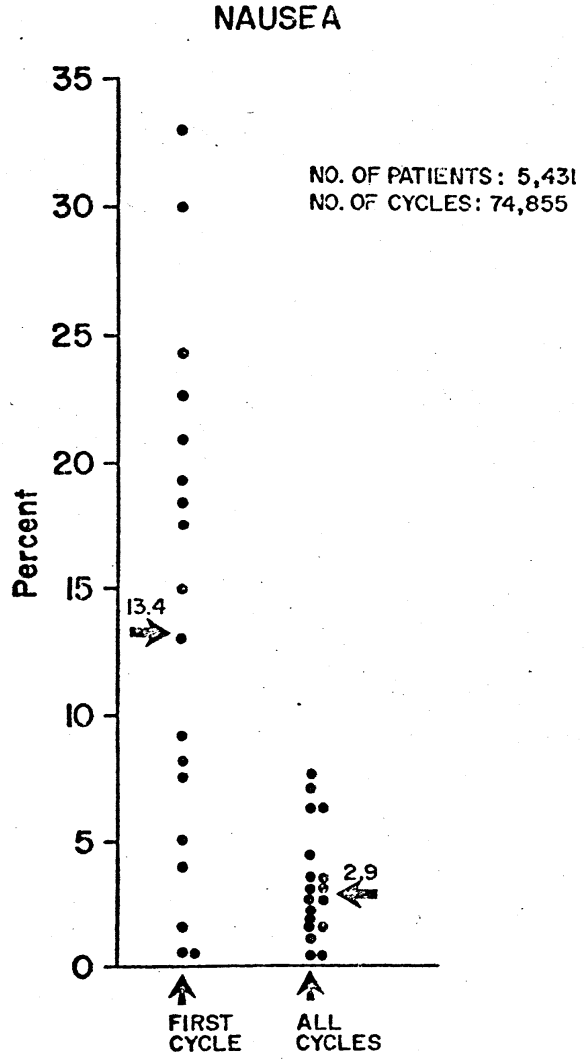
survey recognizes the importance of this problem, which is a particularly difficult one in medical questioning. For example, it has been shown that if a leading question is asked, such as "Have you had headaches (or nausea or depression) this month?" rather than a question such as "How have you been feeling this past month?", one will record a frequency of headache (or nausea or depression) which is four to six times higher than if the second, non-leading question is asked. One may say, why not use the leading question and get a maximum estimate? Simply because the use of this question will suggest to many individuals that they *ought* to be having this symptom even if they do not; if it is asked *repeatedly* during the clinical investigation, more and more subjects will think that they ought to be having it and will say so.

Another problem is that one gets different answers from different population groups. Consider the results of one large clinical study where the *same* drug and the *same* method of questioning were used in different clinics and hospitals throughout the country (Figure 1).



The frequency of reported nausea (which is a known, real side effect of the Pill) varied from almost zero to thirty-three percent! Which value is correct? All of them, and none of them. *There is no single answer that tells the whole truth.*

Consider also, that each of these numbers assumes that *every case* of nausea (headache, depression, etc.) was associated with the Pill. Obviously, women who do not take the Pill also have nausea, depression, headache, etc. from time to time. The real frequency is therefore some number *less* than the reported frequency. This spontaneous occurrence, the so-called *placebo frequency*, has been studied by very few groups aside from our own. We have published a study