure to appreciate the pitfalls of statistical normality. Offer and Offer in their "Profile of normal adolescent girls" state: "Suffice it to say here that we define normal in the context of this study to mean 'that which is average.' This approach is based on the mathematical principle of the bell-shaped curve and its applicability to physical, psychological and social data."²⁴ This approach, however, is based not so much on a principle as on an *assumption*. There was a standing joke in the University of Minnesota Psychology Department that someone had offered a large reward, something like \$10,000, for anyone who could demonstrate a human psychological trait to be "normally" distributed. At last report there were no takers. A recent paper by Elveback²⁴ et al. suggests that there is truth in this anecdote. Elveback et al. measured a number of variables in "healthy" subjects such as calcium, albumin and phosphate levels. Their conclusion was: "The distributions in healthy persons are not gaussian for the majority of variables, and the departures from normal may be major." Elveback et al. emphasize that the law of *errors* is a mathematical theorem, not an experimental fact and that "We have no mathematical, statistical or other theorems that enable us to predict the shape of the distributions of physiological measurements." The same can be said for psychological variables; we do not in fact, know the shapes of their distributions and much basic research needs to be done in this regard. Conclusions arrived at by the assumption of the applicability of this theorem to highly skewed or leptokurtic data will of course be invalid.

Undaunted, Offer and Offer extend the application of the gaussian distribution to new horizons: "A modal or typical student was defined as one whose answers fell within one standard deviation from the mean in at least nine out of ten scales." Not only do they assume that the individual variables are normally distributed, but also that the *collective* variables are normally distributed. It is surprising that Offer and Offer would define a "modal" or "typical"

student in this fashion because in *Normality: Theoretical and Clinical Concepts of Mental Health*¹ there is an allusion to the work of Williams which suggests that the occurrence of such a "normal" person would be a rarity and certainly not "modal." Williams, writing in *Biochemical Individuality*, says: "The existence in every human being of a vast array of attributes which are potentially measurable . . . and probably uncorrelated mathematically, makes quite tenable the hypothesis that practically every human being is a deviate in some respects."²⁵ In support of this hypothesis, Williams offers some correlative biological data which shows that one's chance of being "normal" in a number of parameters such as heart size, thyroid activity, etc., is only 1/6500. Remembering that Offer and Offer defined their "normal" or "typical" student as one whose answers fell within one standard deviation of the mean *in at least nine out of ten scales*, it is possible if not likely, that their so-called "modal" student is an anomaly. There is a curious progression from a highly select group, to the idea of "modal" group, to "normality."

PROPOSAL OF A RESEARCH STRATEGY

Given that the research designs and parameters researched thus far are inadequate, how should the normality seekers proceed? To begin with, it is clear that a valid normality construct will be dependent upon the relevant surrounding body of data, laws and theory. Data collection is only the first step in the generation of a scientifically valid construct. Freud, who appears to have been a shrewd philosopher of science despite what his uninformed critics may say, attempted an early formulation of construct validity: "No conclusions upon the construction and working methods of the mental instrument can be arrived at or at least fully proved from even the most painstaking investigation of dreams or any other mental function taken *in isolation*." More recently Cronbach and Meehl²⁷ have expanded the notion of construct validity: (1) making clear what something is requires a spelling out of the *laws* in which the thing occurs and; (2) that at least some of the laws must be spelled out in observables. They assert ". . . unless the network (interlocking system of laws telling what something is)* makes contact with observations, and exhibits explicit, public steps of inference, construct validation cannot be claimed." To call a population "normal" simply because one has collected data on that population is probably to commit a logical error.[†]

An exception to the latter rule occurs when a researcher simply means "average" in using the word "normal." The Michigan State University consumer marketing data is an example of the restricted use of "normal" as "average." These people collected data without regard to the psychiatric implications of their work. Their concerns were market-place concerns and they were not attempting to generate a valid, scientific construct. If a researcher simply means "average" when he says "normal" and implies nothing beyond the

* Parenthetical statement inserted by author.

† See reference 28 for an explication of the logical error or reification.

data, he ought to say "average" and not give the impression that he is doing something more meaningful.

It is clear in any case that we as behavioral scientists will be able to validly label a behavior, person or population as "normal" only when we have the data, laws, and theory which spell out the construct, "normality." But what of the state of the surrounding body of data, laws and theory constituting the science of psychiatry and forming the potential underpinnings of a normality construct? Freeman et al. have assessed the state of our science as follows: "It has not yet been possible to isolate, measure and witness the interaction of forces necessary for the performance of a particular mental function."²⁹ Methodologically and conceptually, psychiatry is a nascent science. Consequently, it is difficult to be enthusiastic about a frontal assault on what may be the most potentially subtle of all psychiatric concepts.

As an example of the abundant confusion which can arise when attempting a frontal assault on normality in the present day psychiatric framework, let us examine Sabshin's² comments about Freudian normality. Sabshin states that a functional perspective of normality based on the Freudian "ideal fiction" concept is an "Orwellian nightmare." He suggests that there is a "logical connection" between the utopian concept of Freud and "computerized regulation." This is perplexing because it is inordinately difficult to conceive of a nexus between "computerized regulation" and the Freudian theoretical framework with its "primary process." A psychic model embracing an unconscious, mostly irrational element, admitting of near-infinite associations and functioning at times irrespectively of stimulus input seems to one to pose the opposite problem: the utter infeasibility of prediction and control. As Freud has said: "The unconscious is the true psychical reality; in its innermost nature it is as much unknown to us as the reality of the external world, and it is as incompletely presented by the data of consciousness as is the external world by the communications of our sense organs."²⁵

It would appear, therefore, that detour research is in order. If one believes, as I do, that hypothetical constructs are inventions (as distinguished from discoveries) whose characters are limited but not determined by the stimulus properties of the field under consideration, one is permitted a certain degree of arbitrariness in the selection of parameters and frameworks. It is with this in mind that I regard the extensive attempts to clarify the meaning and develop measurements of a parameter such as anxiety as steps in the direction of solving the conceptual and methodological problems which normality research raises. Anxiety is an example of a potentially useful construct to the normality seeker for several reasons: it is a concept central to psychological theory; it refers to a universal phenomenological state (Its form, for example, is probably not idiosyncratic to upper middle class suburbanites); it refers to an internal state likely to be experienced by people of all ages and generations; it holds the promise of being amenable to precise description and measurement; it appears to be integratable with sociological, psychological and neurophysiological constructs; it does, in short, hold promise for the formation of *laws* of human behavior. The research on anxiety is too

massive to review here. Suffice it to say that there have been attempts to develop psychological tests of chronic anxiety³⁰ and immediate anxiety.³¹ There has been a multitude of attempts to develop physical, autonomic and endocrinological correlates of this burgeoning construct.

Unfortunately, the formation of a "normality" construct based on fundamental parameters of human mentation such as anxiety, hostility, intellection, and affection is in the distant future. As Gleser et al. say: "Despite the centrality of the concept of anxiety in psychological theory, it is only within the last decade that attempts have been made to measure the concept objectively."³¹ For those feeling the pressure of demands for a "community psychiatry" the delay may seem too long. There is little choice, however, but to be patient. We have, as an alternative, the formation of a hasty and ill-conceived notion of "normal" which could be easily abused by the individual mental health worker or, worse yet, become a weapon in the hands of a governing body wishing to stifle deviancy. Indulgence in such a notion could well transform Sabshin's "Orwellian nightmare" into an Orwellian reality.

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