WHAT WORKS? HOW MUCH OF EFFECTIVE COUNSELLING IS A PLACEBO EFFECT?

BY **ROBERT BLAKEMAN**

INTRODUCTION

Placebo is a highly stigmatised term, many associating the term with sham interventions or quackery, their view being that the rigors of the scientific method cannot be reconciled with the perceived deception implied through the use of placebos, therefore denying any acceptance that the brain has capacity to mitigate physical and mental issues, considering the placebo effect as unreal (Justman, 2011). Here we briefly review the historical observations and anecdotes of placebos and the placebo effect; consider the evidence in support of the placebo effect provided by neuroimaging; then highlight how the usual approach in providing counselling interventions can be used to good effect in achieving beneficial outcomes for clients through utilising the factors influencing the placebo effect. Finally, we look at spirituality and the placebo effect, discovering that factors usual employed in psychotherapy interventions, factors supporting spirituality and factors influencing placebo effects are identical. The discussion will demonstrate that counsellors who believe in their words and actions, and not just posturing, are well placed to utilise the suggestive power of the placebo effect with clients thereby improving what works.

Discussion

Placebo can be defined as any treatment, including pharmaceutical agents, surgery and psychotherapy, that mitigates symptoms or disease being experienced by an individual, but is in fact inert, or does not specifically have any benefit for the condition being treated. The actual action experienced by the individual from the placebo is known as the placebo effect (Beauregard, 2009). Kohls, Sauer, Offenbacher and Giordano, (2011), offer a more distinct definition, more relevant to psychotherapies, "placebo refers to a reduction in a symptom in an individual which results from one's perception of the therapeutic intervention".

Beecher, (1955), in his seminal paper on placebos, discussed that placebos had been used by physicians, and quacks a like, for centuries, questioning why so little been written on the phenomenon. Indeed, the phenomena has been known for millennia, Hippocrates wrote, around 400BC, "some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician." (Bensing, and Verheul, (2010). De Montaigne, (2003), wrote in 1588 his observation concerning the power of the imagination in relieving perceived pain. His anecdote concerned a young woman who thought she had swallowed a pin and consequently was suffering pain. Being induced to vomit and, through sly of hand, a pin was 'found' in her vomit, her pain subsided. Tuke (1873, 1884), described several anecdotes from his experiences at York Retreat, a Quaker asylum in England, the outcomes of which were accredited to the power of the mind, the imagination (Chaney, 2017).

Beecher, (1955), identified five areas in which placebos could be utilised: as a psychological tool for mental health issues; a resource available for the treatment of a neurotic patient; in determining the true effect of drugs in drug research; eliminating bias of participants and researchers in research; and as a research tool when studying the mechanisms of drug actions. It is in the three latter areas we more readily identify placebo use today, in randomised controlled trials (RCT). In relation to post-operative pain, Beecher discussed positive findings from 15 studies, conducted over several years, having in total more than 1000 participants. Beecher was able to demonstrate that placebos were effective against real and not just imagine the pain, which was a common alternative view at the time. He reported consistent results in which he found placebos gave relief to patients 30% of the time, eventually calculating the placebo effect was in the order of 35% ±2.

In the employing placebos Beecher, (1955), found no difference in regards of gender and intelligence between those patients who experienced a placebo effect and those who did not. However, he did note differences in patients' attitudes, habits, educational background and personality, with those who were more positive in outlook more likely to experience a placebo effect. There is evidence today that the beliefs and expectations of individuals regarding interventions they receive is a determination of the placebo effect they experience. To this end the more positive an individual is about the outcome of an intervention the more positive their experience of a placebo effect will be (Benedetti, & Amanzio. 2011).

Neuroimaging studies, functional magnetic resonance imaging (fMRI), positron emission tomography (PET), single photon emission computed tomography (SPECT), examining reactions in the brain and the placebo effect as a result of psychotherapy interventions, showed that there was critical influence of the functioning and plasticity of the brain (Beauregard, 2009). In cases of major depression disorder, placebo effects, associated with psychotherapy, was found to induce in the cortical and paralimbic brain regions metabolic changes comparable with those associated with fluoxetine use (Beauregard, 2009). Placebo effects have been found to diminish neural activity in regions of the brain responsive to pain such as the rostral anterior cingulated cortex, anterior insula and thalamus, and activating the endogenous opioid and endocrine systems. Results from such studies give weight to the mentalist theory approach to human behaviour. Mentalism being based on the power of thought, suggesting that beliefs and expectations significantly influence neurophysiological and neurochemical activity in the brain regions concerned with perception, movement, pain and various aspects of emotional expectations, having a fundamental influence on the effect experienced, which can be very specific. Neuroimaging studies clearly demonstrate that these regions are influenced by beliefs and expectations (Beauregard, 2009). These findings provide evidence contrary to alternative theories concerning human behaviour, being psychophysical identity theory and epiphenomenalism, and support a mind/body relationship.

Whilst we tend to consider placebos within the context of

research environments, particularly randomly controlled trials, should we be considering the placebo effect within the context of a psychotherapy clinical practice environment? In a medical context the use of placebos became somewhat ethically unacceptable as the medical profession evolved from a traditional paternal approach to a position of prescribing treatment by providing full explanation, both positive and negative, enabling patients to form an understanding necessary to provide informed consent. Although it is suggested physicians continue to seek a placebo effect by over prescribing antibiotics to pacify patients and requesting numerous blood tests to induce the belief that something is being done in the patient. Bensing, and Verheul, (2010), report that it is still common practice for approximately 50% of Interns and Rheumatologists in the USA to prescribe treatment to obtain a placebo effect in patients. Further pressure on placebos resulted from a number of unethical research studies, such as the Tuskegee Study of untreated syphilis, (White, 2000), further helping to assign openly employed placebos from clinical practice to research, strongly intimating that placebos had no place in scientific based clinical practice. However, in the context of psychotherapy, the accepted usual approach of intervention; establishing goals as positive outcomes, educating clients to adopt more positive beliefs and expectations, developing an effective working alliance, employ the very factors which promote a placebo effect. Therefore, unlike medical implementation of placebos where an inert substance, or sham surgery, is prescribed, psychotherapists are using techniques which can be shown to have plausibility and are intended to positively promote a client's beliefs, expectations, hopes, optimism and motivation (Hyland et al., 2007; Justman, 2011).

Psychotherapies are based on the premise that clients believe in and interact with rituals surrounding the intervention to improve their health, this holds even if the ritual is a myth and untrue, clients have preconceived expectations concerning psychotherapists, their behaviour, environment and persona. Ritual surrounding intervention, such as psychotherapy, adds to the strength of the placebo effect. The attendance at professional rooms, the ambiance of the rooms, the demeanour of the therapist and other staff, all compound the effect. Interestingly in pharmaceutical studies the placebo effect is stronger when participants believe the placebo they are receiving is an expensive drug, this effect, the more expensive item must be somehow better, is widely known in marketing theory, does this imply therapists should appear somehow successful implied by their surroundings or even their billing habits (Hyland, Whalley, and Geraghty, 2007; Schmidt, Skvortsova, Kullen, Weber, & Plassmann, 2017)? The recognition of ritual influencing the placebo effect suggests a second theory, underlying the placebo effect, other than that relying on expectations, that of conditional learning. After repeated treatments a ritual is established which individuals associate with positive outcomes, therefore the ritual becomes the conditioned stimulus. Although this can be interpreted as reinforcing expectations, which are consider the stronger influence, as a placebo effect can be experienced without any previous exposure to treatment (Hyland, et al., 2007).

Can an individual's spirituality influence the placebo effect? Spirituality is formally defined as "concerned with the transcendent, addressing ultimate questions about life's meaning, with the assumption that there is more to life than what we see or fully understand" (Kohls et al., 2011). For the current discussion spirituality should be interpreted very broadly, recognising that there is little to distinguish spirituality and religiosity (Good, Willoughby, & Busseri, 2011). Bryant-Davis, and Wong, (2013), note interest in examining the role of spirituality in the treatment of interpersonal trauma, include medical traumas such as HIV, natural disasters, intimate partner violence, community violence, and traumatic grief. is growing, noting that Worldwide 80% of the population are affiliated with religious groups. For interventions to be effective it is suggested that psychotherapist should respect coping strategies adopted by clients with spiritual/religious faith beliefs. Positive religious coping is derived from holding the belief that God is benevolent, negative religious coping derives from the belief of a condemning God (Pargament, Koenig, Tarakeswar, & Hahn, 2001).

We have previously discussed the effect of an individual's expectations, hope and optimism in relation to the placebo effect. Hyland et al., (2007), recognise that the placebo effect is enhanced through an individual's perception of their meaningfulness, purposefulness, and self-actualisation, commentating that these elements are also common to spirituality. It is suggested that individuals who are more spiritually active are more likely to engage in rituals more purposefully thereby enhancing the effects of rituals associated with intervention, this is commonly observed in those who use complementary and alternative medications. Kohls, et al., (2011) make the point that an individual may interpret existential values of contextual experiences, circumstances, rituals and activities, thus transforming events into spiritual experiences, increasing the possibility and strength of the placebo effect. However, they also express caution noting that for some clients the faith they hold may result in increased stress, anxiety and pessimism, negative religious coping.

Conclusion

The above discussion has identified a number of areas which need to be examined to gain some understanding that, certainly in relation to psychotherapy, placebos should not be dismissed out of hand. The discussion emphasises the importance of client's expectations, hope and optimism, outcomes usually accepted as positive outcomes in psychotherapy, as basic factors which influence the placebo effect, to this end psychotherapists should be encouraging these factors through their communication skills, this includes verbal and nonverbal communications (Bensing, & Verheul, 2010). Di Blasi, Harkness, Ernst, Georgiou, and Kleijnen, (2001), report that clinicians who are warm, friendly and project a reassuring manner are consistently more effective than those who are

more formal in their approach and fail to offer reassurance. The broad question raised is should we be less concerned with which type of therapy modality works, but rather examine how therapists engage clients, in whatever modality, with a view to encouraging a positive influence on strengthening those common factors identified as therapeutic outcomes for psychotherapy, providing strength and support to clients' spirituality and influencing the placebo effect? It may be found what we consider is working, will work more effectively.

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