beer, and a movement was started for its abolition. Almost the whole country was divided on the issue, but eventually the small but powerful anti-alcohol parliamentary faction won, and 2B was banned. Did this decrease alcoholism? Of course not: drinking habits were altered and 2B abusers turned to cheap wines, whereas the rest of the population had to be satisfied with the rather tasteless 2A or 2 as it is now called.

Joys of the bottle

What of the future? To understand the present abolitionists' demands, I must briefly recount Sweden's drinking past.

It seems that Swedes from the Vikings onwards have always delighted in the joys of the bottle. In the early years of the century authorities were so alarmed by widespread alcoholism that a nationwide referendum was held as to whether alcohol should be forbidden. Those against prohibition won, but by such a narrow margin that a compromise, deemed expedient, resulted in a law severely restricting the sale of all alcoholic drinks. The adult population was issued with a "ration card" (Motbok), which permitted limited monthly amounts of spirits and wine to be bought and recorded at the State shops. Women were allowed less than men, and white collar workers more than labourers. Strong beer was at this time available only from the chemist on production of a doctor's prescription. Limited amounts of spirits and wines were served in restaurants with a meal, but never alone. Although State-employed spirit spies disguised as alcoholics were used to supervise enforcement, a free meal could be obtained by "donating" your drinks to a bypassing benefactor. These restrictions were abandoned in 1955.

Well, as can be expected, the cry is now "back to the Motbok," although possibly in a somewhat different guise to pacify the exponents of Women's Lib. Abolitionists, although only a tiny minority of the population are politically powerful (about one-third parliamentary members) and having successfully banned 2B beer, without any drastic improvement in national spirit consumption, now believe that the alcohol problem can be solved by further partial or total prohibition.

Bootleggers rejoice—salvation is at hand!

Scientifically Speaking

Assessing the benefits

BARBARA J CULLITON, WALLACE K WATERFALL

Washington DC—These days no research into new treatments for disease seems to be getting as much emphasis as that into old treatments to find out how well they work. Much encouragement for studies of the effectiveness of established treatments, at least in the United States, comes from the federal government, which pays for an increasing number of treatments and pays an increasing cost for most of them.

The principal method of making an acceptable test of therapeutic effectiveness is still the prospective, randomised, controlled clinical trial. Because there are very few ills today for which no old favourite remedy exists, clinical trials usually pit a promising new treatment against an entrenched older one; placebos are less often feasible. And, if the shade of difference between the effectiveness of two treatments is small enough, beating the 0·05 p value requires a staggeringly large enrolment of patients in the study. Several questions have popped up recently about the applicability of the randomised, controlled trial, and even about its objectivity.[1] But increasingly it is invoked to settle medical matters that could upset the public health or purse.

A recent success of such a trial was achieved by an immense investigation that apparently proves the worth of treating borderline hypertensives, which we'll get to in a moment. But one of the biggest challenges ever to the art of effectiveness testing is shaping up now in murmurings in both Congress and a major federal health agency. The question: how worth while are treatments for mental disorders?

Treatment for medical disorders

More and more legislative proposals in Congress would expand government payment policies for psychotherapies. Care for mental illness under most federal programmes has more constraints on payment than care for physical illness does. And, although government still pays slightly less than half of the American bills for health care, many private health insurance plans follow the government's lead as to what ills, what treatments, and even what kind of healers will be taken care of by insurance payments.

Last autumn the head of the government's mental health agency asked his advisers to come up with ideas for clinical research that could assess the worth of psychotherapies. Without proof of effectiveness, he suggested, not only might mental health treatment be neglected in bigger health insurance programmes, but it might also be cut out of any coverage. A short time earlier the appropriate congressional subcommittee, whose purview includes legislation that determines what kinds of sickness care the government will pay for, let it be known that there should be a feeling of urgency about studies of psychotherapeutic effectiveness. It appears, wrote the subcommittee's staff chief, that "there are virtually no controlled clinical studies, conducted and evaluated in accordance with generally accepted scientific principles, which confirm the efficacy, safety, and appropriateness of psychotherapy as it is conducted today."

That is true, as far as it goes, but it tends to discount the knowledge that has been amassed by uncounted clinicians and

5026 Eskridge Terrace NW, Washington DC 20016, USA

BARBARA J CULLITON, AB, news editor of *Science*, the weekly journal of the American Association for the Advancement of Science

WALLACE K WATERFALL, AB, senior professional associate and director, Office of Communications, Institute of Medicine, National Academy of Sciences

small-scale investigations. Conclusions from that body of knowledge have recently been made public in a review prepared by a group of staff members at the National Institute of Mental Health. The paper is one of several submitted in 1978 to the President's Commission on Mental Health but never published or distributed beyond the informal circulation of a limited number of volumes that could be duplicated on a copying machine.[2]

The review group, headed by Morris B Parloff, winnowed relevant publications for evidence that "psychosocial therapies" work; for clues to what constitutes a "good" therapist, a "good" patient, or a "good" match of the two; for indications of therapeutic effectiveness against specific disorders; and for evidence that could firmly connect mental health disorders to general health, so as to bring psychosocial therapies into the mainstream of health care.

Because they were trying to pull together enough of the same types of disorders and treatments to form a discernible mass of evidence, the authors chose only the "more established and more adequately tested" methods of psychotherapy and behavioural intervention. These did not include—and the list provides some feeling for the specialty's fringes—"primal therapy, re-evaluation counselling, bioscream therapy, transactional analysis, network therapy, psychodrama, gestalt therapy, encounter groups, marathon groups," and so on through "structural reintegration (rolfing)."

Acknowledging that the more established types of psychotherapy still make up a great variety, that therapists in any one of the methods vary in "skill, style, and conviction," and that clinicians and researchers are not after the same goals, Parloff and colleagues find sufficient evidence of positive effects of treatments to negate contentions that "spontaneous remissions" can post as good a record. But they also find that such treatments may have negative effects—may be psychonoxious—although there are fewer good studies of the phenomenon.

An almost overwhelming amount of information in snippets, but never in volume for consistent or comparable conditions, leaves the Parloff group unable to identify one or a few most effective types of treatment, to pick out qualities that characterise a most effective therapist, or to describe the type of patient most likely to benefit from treatment. There are several reasons for this inconclusiveness. Perhaps the greatest complication in psychosocial therapy research is the fact that, in contrast to the therapist's ability to maintain an objective, detached attitude while he or she participates in a drug evaluation study, the evaluation of psychological treatments is more often viewed by the psychotherapist as a personal treat. Since the therapist is the mediator of the technique and the theory on which it is based, the assessment of effectiveness is often seen as a test of the adequacy of the therapist rather than of the techniques or the theory. In addition, the assessment of the effectiveness of a particular school of therapy is seen as a potential threat to the profession.

Notwithstanding that research sapping, some therapeutic tendencies to effectiveness are identified by the reviewers. Schizophrenia is better treated in an institution with psychotherapy and drugs, but out of hospital the most important factor for success appears to be the support of family or friends. In depression, drugs alone may ameliorate symptoms, but psychological treatment is often necessary to revamp a patient's patterns of behaviour and thought. With the neuroses—anxiety, phobias, obsessive-compulsive disorders—there is some evidence of successful intervention, with behaviour therapy making the best case in some specific disorders.

A strong hint that psychosocial therapies lessen the occurrence of somatic complaints runs through published work, but, the Parloff group concluded, the research methods used to establish the connection raise many uncertainties. In this particular, as in most other aspects of the subject, "credible research evidence will be required, and the improvement of the quality of research during the past 20 years indicates that it can be supplied."

Parloff and company say that the basic questions now being asked with increasing insistence—"what kinds of changes are effected by what kinds of techniques applied to what kinds of patients by what kinds of therapists under what kinds of conditions?"—can be answered only by a type of co-ordinated, systematic acquisition of knowledge that has never characterised psychosocial therapy. The large-scale clinical trials used so widely in the study of drugs can be adapted to psychosocial therapy research once the nomenclature and measurements are worked out to standards, the authors contend. And some of this research will have to be directed towards investigating psychosocial intervention as it is practised, not only as it is probed in academic institutions. The Parloff group found that the best research has been done in the least applied techniques, such as behavior therapy, while very little solid research work validates the widely offered psychotherapy.

Borderline hypertension study

Studies of the process and outcome of psychosocial therapies will presumably be far more complex than studies of drugs, which raises a vision of prodigious populations of patients. The numerous variables that might have to be accounted for in a psychotherapy study can only be guessed from the actual numbers employed in the borderline hypertension investigation mentioned earlier.

The hypertension study[3] enrolled nearly 11 000 people, enlisted 14 clinical centres, cost $17m, and compared the mortality at five years for patients randomly assigned to one of two treatment groups. One group received "stepped care" in whatever increments were necessary to hold blood pressure at or below goals established according to their pressure on entering the programme. The other group got "referred care," which simply meant they were sent to their customary doctor or clinic, where it was presumed that treatment would be less systematic—partly because of medical uncertainty about the value of treating mild hypertension. Well, more than half of the patients in each treatment group had diastolic pressures of 90 to 104 mm Hg at the outset of the study—"mild" by American definition.

The mortality rate was 20% lower among mild hypertensives who got stepped care than it was for those who got referred care. For all subjects in the study, at whatever entry diastolic pressure, mortality was 17% lower for stepped care as compared with referred care. Preliminary figures on cause-specific deaths for the two treatment groups of mild hypertensives give a slightly sharper discrimination. The stepped care group had 45% fewer deaths from cerebrovascular disease, 46% fewer from acute myocardial infarction, and 20% fewer from all coronary heart disease.

The frequently confounding risk factors of smoking, obesity, and hypercholesterolaemia were so similar for the two treatment groups as to be meaningless. The only difference that cannot be dismissed completely is the stepped care group's more frequent contact with medical care practitioners.

But, then, that verges back on to the psychosocial therapies.

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