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From medicine to psychotherapy: the placebo effect

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Abstract
If placebos have been squeezed out of medicine to the point where their official place is in clinical trials designed to identify their own confounding effect, the placebo effect nevertheless thrives in psychotherapy. Not only does psychotherapy dispose of placebo effects that are less available to medicine as it becomes increasingly technological and preoccupied with body parts, but factors of the sort inhibiting the use of placebos in medicine have no equivalent in psychology. Medicine today is disturbed by the placebo effect in a way psychotherapy is not. Psychotherapy does not have to grapple with such a disconcerting paradox as successful sham surgery, and unlike those physicians who once pretended to treat the patient's body while actually attempting to treat the mind, the psychotherapist can treat the mind in all frankness. Perhaps it is because psychotherapy is less burdened by doubts about the placebo effect that it was able to come to its aid when it was orphaned by medicine. It is vain to expect something with so long a history as the placebo effect to disappear from the practices of healing.

Keywords
ethics, evidence, medicine, placebo, psychotherapy

If medical history until recently is a chronicle of the placebo effect (Shapiro and Shapiro, 1997: 2), that does not mean the use of placebos died out with the medical innovations of the 20th century. On the contrary, placebos in the form of distilled water, saline solution,

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bromides, vitamins, starch, and the now-infamous sugar pill were administered by doctors at their own discretion well into the century. The scope of the placebo effect was suggested in a 1955 article by Henry Beecher on 'The Powerful Placebo' that remains to this day a starting-point for discussion of the subject, even if the author's data now appear somewhat less solid. According to Beecher's estimate, approximately 35 per cent of a given treatment group will respond to a placebo as to a medication. An effect of this magnitude is something to be reckoned with, and the practice of accounting for the placebo effect has since been built into clinical trials of new drugs and treatments. Formerly a ruse to be practised at the doctor's discretion, the placebo became a control in a study. Yet if the introduction of the double-blind trial to control for the placebo effect and establish a drug's efficacy 'above and beyond placebo' marked a new phase in their use, to many investigators placebos have come to represent more than dummy treatments that activate a capacity for delusion.

Concurrently with the seismic shift from paternalism to informed consent (to which another historic paper by Beecher, this one deploring the practice of experimenting on subjects without their knowledge [Beecher, 1966], contributed), everything about the placebo effect including the sugar-pill model itself came to be rethought. Is the placebo effect nothing but a sham? How then does it happen that 'inert' medications can produce physiological effects and actual benefits? Is it not closer to the truth to say that the body possesses resources for healing that the rituals of medicine can tap? For that matter, can mind be distinguished from body quite as sharply as the model of placebo as trickery presumes? Questions like these animate recent literature on the placebo effect, which has become an object of research in its own right as well as a topic of general fascination. But for all the reaction against the reduction of the placebo effect to the dimensions of a sugar pill, its reputation, at least in medicine, has not been fully rehabilitated. It remains true that 'even when . . . physicians are convinced that impressive forces may be rallied through [the placebo effect], they often cannot shake themselves free of the conviction that this practice is at best unreal and at worst chicanery' (Harrington, 1997: 1).

Although reportedly placebos are still used in medical practice, they cannot be prescribed as freely as they once were. Decades into the era of informed consent, doctors are simply not at liberty to act as if their former prerogatives had never been called into question. But if we understand the placebo effect as a benefit arising from a treatment not specifically effective for a given condition, then not all applications of the placebo effect involve such stark deception, or indeed deception of any kind. This article argues that even as the routine use of placebos in medical practice (as opposed to clinical trials) lost legitimacy, the placebo effect in the form of suggestion flourished in the practice of psychotherapy; that the robust exercise of the placebo effect, at a time when medicine was becoming more impersonal and more uneasy with the effect itself, enhances the experience of psychotherapy; and that even though the therapist engaged in a talking cure is not to be confused with a medical doctor knowingly administering a sham treatment, the epistemological foundation of psychotherapy is questionable. It can hardly be otherwise, given that 'there are no objective tests for mental illness and the boundaries between normal and abnormal are often uncertain', in the words of a former editor of *The New England Journal of Medicine* who has excoriated the lax standards of evidence in the

directory governing the classification of mental disorders in the United States – the *Diagnostic and Statistical Manual*, or *DSM* (Angell, 2009).

I will argue first that psychotherapy constitutes a rich habitat for the placebo effect, then that the effect is exploited more freely – with less reservation and constraint – in psychotherapy than in medicine. A practical implication of the dubious epistemological basis of psychotherapeutic insight and 'story-work' will be considered in closing.

'Rife with Placebo Effects'

If the placebo effect is a benefit (1) derived from the expectation of benefit (an expectation encouraged by the receipt of treatment) and (2) registered in the form of feeling better, then psychotherapy that centers professional attention on the patient in the interest of helping him or her feel better is very likely to engage it. As the most comprehensive and searching study of its kind puts it, 'Psychiatry and psychotherapy are rife with placebo effects' (Shapiro and Shapiro, 1997: 231). But where such effects can be distinguished both in theory and practice from the clinical effects of drugs – hence the methodologically demanding trials pitting drug against placebo – they are so woven into the practice of psychotherapy as to complicate the attempt to differentiate them from less impressionistic benefits even in principle. According to a noted article that appeared in *Psychological Bulletin* shortly after Beecher's groundbreaking study of the placebo effect, 'Certain general aspects of the psychotherapeutic relationship seem very similar to those responsible for the so-called placebo effect, which is well known to investigators of the therapeutic efficacy of medications' (Rosenthal and Frank, 1956: 294). One of the authors of this seemingly compromising admission went on to publish the also well-known *Persuasion and Healing: A Comparative Study of Psychotherapy*, where the point is confirmed, for good or ill, by case histories of patients led to insights about themselves that are believable and encouraging but possibly false. 'To be effective, interpretations, the primary means of transmitting the therapist's conceptual framework, need not be correct, only plausible' (Frank and Frank, 1991: 48; cf. Jopling, 2008: 44–8, 261–2). Unlike a medical doctor carrying out a sham procedure, the psychotherapist on this showing need not disbelieve in proffered interpretations that may be quite untrue but nevertheless make enough sense to the patient for that person to invest in them. And if the healer who is not just an actor but believes in his or her words and deeds makes an especially effective conduit for the placebo effect, then the therapist committed to a 'plausible' interpretation is such a conduit.

In their concern to establish the efficacy of tested drugs above and beyond placebo, those hired by pharmaceutical companies to run clinical trials of promising drugs seek to hold the placebo effect to a minimum – even avoiding giving the placebo group the impression of being helped 'in any way', because such 'covert psychotherapy', as it is called, can induce a placebo response (Lakoff, 2007: 66). Psychotherapists per se have an interest not in suppressing but encouraging the impression of helping the patient, and not only take no procedural safeguards against the placebo effect but are able to offer it in concentrated doses. One of the authors of *Persuasion and Healing* went so far as to portray psychotherapy as a sort of placebo institution, contending that 'With many patients the placebo may be as effective as psychotherapy because the placebo condition contains

the necessary, and possibly the sufficient, ingredient for much of the beneficial effect of all forms of psychotherapy. This is a helping person who listens to the patient's complaints and offers a procedure to relieve them, thereby inspiring the patient's hopes and combating demoralization' (Frank, 1983: 292). It is presumably because of this inspirational effect that various modes of psychotherapy seem to work equally well even though founded on different presuppositions.

Not only is the psychotherapeutic relationship itself patently loaded with placebo potential, but its nature rules out the double-blinding built into clinical trials such as one that recently found vertebroplasty no more effective than a placebo. 'Psychotherapy studies cannot be made blind in the manner of placebo controlled medical studies. Quite obviously the therapist must be aware of the treatment being delivered to follow the treatment protocol' (Baskin *et al*., 2003: 974; cf. Benedetti, 2009: 142). Questioning the applicability of the randomized clinical trial – the gold-standard of verification – to psychology, a former president of the American Psychological Association has referred to randomization and rigorous controls, as well as double-blinding, as 'niceties' (Seligman, 1995: 965, 974) and contended that it simply does not matter that the most common modes of psychological treatment have not been validated experimentally. It is hard to imagine a medical doctor showing quite this insouciance toward evidence, whatever his or her degree of enthusiasm over evidence-based medicine. One reason psychotherapy is 'rife with placebo effects' is that no effort to account for them, comparable to the effort to distinguish the placebo component of medical treatments, has been or perhaps could be made.

That the list of accredited mental illnesses has ballooned in successive editions of the DSM (now filling some 900 pages), even while medical research has committed itself to stringent norms of evidence, in itself marks the diverging paths taken by psychology and medicine in our time. So does the former's spectacularly successful challenge to psychiatry's proprietorship of psychotherapy as a sort of medical art. So does the argument that while the placebo effect may be looked down upon in medicine, its dubious reputation in that venue should not be allowed to cast a shadow over psychotherapy (Parloff, 1986). How the placebo effect came to flourish in the therapist's office belongs to the history of the human sciences, especially medicine, its original homeland. In medicine the use of placebos has perhaps all too much of a history. In recent decades the former use of placebos to deceive returned to haunt medicine, with the result that placebos themselves came to share in the disrepute of traditional paternalism. Regarding the placebo effect not only as a confounder in clinical trials but a powerful *x* with a dubious past and an uncertain place in clinical practice at this hour, and a riddle insofar as it mimics actual physiological responses, medicine today is disturbed by it in a way psychotherapy is not. Psychotherapy does not have medicine's commitment to the model of specific causes and mechanisms and does not have to grapple with such a disconcerting enigma as successful sham surgery (the placebo treatment in the vertebroplasty trial among others). Unlike those physicians who once pretended to treat the patient's body while actually attempting to treat the mind, the psychotherapist can treat the mind in all frankness. Neither, therefore, does psychotherapy have medicine's troubling memory of its own use of the ploys we call placebos – ploys that seem innocent one moment but indefensible the next; producing responses now imaginary, now bewilderingly potent. 'The entire

enterprise of medicine must necessarily find the notion of placebo effects at the least uncomfortable' (Wampold *et al*., 2007: 380–1). Interestingly, the authors do not say the same of psychology even though they write in the *Journal of Clinical Psychology*.

When a specific mode of psychotherapy is tested head to head against a generic therapy in the manner of a drug tested against a placebo, the generic therapy lacks the ingredient in question but includes empathy, attention, support, and other 'common factors'. In other words, what some call the placebo treatment features the cardinal virtues of the profession itself. There is thus good reason why psychologists should be well disposed toward the placebo effect even if they do not like the term; and being so disposed, they have come to its aid now that it has fallen from favor in medicine.

The Placebo Effect's Loss of Standing in Medicine

'The placebo effect' is a simple name (which out of deference to common usage I will continue to employ) for a spectrum of responses ranging from the imputed benefits of sham medications and even non-existent surgical procedures, to the intangible but nevertheless demonstrable benefits of trust and hope, to actual bodily changes resulting from fictitious agents (see also Harrington, 2006; and Justman, 2010). Little wonder that a phenomenon at once so far-reaching, so cunning, so potent and so nearly scandalous, and so inconsistent with our usual ways of thinking about mind and body, should be regarded by medicine with reserve and suspicion.

The soul-searching that the placebo effect can inspire in medicine is hinted at in an article that appeared a decade ago in the *Journal of Family Practice*:

> Two recent findings highlight the continued controversy over the placebo response. The apparent importance of the placebo response was recently emphasized by the ethical debate over the use of sham surgery control groups in studies of fetal cell brain implants for intractable Parkinson's disease. The need for a sham group and the ethical question of whether exposing subjects to this risk is warranted arises [*sic*] because subjects receiving the sham procedure typically exhibit marked improvements in their Parkinson's symptoms for up to 6 months and are indistinguishable from patients given the active treatment. This improvement does not seem to be due to either the natural history of the disease or observer bias. (Brody, 2000: 649)

'Controversy', 'ethical debate', 'sham', 'does not seem': the placebo effect appears to pose a profoundly unsettling challenge to medicine. Perhaps if the rituals of daily medical practice nurtured hope and trust – the stuff of the placebo effect – such concerns would seem academic; but the rituals of medical practice have frayed, and in any case hope and trust can be misplaced.

If, as most informed commentators agree, the placebo effect was once instrumental to the practice of medicine, its principal vehicle was the very rite of ministering to the patient. The sense of being treated, of receiving care, nourishes the placebo effect, but in order to gain this sense the patient has to be heard, not just processed. With the pressures now bearing on the physician – especially the necessity to see patients speedily, one after the other – some element of the rite of medicine is sacrificed even as tools and

drugs of unprecedented efficacy enter medicine's arsenal. In a social history tracing the strained relations between patient and healer, Edward Shorter writes, 'It is, to our postmodern minds, quite incredible that [three-quarters of a century ago] patients expected the doctor to call *virtually every day*' – three or four days successively for the mumps, five days for a nervous condition, and so on (Shorter, 1991: 160). Outside of a hospital, doctors no longer visit their patients at all.

Compared to the postmodern physician for whom a call means a phone and time is a commodity in short supply, the attentive physician of the 1920s or 1930s had little power to treat and cure. Hence the use of bromides. Allowing patients to tell their story and hearing them out was itself a sort of bromide, which is not to say that this rite was without some therapeutic effect. On the contrary, it is probable that many complaints were alleviated by the release of telling and the consolation of being heard by a gentleman of science, especially if they were non-specific to begin with. The ritual of healing may promote healing. 'Suggestion', concludes Shorter, 'plays an enormous role in the practice of medicine, even though neither doctors nor patients like to admit it. What interests me is the declining ability of doctors today to cure by suggestion' (Shorter, 1991: 151), declining if only because they no longer have either the luxury or the inclination to take the patient's history and devote time to the passivity of listening – to be patient themselves. 'Eleven minutes may be enough to make an organic diagnosis and write a prescription, but are they enough to heal?' (ibid.: 210).

Even as physicians at one time helped patients by the very rite of attending to them, they or others also played deceptively on the placebo effect by administering 'medications' known to them to be useless, from distilled water to sugar pills. An open professional secret, this practice was never intended to stand up to the light of public examination, and when subjected to such scrutiny a generation ago it very soon came to appear indefensible. Sissela Bok's historic article questioning 'The Ethics of Giving Placebos', published in the *Scientific American* in 1974, opens by telling of a number of

> . . . Mexican-American women who applied to a family-planning clinic for contraceptives. Some of them were given oral contraceptives and others were given placebos, or dummy pills that looked like the real thing. Without knowing it the women were involved in an investigation of the side effects of various contraceptive pills. Those who were given placebos suffered from a predictable side effect: 10 of them became pregnant. Needless to say, the physician in charge did not assume financial responsibility for the babies. Nor did he indicate any concern about having bypassed the 'informed consent' that is required in ethical experiments with human beings. (Bok, 1974: 17)

In the most infamous medical study in American history, black field workers afflicted with syphilis were given aspirin to make it appear they were being treated while in fact the authorities withheld available treatments, eventually including penicillin, in order to follow the progress of the disease right to the autopsy table. Launched in the 1930s, the Tuskegee Syphilis Experiment continued of its own momentum for decades until it burst into public notice in 1972, two years before Sissela Bok's article. Immediately notorious, the experiment fueled the sort of prohibitive disrepute that now surrounds the medical practice of deceiving patients with sham treatments.

Research into the placebo effect has, if anything, intensified in recent years, with new confirmations of its power and extent leaving practising doctors right about where they were. Given that 'the ordering of diagnostic tests appears to improve patient satisfaction and well-being' (Oken, 2008: 2816), should doctors then order tests to make patients happy? Given that 'when the clinician stated positive outcome expectancies as opposed to cautious or skeptical expectancies, most studies found improvement in patient self-reports of reduced anxiety, pain, and distress' (Caspi and Bootzin, 2002: 452), should doctors put on the smile of paternalistic benevolence as their predecessors are now reproached for doing? With attention turning to the physiological mechanisms by which placebos reduce pain (one of their best-attested effects), should doctors go ahead and prescribe sham drugs? Considering that much research into the placebo effect depends on deceptions and breaches of informed consent that would be inexcusable in medical practice (Miller and Kaptchuk, 2008a), it only stands to reason that this research does not translate well into practice. So dubious both legally and morally are many medical applications of the placebo effect that a principled doctor might well want nothing to do with placebos despite the surge of research interest in them. The term itself is one of ill repute; hence the proposal to replace it with something more fragrant, like 'remembered wellness' (Benson and Friedman, 1996). It is significant that one of the last strongholds of placebo medicine – the over-prescription of antibiotics, possibly to appease demanding patients – has come under heavy attack, though more for reasons of public health than ethics.

From Medicine to Psychotherapy

If placebos have fallen from favor in scientific medicine (Nuland, 2001) – suffering such a loss of repute that their only official place is in clinical trials designed to account for their own confounding effect – nevertheless there remains a market for them. A few years ago it was reported that in their disenchantment with institutional medicine Americans spend some $27 billion annually on alternative forms of it, such as herbal remedies, of whose efficacy 'little, if any' evidence exists (Carey, 2006). But so does psychotherapy offer a livelier experience of the placebo effect than is available in medicine. 'Modern patients lose the catharsis that only the "listening healer" can give' (Spiro, 1997: 39). In retrospect it appears that the physician who once treated mental disorders under the pretense of treating bodily complaints – humoring the patient with sham prescriptions – has given way to the therapist who treats mental disorders openly but with implicit reliance on the placebo effect. If the doctor's authority once charged his or her words with suggestive power, now that authoritarianism has gone out of fashion it is the transactional style of the psychotherapist that best lends itself to the placebo effect. It seems naïve to assume that a response as powerful, ambiguous and deeply rooted in history as the placebo effect could be driven out of existence, or for that matter confined to counter-cultural channels, by the changed conditions of postmodern medicine.

It has become conventional to deplore the waning of the human element in medicine, especially the concentration on body parts to the exclusion of the whole person. Psychology takes the whole person as its mandate. Where patients were once 'attended' by physicians, we now look to the psychologist to 'attend' to us, to listen; the figure of the

psychologist listening wisely, concentrating, belongs to conventional lore in its own right. If the doctor takes our history perfunctorily if at all, psychotherapy enables us not just to present our history but to reflect on it, and if the doctor takes care of us but does not care about us, the therapist seems to do both. Placebo benefits that once flowed through the rite of the patient's meeting with 'an interested, sympathetic adviser' (Shorter, 1991: 195) have thus passed to the psychologist's office. What is the persona of the therapist if not that of an interested, sympathetic adviser? As Shorter argues, at one time seeing a doctor for an unspecific complaint could genuinely help the patient provided that

1 the doctor showed an active interest in the patient;
2 the patient had an opportunity to tell his story in a leisurely, unhurried way. (ibid.: 157)

Today a patient searching for these good things knows exactly where to find them – in the therapist's office. When *Consumer Reports* polled readers in 1994 about their experience over the past three years with providers of mental health services including family doctors, psychologists and psychiatrists, 1,000 respondents had seen their doctor for an emotional problem and three times that number a mental health professional. Of those who saw their doctor, 'significant' numbers were dissatisfied (Seligman, 1995: 976, 972).

That many of the ailments for which patients seek out their doctor remain non-specific and possibly psychogenic to begin with only makes these patients better candidates for a talking treatment. The common complaint that doctors are too rushed finds its cure, likewise, in the therapist's confessional. When doctors with the exception of psychiatrists could or would not listen by the hour, therapists – sometimes popularly confused with medical doctors – offered to do just this. (Who can imagine a doctor meeting with a patient, say, a dozen times, 50 minutes each session, over 16 weeks?) Even as medicine became more powerful but less personal, psychology surged in popularity, quite as if it had assumed the functions of listening, advising and comforting defaulted by medicine. By the turn of the 21st century there were some 50,000 clinical psychologists among a quarter million psychotherapists in the United States practising untold varieties of treatment – possibly hundreds. 'But it is hard to believe that all of them are really effective' (Benedetti, 2009: 3).

From 1979 (five years after Sissela Bok's exposé) to 2007 there were virtually no studies of the use of placebos in American medical practice (Sherman and Hickner, 2007: 7), an indicator of how touchy or indeed untouchable the subject had become. Good information is still hard to come by, but if, as some think, placebos are most likely to be used to pacify demanding patients who threaten to take up too much time (Benedetti, 2009: 12), this in itself would illustrate the acceleration of medicine that has sent care-seeking patients elsewhere. Not only does psychotherapy dispose of placebo effects that are less available to medicine as it becomes increasingly technological and preoccupied with body parts, and increasingly pressed, but factors of the sort deterring the medical use of placebos have no equivalent in psychotherapy. The therapist does not look back to chilling precedents of deceit – men with syphilis treated with aspirin, women seeking contraception and receiving dummy pills instead. Whereas a doctor who

prescribes a placebo 'may feel a little guilty' nowadays (Frank and Frank, 1991: 134) or salve a wounded conscience by informing patients that they *may* receive a placebo (Sherman and Hickner, 2007: 8), a therapist can proffer comforting but empty words or indeed comforting fictions – for 'false interpretations and insights may be just as plausible and credible as veridical interpretations and insights; perhaps even more so' (Jopling, 2008: 47) – without necessarily having any sense of offering a placebo. Presuming the truth both of his or her theoretical models and of the case histories fitted to them (ibid.: 31), the therapist could not be farther from a doctor who prescribes a sham treatment. The very freedom to offer placebos and the lack of both cautionary precedents and epistemological checks, all in a setting uniquely conducive to suggestion, leave the field wide open for the placebo effect.

Some psychologists, while maintaining that psychotherapy does not come under the medical model of diagnosis and treatment (Mayes and Horwitz, 2005), nevertheless do not wish to be associated with the placebo effect. Others have no such aversion, and to the allegation that they cultivate the placebo effect, might answer, 'So what?' So say Gerald Koocher and Patricia Keith-Spiegel in their influential *Ethics in Psychology and the Mental Health Professions*:

> Research has . . . taught us that a powerful placebo effect exists with respect to psychotherapy, meaning that good evidence demonstrates that seemingly inert 'agents' or 'treatments' may prove to have psychotherapeutic benefits . . . From the client's viewpoint, it may matter little whether positive changes or perceived improvements result from newly acquired insights, a caring relationship, restructured cognitions, modified behaviors, abandoned irrational beliefs, expectancies, *or* a placebo effect . . . If the client improves as a result of the therapist's placebo value, so much the better. (Koocher and Keith-Spiegel, 2008: 102; original emphasis)

What if perceived improvements should be only that, perceived? What if new insights and cognitions and beliefs have rubbed off on the client – what if they themselves should be artifacts of the placebo effect? (After all, the model of therapy that defines interpretations as 'means of transmitting the therapist's conceptual framework' [Frank and Frank, 1991: 48] practically calls for ideas to rub off on the client.) These possibilities are simply passed over. Somehow one of the most ethically troubling things to be said about psychotherapy, that it plays on the placebo effect, is granted in a work on 'Ethics in Psychology' as if it were not troubling at all. To a therapist who welcomed the placebo effect in this way, human suggestibility – the factor responsible in other settings for the greater reported efficacy of pills of one color than pills of another – would represent not a cause of concern but a reservoir of the trust and expectation necessary to successful treatment.

Underlying the acceptance of psychotherapy as an alternative to medicine is its exploitation of the placebo effect – a resource deeply a part of the history of healing – without medicine's inhibitions and impediments, as in the passage just cited. (There are doctors so wary of exciting the placebo effect that they maintain a kind of strict neutrality as to hope itself and act as if an encouraging word to the patient were a violation of professional demeanor.) The American Medical Association Code of Ethics tightly regulates the use

of placebos in clinical practice – permitting their administration only with the patient's consent, a protocol most will find very strange – while the corresponding American Psychological Association document makes no mention of placebos at all. Debate over the use of placebos in medicine is far more robust than debate over their use in psychotherapy (Jopling, 2008: 231).

The claim that the placebo effect has freer scope in psychotherapy than in medicine finds support in a paper on 'The Placebo Response' urging doctors to make the most of that resource by becoming, in effect, therapists themselves. Doctors are exhorted not only to take time to listen to the patient (among other unexceptionable proposals) but, when no bodily ailment can be detected, to do story-work with the patient and to say things like 'Between now and the next visit, see if you can discover things that you can do, on at least some days, to make you feel more in control' or 'Do you think, now that you have done such a good job of finding the thing that works, that you might think of another?' – all the while taking care to praise the 'somatizing' patient and 'to stifle the advice-giving urge' (Brody, 2000: 652). A physician who gets drawn into this sort of dyad has at some point abandoned medicine in favor of psychotherapy.

But the psychotherapist who supports and encourages does not think of this activity as a cultivation of the placebo effect. The former president of the American Psychological Association cited above as denying that the standards of medical research apply to psychology has written a volume entitled *Authentic Happiness: Using the New Positive Psychology to Realize Your Potential for Lasting Fulfillment*. No doubt the author believes that 'potential for lasting fulfillment' refers to some actually existing entity analogous to a seed, but the notion that a second, truer, happier, more authentic self resides within waiting to be activated is plainly more fairy tale than finding. The patient who goes on a search for this mysterious inhabitant is doing story-work indeed.

A Caveat

It is reported that with the transformation of the hospital at Bath into a renowned center for the study of rheumatology, the once-famous spa went into decline:

> Paradoxically, Dr. [George] Kersley [a mover in this transformation] is now one of the most vigorous campaigners to re-establish the city as a spa, lamenting that perhaps he and his colleagues in the heady days of the 1950s had 'knocked the spook out of the waters' too thoroughly, forgetting the phenomenal effect of mind over matter when they insisted on complete scientific appraisal of all treatment. (Rolls, 1988: 166)

Having exposed the placebo effect as a paternalistic sham and a trick of 'expectancy' – having subjected the effect to rigorous suspicion by controlling for it in clinical trials – medicine itself has knocked the spook out of the waters only too well. But the spook has not been slain, only displaced. If human healing until recently has been a tale of the placebo effect, by the same token the effect is so deeply embedded in our history that it seems vain to expect it to vanish from the practices of healing even if relics, charms and waters have lost their magic. Just as we have all heard of people who lose the will to live and shut down, so, conversely, may hope contribute to recovery (Nuland, 2001; Miller

and Kaptchuk, 2008b). Beyond this, however, the effort to rein in the placebo effect as medicine has done may leave patients disappointed and inspire their search for a fuller enjoyment of its benefits. Arguably, psychotherapy – a uniquely rich medium for the placebo effect – offers just this prospect.

As paternalistic medicine came under criticism around the time of Sissela Bok's exposé of the abuse of placebos, talk turned toward partnership between patient and healer. Far more than medicine, psychotherapy is premised on partnership, and insofar as the patient ('client') is an active party, his or her investment in therapy's course and conclusions is apt to be greater. But what if the appeal of the 'story' constructed jointly by therapist and patient should reside in its way of fulfilling conventions? Stories, after all, rely on conventions; that is why authors since the Renaissance, in reinventing fiction, have also contested the very conventions of narrative (Kermode, 1966; Morson, 1987). What if the conclusions of therapy should be persuasive because, like an all-too-common storyline, they satisfy an expectation, not because they are valid? If 'to be effective, interpretations, the primary means of transmitting the therapist's conceptual framework, need not be correct, only plausible' (Frank and Frank, 1991: 48), that possibility is certainly in play.

Just as the possibility of ill-founded therapeutic insights and interpretations is immediate, not remote, so the issues at stake are anything but academic. The most philosophically rigorous study of psychotherapy yet written finds the talking therapies extensively contaminated by an epistemological license that authorizes fictitious theories and spurious insights, the worse because the object of this pseudo-knowledge is our very selves, and because the theories (etc.) are credited as if they were not epistemologically compromised at all. Writes David Jopling in *Talking Cures and Placebo Effects*:

> There is an . . . ethical dimension to the idea that truth matters. False, bogus, or fictional psychodynamic interpretations and insights can be as psychologically harmful as false memories. Like false memories, they can lead to the break-up of families, the dissolution of marriages or partnerships, the radical alteration of life plans, the erosion of religious faith, or the morally self-serving rewriting of the past. What looks like *bona fide* insight, or self-knowledge, or a genuine realization, or a new and more empowering way of looking at oneself, may in fact be ethically calamitous. (Jopling, 2008: 16)

As long as therapists who engage the power of the placebo effect take the position that interpretations 'need not be correct' (Frank and Frank, 1991: 48) or that 'If the client improves as a result of the therapist's placebo value, so much the better' (Koocher and Keith-Spiegel, 2008: 102), this disturbing possibility will remain a clear and present one. I mentioned above that the healer who believes in his or her words and deeds, as opposed to merely play-acting, is especially well positioned to exercise the suggestive power of the placebo effect. (That a therapist could not be expected to believe in a placebo treatment has been cited as an argument against the possibility of placebo-controlled trials of psychotherapy.) Jopling concludes that most practitioners of the talking cure believe all too much in their own theories and explanations. He finds among them 'little awareness . . . of the epistemic complexities of psychodynamic insights and interpretations, coupled with high levels of epistemic confidence and theoretical self-assurance

about their authority' (Jopling, 2008: 257). Such practitioners risk abusing the placebo effect because their belief in their insights makes them that much more persuasive and because their play on the placebo effect is bound up with entirely laudable goals such as 'combating demoralization'.

Accompanying the shift from paternalism to informed consent in recent decades has been a shift in the use of placebos at the doctor's discretion to their use as controls in clinical trials. As a result of these and other changes, medicine has left the cultivation of the placebo effect to other domains, principal among them (as I have argued) psychotherapy. It rests with the practitioners of psychotherapy to question their use of this ambiguous power.

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