Chapter 11
Informed Consent, the Placebo Effect and Psychodynamic Psychotherapy

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11.1 Introduction

Psychobabble is not mere babble (David Jopling 2008: 157)

The study of paternalism arguably becomes most penetrating when the discussion moves to authentic case studies. In the medical setting, paternalism was — until recently — the *sine qua non* of professional excellence. Physicians were guided by the principle of therapeutic privilege: a physician’s knowledge and training, it was gauged, trumped the right to patient choice. Nowadays in (Western countries) the medical profession eschews these ethical norms: patient autonomy and choice are now (in codified form, at least) principles to which physicians must legally adhere.

This paper examines the issue of paternalism and informed consent through the lens of psychotherapy: in particular the varieties of psychotherapy that go under the collective label ‘psychodynamic psychotherapy’ (such as Freudian approaches). I consider the extensive (and long-standing) evidence for the charge that psychodynamic psychotherapy does not work as a result of its theoretical underpinnings: rather, it is only effective because it elicits the ‘placebo effect’. The term ‘placebo effect’ has a long history of ill-definition (and I will hold back from addressing this until later). The fundamental assumption in the medical ethics literature is that the use of the placebo effect infringes on patient autonomy since it necessitates deception by clinicians. The ensuing debate on the ethics of placebos has pivoted on whether it is ever justifiable to deceive patients about a treatment in order that patients might thereby therapeutically benefit. Given that psychodynamic psychotherapy is frequently recommended by physicians for many conditions (including childhood abuse, trauma, depression, and anxiety), I argue that physicians and
psychotherapists are not currently providing adequate disclosure about how this form of therapy works (namely, that it may work by triggering the placebo effect).

The paper begins with some background discussion on informed consent in clinical practice (Sect. 11.2.1), including a survey of ‘standard’ and, as I later argue, empirically impoverished ethical perspectives on the ethics of placebo use (Sect. 11.2.2). Next, I turn to psychodynamic psychotherapy: I describe the received view that psychodynamic psychotherapy is effective because it affords patients therapeutic, truthful insights into aspects of their psychological history (Sect. 11.3.1). I briefly explain the serious (and well known) scientific objections to the received view (Sect. 11.3.2), before considering the charge that psychotherapy only works (to the extent that it does) because it is placeobogenic (Sect. 11.3.3). In the next section of the paper, I pause to observe how the term ‘placebo’ refers to a range of triggers in the healthcare encounter, and offer a definition of the term ‘placebo effect’ (Sect. 11.3.4). Finally, in Sect. 11.4, I diagnose the current failings among health professionals, with respect to adequately informing patients about how psychodynamic psychotherapy is thought to work. I also analyse Jopling’s solution for ‘open placebos’ disclosure in psychotherapy and contend that his formulation depends on too narrow an understanding of the placebo effect, and what triggers it. I conclude that providing adequate disclosure for psychotherapy leads to some counterintuitive but perhaps unavoidable consequences.

11.2 Informed Consent

11.2.1 Background

Dworkin formulates paternalism as follows (2014): “X acts paternalistically towards Y by doing (omitting) Z:

1. Z (or its omission) interferes with the liberty or autonomy of Y.
2. X does so without the consent of Y.
3. X does so just because Z will improve the welfare of Y (where this includes preventing his welfare from diminishing), or in some way promote the interests, values, or good of Y.”

Physicians are duty-bound to respect patient autonomy: medical ethics guidelines oblige physicians to tell the truth and to ensure that informed consent is obtained before undertaking any medical intervention. The Code of Ethics of the American Medical Association (AMA) states that, “withholding medical information from patients without their knowledge or consent is ethically unacceptable” (2006a: Opinion 8.082); and “The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical

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\[1\] I variously use the term ‘psychotherapy’ in this paper to refer to ‘psychodynamic psychotherapy’.
practice" (2006b: Opinion 8.08). The UK’s General Medical Council (GMC) asserts that physicians must obtain “consent or other valid authority” (2010: paragraph 36); physicians must “discuss with patients what their diagnosis, prognosis, treatment, and care involve”, and “share with patients the information they want or need in order to make decisions” (2008). The American Psychological Association now obligates therapists to obtain consent for psychotherapy (1992); and the American Psychiatric Association also urges that “[a] psychiatrist shall not withhold information that the patient needs or reasonably could use to make informed treatment decisions” (1998: 24).

But what does ‘informed consent’ mean in clinical practice? It cannot entail providing exhaustive amounts of information on different medical options. Beauchamp and Childress understand ‘informed consent’ to comprise the following components: “(1) competence; (2) disclosure; (3) understanding; (4) voluntariness; and (5) consent” (2009: 120). On this analysis, patients must have the mental capacity to understand the information disclosed to them and to make a decision about their treatment options; there should be no coercion involved if the patient has received adequate information and understood her choices. In regard to disclosure, Beauchamp and Childress contend that information relevant to decisions includes, “those facts or descriptions that patients or subjects usually consider material in deciding whether to refuse or consent to the proposed intervention” and “information that the profession considers to be material” (2009: 121). These stipulations are sufficiently ‘gappy’ to provide some problems for physicians; however, we might summarise them as the need to provide patients with relevant information regarding current knowledge about success rates of interventions, side-effects, other benefits and risks. Physicians should also be prepared to provide information (on occasion) about how interventions are thought to work. How this information is to be determined also poses problems for physicians. If we can simplify by talking of heuristics the approach that might best forge a ‘patient-centred’ approach is one that combines the “reasonable person standard” and the “subjective standard” in information disclosure (ibid, pp. 122–124). The “subjective standard” involving physicians tailoring the information needs to each patient as best as possible, according to their belief set, their prior medical history, anxieties about a procedure, and so on. There is also a need to disclose a background benchmark of relevant information and this might be determined by estimating the kinds of information that a “reasonable person” would require in treatment decisions. Whilst there are certainly outstanding problems with conceiving an idealised rational patient for our purposes we can minimally defend the notion that, for many treatments, there will be prominent and perhaps significant facts about which patients ought to be informed.

This minimal assumption leads to the next consideration: the issue of patient understanding. Physicians are confronted by patients who vary in their aptitude, ability, and their prior beliefs – all of which can influence or impede the processing of information. In addition, a patient’s condition may directly or indirectly impair his or her ability to grasp information. One problem that deserves special emphasis (for later discussion) involves what Beauchamp and Childress call “the problem of nonacceptance and false belief” (2009: 130). They argue that “A single false belief
can invalidate a patient's or subject's consent, even when there has been a suitable disclosure and comprehension"; and assert that, "If ignorance prevents an informed choice, it may be permissible or possibly even obligatory to promote autonomy by attempting to impose unwelcome information" (2009: 130–1). Later in the paper, I argue that this is a significant consideration in psychotherapy: patients are inadequately informed about how psychotherapy works.

11.2.2 Autonomy and the Placebo Effect

The use of placebos in clinical practice has been understood to present a particular problem for informed consent: it has been argued that placebos necessitate intentional deception on the part of the physician. At the outset it should be emphasised that how we understand the term 'placebo' has pivotal bearing on the ethical consequences of placebo use [in Sect. 11.3.3 I will reflect on recent research on placebos including the possibility of 'open placebos']. For now, we can note that the overwhelming conception of placebos in the medical community (including among medical ethicists) is that placebos are sham treatments that only work because of some kind of deception: for example, a physician might prescribe a medication that is known to have no pharmacological effect on a particular ailment but (it is assumed) if the patient believes that the medication may be palliative there is likely to be some symptomatic relief as a result (Raz and Guindi 2008). This definition appears to underpin professional medical ethics codes. For example, the AMA declares that, "the use of a placebo without the patient's knowledge may undermine trust" and "compromise the patient-physician relationship" (2006: Opinion 8.083). This reveals the common, "a priori empirical assumption"[2] that the AMA understands placebos as necessarily invoking deception if they are to elicit therapeutic effect. The AMA guidelines continue: "A placebo may still be effective if the patient knows it will be used but cannot identify it and does not know the precise timing of its use. The physician need neither identify the placebo nor seek specific consent before its administration" (2006: Opinion 8.083). This prescriptive claim appears to display some conceptual (and, more to the point, empirical) confusion. On a charitable reading there appears to be a consistent underlying commitment to the view that placebos necessitate deception; yet, the guidelines also seem to suggest that the only ethical way of harnessing the placebo effect (and avoiding the charge of non-disclosure) is by demanding that physicians reveal, in a sort of semi-covert manner, that placebos are being deployed. This stipulation appears to draw on the idea of authorized concealment (something that has been advocated in nocebo use (Colloca and Miller 2011)). The thinking behind this perspective is that the person is not deceived about placebos being used but merely about the particular tokens or timing of their usage. As we will see later this is a view that is peculiarly philosophical and impractical – it ignores the possibility of placebos which cause side effects, for

example. Indeed, it might be contended that the AMA clause calls to mind the proverbial case of having one’s cake and eating it. On ethical grounds we might query whether the patient is able to make an autonomous choice about treatment if: (i) the timing the treatment is out of kilter with consent; and (ii) the placebo in question is hidden. In any case, we can avoid messy oversights by confronting a neglected issue: it is an empirical issue whether giving patients a placebo and disclosing this information to them undermines the placebo’s therapeutic effects.

Ethical debate over the justification of the use of placebos in clinical practice has (overwhelmingly) turned on the conceptual assumption that placebos involve either partial disclosure or outright deception. On a deontological approach to this understanding the use of placebos constitutes an infringement of patient autonomy: regardless of therapeutic gain for the patient, the physician must always disclose to the patient information regarding treatment intervention (Brodby 1980; Kleinman, Brown and Librach 1994). For example, taking the case of ‘sugar pills’ prescribed for pain relief it is argued that a reasonable person would desire to know this fact: namely, that the pills do not work because of any pharmacological properties per se. The argument continues that failure to inform the patient (to intentionally withhold this information) invokes flagrant deception and an infringement on patients’ autonomous treatment choices.\(^3\)

The debate from a utilitarian perspective is less clear-cut. On the one hand, it has been argued that the consequences of not informing patients about placebos will lead to a harmful “domino effect” on patient trust in the medical profession and that this will negatively outweigh any immediate therapeutic effects to the patient as a result of non-disclosure (Bok 1974; Beauchamp and Childress 2009: 124; Kanaan 2009; Schwab 2009). In this vein, Bok argues that, “to permit a widespread practice of deception...is to set the stage for abuses and growing mistrust” (1974: 23): patients may delay or avoid seeking orthodox medical treatment, or come to understand some medical interventions to be “inert” and therefore a “sham”.

A different utilitarian defence is the view that, on balance, the deceptive use of placebos can be justified in certain circumstances (Rawlinson 1985; Lichtenberg et al. 2004; Foddy 2009). Foddy, for example, claims that disclosed placebos would diminish their effectiveness by lowering the expectations of patients. Adopting this line of reasoning, Rawlinson identifies the following conditions for placebo use (Rawlinson 1985: 415):

1. Placebos are only employed for the patient’s benefit and not for some expedient reason, on the part of health professionals;
2. Placebos can only be used when there is weighty evidence that they are necessary;

\(^3\)Note that most patients assume that painkillers work due to their specific chemical properties – so in this case, the doctor does not have an obligation to disclose anything further about how those chemicals work – rather, this information in itself is adequate because a reasonable patient already has adequate knowledge. Where the presumption of adequate information comes undone is if most reasonable patients have the wrong assumptions about how a treatment works and this false information has the potential to infringe on the patient’s treatment choice (see Bleas 2014).
3. The physician can make the case for the necessity of the deception to the satisfaction of a reasonable observer;
4. The physician determines that the long-term dependence on the placebo effect would not conceal the disorder to the patient;
5. The physician takes into consideration the values of the patient and whether deception would undermine the patient's future relationship with the physician.

It appears that the dispute over the utilitarian justification for “deceptive placebo use” pivots on differing commonsensical estimations of the impact of deception on patient trust, in the long-term. This is something that can only be settled by empirical evidence; moreover, the suggestion that a physician is in a position to judge (from the armchair, as it were): (i) the reasonableness of placebo use for an “ordinary bystander”; and (ii) individual patient’s views on medical deception (Rawlinson’s clauses 3 and 4), shows an overestimation of our folk psychological capabilities. Underlying these views is a naïve psychological view of cognition: we can object that it is surely an empirical matter whether informing patients explicitly about placebos does, in fact, have a causal bearing on distrust in the medical profession in the long-term. These are facts that can neither be discerned by the “reasonable” person in the street; nor by the “reasonable” doctor in the surgery. It is a matter for scientific psychological study to reveal if patient distrust is affected by either the deceptive or the non-deceptive use of “placebos” (see Kapchuk et al. 2010; Kelley et al. 2012).

Other notable attempts to reconcile the problem of informed consent and placebo use include O’Neill’s argument that deceptive placebo use does not infringe on patient autonomy (1984). O’Neill contends,

In human contexts, whether medical or political, the most that we can ask for is consent to the more fundamental proposed policies, practices and actions… Respect for autonomy requires that consent be possible to fundamental aspects of actions and proposals, but allows that consent to trivial and ancillary aspects of action and proposals may be absent or impossible. (1984: 176)

O’Neill claims that autonomy needs to be recognised; it cannot be defined as the exhaustive opportunity of decision-making in any given domain; O’Neill describes this as “idealististically autonomous”. She argues that autonomous decision making is only relevant when it comes to “fundamental” choices. And for O’Neill disclosure of placebos by physicians does not constitute a fundamental aspect of medical intervention – therefore deceptive placebo use does not jeopardise patient autonomy.

O’Neill’s argument moves too fast. First, contrary to O’Neill’s speculation, placebos may (in fact) be perceived by patients to be a fundamental aspect of their treatment: we need empirical evidence whether patients perceive placebo use to be a significant treatment in itself rather than some “trivial” therapeutic supplement. Second, O’Neill’s account (like so many others) depends on unargued assumptions about the nature of “placebos”: it relies on a conceptually and empirically impoverished view of “placebos” (as something like sugar-pills that necessitate deception in order to elicit therapeutic effect) but as I argue in Sect. 11.3.3, placebos refer to
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more than just “sugar pills” and placebo treatments have significant (and serious) side-effects (Blease 2013a, b); I also examine the evidence for ‘open placebos’ and the claim that deception may not be necessary in eliciting placebo effects.

First we need to understand the problem of informed consent in psychotherapy. In the next section, I describe the standard explanation of how psychodynamic psychotherapy works — what I dub “the received view” (Sect. 11.3.1); before summarizing the criticisms of this view (Sect. 11.3.2), and evaluating the hypothesis that psychotherapy is only effective because it is a placebo (Sect. 11.3.3) (this will necessitate a much more detailed account of what we mean by the term ‘placebo’).

11.3 Psychodynamic Psychotherapy

11.3.1 The Received View

In the late 1990s Shapiro and Shapiro estimated that there were around 500 formalized versions of psychotherapy currently used in clinical settings (Shapiro and Shapiro 1997); today the current estimate may be closer to 700.⁴ These can be further classified into some major sub-groups which chiefly include psychodynamic, cognitive-behavioural, and person-centred versions of psychotherapy. The chief differences are as follows: psychodynamic psychotherapy is characterised by the goal of uncovering why the patient is feeling and behaving as she does; in cognitive behavioural therapy (“CBT”) the objective is simply to change dysfunctional patterns by reflecting on undesirable behaviours, emotions and thought-patterns through a process of re-training; and in person-centred therapies (“PCT”) the principal therapeutic goal of the therapist is to establish a non-judgmental ‘therapeutic alliance’, or empathetic relationship with the patient. Whilst the aim of psychodynamic psychotherapy is to analyse the patient’s current problems and psychological history, CBT is only concerned with solving the patient’s present-day problems, and person-centred therapies aim to create an environment that facilitates the patient’s own reflection and problem-solving. Finally, psychotherapy usually takes much longer than CBT and PCT (usually not less than 6 months of weekly hour-long sessions), compared to 3–4 months in the case of CBT, and invariably but usually shorter time frames than PCT.

In this paper I will be only be concerned with psychodynamic psychotherapy for two main reasons. First, the theoretical principles of psychodynamic psychotherapy have been challenged even more extensively in the scientific and philosophical literature than CBT or PCT. This makes it a particularly salient form of psychotherapy to investigate from an ethical standpoint: if its basic theoretical principles are highly questionable, we need to consider the range of ethical problems pertaining to its use as a treatment. Second, psychodynamic psychotherapy involves the

⁴ Estimate owed to Bruce Wampold (in conversation).
commitment of more time on the part of the patient and therefore a greater financial obligation by the patient or healthcare authority: for personal investment in cost and time it is a form of therapy that deserves serious ethical analysis.

The list of therapies that come under the label 'psychodynamic' [which I will hereafter refer to as 'psychotherapy' for brevity] include versions of therapy derived from the theorists Freud, Jung, Adler and Klein. These therapies are unified in their claim that patients undergo a process of exploration that leads to the uncovering of (bona fide) psychological insights about themselves. According to the received view, this process involves interpretation and self-reflection on the part of the patient, as she is guided through what is often termed an "excavation" of her emotions, behaviour, and thoughts: the process is considered to be excavational because only through interpretive analysis can the patient discover hidden insights about her troubled psychology. This process of self-exploration, however, is dependent on the particular theoretical framework of each version of psychotherapy: that is to say, each particular theory of psychotherapy posits very different unconscious psychological processes that will be revealed during the therapy. So, depending on the therapist's particular theoretical purview, resistances, repressed memories, dreams, unconscious drives, displacement activities, repressed denials, neuroses, or inferiority complexes, may be revealed to the patient during guided dialogue with the therapist. Jopling carefully formulates the received view as comprising two epistemic features: first, the therapeutic exploration is "authentic and truth-tracking": the putative 'insights' are not considered to be mere fictions or artefacts of therapy; second, it is the process of putative self-discovery that produces therapeutic benefit to the patient (2008: 71ff).\(^5\)

### 11.3.2 Criticisms of the Received View

The most serious objections to the received view come from cognitive and social psychology. The first is the charge that the ontologies and processes that comprise the theories of psychotherapy have simply not been assimilated, or vindicated by scientific psychology: for example, references to "oral", "anal" or "phallic" stages of development (as Freud's theory of analysis claims) have not found any analogues in scientific theories of infant development. The list could be developed to include Jung's notion of a "collective unconscious", Adler's "inferiority complexes" and so on: these terms receive no theoretical preservation within prevailing scientific psychological theories. This means that psychotherapists are not referring to entities or processes that are psychological "real" in their dialogue with patients.

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\(^5\)Interestingly there is some evidence that Freud equivocated about whether analysis was curative.

"I often console myself with the idea, that even though we achieve so little therapeutically, at least we understand why more cannot be achieved. In this sense our therapy seems to me to be the only rational one", Gerhard Fichtner, ed, Sigmund Freud/Ludwig Binswanger: Briefwechsel, 1908–1938, cited in E. Shorter (1997: 152)
The second objection relates to how the patient purportedly obtains information about such entities and processes: this is the criticism from introspection. From the perspective of current science, the methods of psychotherapy are based on false claims about the epistemic access afforded by introspection (cf. Wilson 2002; Kurzban 2010). Psychotherapy depends on the assertion that patients can track and interpret the reasons and causes for their inner-thoughts and feelings - that we can have privileged access to the mechanisms that give rise to psychological states. But as experimental work in social and cognitive psychology shows, “People tell more than they can know” (Nisbett and Wilson 1977): we have no direct access through conscious reflection (or through the kind of conversational exchange that occurs in therapy) to the cognitive mechanisms that give rise to our psychological states. Evolutionary psychology sheds light on why this is the case and is it worth pausing to consider the significance of this field of research (which is still underappreciated by humanities and social science scholars) (Barkow 2006). The mind-brain, just like the rest of our physiology, has been shaped by natural selection - it has been adapted to solve a vast range of recurrent problems in our ancestral environment (ranging from navigation, finding mates, foraging, negotiation, detecting free-riders, and so on). Cognitive and evolutionary psychology understands the mind-brain to be an information-processor: it detects information in the environment and processes it in a way that elicits behavioural responses. Since natural selection works as a biological filter on genetic variation, it is a directionless, satisfying process which (as has often been stated) is only concerned with the four Fs: feeding, fleeing, fighting and fucking. Thus, from evolutionary perspective there is no adaptive, functional reason for us to be privy to the non-conscious cognitive mechanisms underlying this information processing: in short, as Wilson contends, “The modern view of the adaptive unconscious is that a lot of the interesting stuff about the human mind – judgments, feelings, motives – occur outside of awareness for reasons of efficiency” (Wilson 2002: 8). The epistemic claim that we can access causal mechanisms giving rise to thoughts, feelings and behaviour via introspection or psychoanalytic excavation is deeply flawed: these mechanisms can only be revealed by scientific psychology and not first-person analysis.

There are other important consequences of these evolutionary considerations for psychotherapy and mental health. Natural selection is not a goal-directed, “truth-tropic” process: therefore, it may be advantageous (because conducive to survival and reproductive ability) to select false beliefs and false belief-forming strategies, over true beliefs and truth-tropic cognitive processes (Churchland 1987; Barkow 1989; Kurzban 2010). In fact, research from social psychology shows that marginally over-estimating one’s abilities, popularity, level of attractiveness, and even the future (the so-called ‘Pollyanna principle’) is linked to mental well-being (Taylor and Brown 1988; Wilson 2002; Kurzban 2010; Trivers 2011; Blease 2011). Indeed, individuals who are suffering from mild-depression, furthermore, have more realistic evaluations of themselves (Alloy and Abramson 1979; Kapci and Cramer 1988; Blease 2012b, 2015a).
11.3.3 The ‘Psychotherapy as Placebo’ Hypothesis

At the outset: we can note that the evidence shows that psychotherapy works very well for many patients who suffer from depression, anxiety, or trauma (Shapiro and Shapiro 1997: 102). However, studies also show that the version of psychotherapy (including CBT) appears to be irrelevant to outcome – there is no significant difference in effectiveness between varieties of psychotherapy (Sloan et al. 1975; Luborsky et al. 1975; Sloan and Staples 1984; Wampold and Imel 2015). If we assume: (i) that psychotherapy can be instrumental in treating patients; and (ii) defer to the scientific majority that psychotherapy is explanatorily bankrupt; we need to enquire: What are the components in common to different psychotherapies that appear to lead to beneficial effects? In response to this question, Frank and Frank have forwarded the “common factors” hypothesis. This is the view that it is the common features shared by all versions of psychotherapy that are causally relevant in treatment (1991). One important shared feature of psychotherapy, it has been proposed, is that that all versions of psychotherapy endow the patient with a narrative framework that provides a rationale or sense of coherence with regard to his or her feelings, thoughts and problems (Frank and Frank 1991; Jopling 2008). It may be that story-making affords patients a means of organising and explaining problems in a way that produces some therapeutic benefits; studies of victims of trauma show that individuals who manage to forge some sort of explanatory understanding about why the traumatic event happened and who believe that the experience has enhanced their lives as a result (“if happened for a reason”), tend to recover best (Janoff-Bulman 1992; Pennebaker 1997). So, psychotherapists and their patients may forge “explanatory fictions” (Jopling 2008) that may carry some beneficial import. We might therefore speculate that in order for the patient to derive benefit from the interpretation of her life that is being forged, she should find the version of psychotherapy to be plausible.

Other factors common to different versions of psychotherapy include the context, the status of the psychotherapist (for example, authoritarianism), the social prestige associated with a form of therapy, the psychotherapist’s qualities (including confidence, empathy, ability to listen), the psychotherapist’s optimism, the patient’s expectations about the treatment, being given a diagnostic label for one’s problems, and being given a set of routines or techniques to practice or work on between therapy sessions (Parloff 1986; Frank and Frank 1991; Kaptchuk 2002; Jopling 2008; Wampold and Imel 2015). All of these factors have variously been grouped together under the label ‘placebos’. But how should we understand the terms ‘placebo’ and ‘placebo effect’? In the next section I will answer by elaborating on recent scientific findings that pull away from conventional (yet established scientific) wisdom on the subject.

11.3.4 What Science Tells Us About Placebos

Focusing on scientific findings is especially important given the widespread misconceptions about placebos including the claims that: placebos are “inept” and have no “real” physiological or psychological impact on the patient’s symptoms; that
Placebos only have "non-specific" effects; that placebos involve only subjective or transitory relief from symptoms; and, (as noted) that if placebos are to produce any effect this must involve deception (see Raz and Guindt 2008).

If we are to embark on an ethical analysis on the use of placebos we need to have a clear definition of what we mean by 'placebo' and 'placebo effect'. At present the term 'placebo' is employed by empirical researchers in a variety of ways; it might appear that the term placebo is a placeholder for a plethora of very different therapeutic interventions that trigger 'the placebo effect'. Consider the following: today, empirical researchers contend that the placebo effect constitutes a significantly beneficial effect for specific disorders (including angina, asthma, anxiety, depression, pain, Parkinson's disease, irritable bowel syndrome). It is also claimed that placebo effects are highly specific effects, and inter-subjectively measurable including via blood sugar, cholesterol, and cortisol levels, and blood pressure (see Joling, forthcoming). But there is still ambiguity in what is being referred to as a placebo effect and care is still required in deployment of these terms. To illustrate: 'placebos' (for example dummy pills) may not trigger 'placebo effects' but only provide a 'placebo response' – that is to say, a response to what has been dubbed 'a placebo'. Yet, specifying 'the placebo effect' therefore necessitates the harder, scientific task of delineating the specific mechanistic pathways that induce particular therapeutic effect(s) in patients. How do we decide which therapeutic benefits arise from the placebo effect, as opposed to other unknown therapeutic aspects of an intervention? How do we decide what is a bona fide placebo from that which is not? In the long-term, these questions require greater focus and attention among placebo researchers. For now, we can note that there may be more than one mechanism of action for what researchers currently dub 'the placebo effect'. And for the purposes of this paper, I will avoid the thorny, theoretical-cum-empirical issues about how best to define 'placebo effect'. I only note that this is (of necessity) an important work in progress at the philosophical-theoretical end of empirical research. In this paper I will tender a pragmatic (but undoubtedly short-lived) working definition of 'placebo effect' to encompass "positive care effects" where these include beneficial effects to the patient which are incidental to the principle mechanism of action of the target biomedical or bio-psycho-social treatment (Blease 2012a). Placebos, on this definition, are reliable triggers for such beneficial effects. It should also be noted that this definition of "placebo effect" provides a 'moving classification': therefore, it is likely that some of the processes dubbed "placebo effect" under this definition may later be expunged and re-defined as other therapeutic phenomena.

Examples will help to illuminate this definition. Medication for pain-relief has specific pharmacological properties which target pain-receptors in the nervous system: this is the principal mechanism of action for painkillers such as paracetamol.

Explanations for the placebo effect include the claim that placebos are "meaning" responses since the responses vary according to different cultures (Moerman 2002); the trigger for conditioned responses with medical phenomena (e.g. pills); psychological "expectancy responses" (Kirsch et al. 2004; Benedetti 2005); and the claim that the context of care and communication style of healers can be placeogenic (Di Blasi et al. 2001; Kaptchuk 2002; Blease 2012a).
But pain relief can be augmented by the following factors: the pills are red in colour to the patient's vision, the dosage is equivalent); the pills have a brand name; the pills are pricier than other varieties (Huskinson 1974; Branthwaite and Cooper 1981). Other factors can also influence or augment these analgesic effects including the mode of administration of the medication (for example, injections for pain relief are more effective than pills), and telling a patient that he is receiving medication compared to giving pain-relief medication surreptitiously (De Craen et al. 2000). These factors are incidental to the principal mechanism of action: the analgesic properties of the drug paracetamol.

A growing body of research also shows that individuals suffering from depression may be responsive to placebo effects as defined; indeed – and contrary to O'Neill's assumption that placebos are trivial aspects of care (1984) – it has been claimed that antidepressants, and even electroconvulsive therapy may wholly depend on their effectiveness on the placebo effect (Kirsch 2009; Blease 2013b). It has also been hypothesized that the numerous common side effects of antidepressant medication (e.g. dry mouth, drowsiness, low sex drive) make it a particularly potent placebo: individuals expect that they are receiving 'strong' medication, which somehow triggers palliative expectancy effects (Kirsch 2009); in the case of electroconvulsive therapy it has been hypothesised that the 'theatre' of the intervention, the attention given to the patient, the side effects (including headaches and memory loss), the patient's belief in the effectiveness of the treatment (Blease 2013a, b) may trigger beneficial effects.

In addition, new research also appears to challenge the assumption that placebos necessitate deception: recent 'open placebo' research purports to show that disclosing to patients that they are receiving a placebo does not diminish the placebo effect (Park and Covi 1965; Sandler et al. 2008, 2010; Kaptchuk et al. 2010; Kelley et al. 2012). These studies used placebo 'sugar pills' and, (for example, in the Kaptchuk study, 2010) patients were informed that they were being given "placebo pills made of an inert substance, like sugar pills, that have been shown in clinical studies to produce significant improvement in IBS symptoms through mind-body self-healing processes." The conclusions of these researchers is that there is some (albeit limited) vindication for the compatibility of open disclosure and placebo use in clinical practice.

What does any of this mean for psychotherapy? According to my proposed definition of placebos – 'therapeutic effects which are incidental to the principle mechanism of action of the target treatment' – the following components of psychotherapy may be placeboogenic: patient expectations, the cultural prestige of the therapy, the therapist's empathy, the lowering of inhibition, social contact with someone considered to be authoritative and trustworthy, the ritual of healing, the healing environment and its trappings, and even the expense of the treatment; we can add to this the construction of an explanatory narrative for the patient's problems.

Testing forms of psychotherapy for their effectiveness against a placebo intervention presents methodological problems. In order to test any treatment the control must satisfy the following conditions:
1. The placebo control contains all the relevant non-characteristic features of the test treatment t, to the same degree that they are present in the experimental treatment process;
2. The placebo control has no additional relevant features over and above the non-characteristic features of the experimental treatment. (Howick 2011: 82)

No study in psychotherapy has successfully fulfilled these conditions: in order to conduct comparative research of psychotherapy with a placebo, one would need to formulate a version of sham psychotherapy replete with psychotherapists who “believed in it” (since double-blinding is also a standard requirement in placebo studies) (Shapiro and Shapiro 1997: 108; Kirsch 2005). One way to circumvent the problem of constructing a sham psychotherapy is to draw on comparison studies of different versions of psychotherapy whereupon the epistemological claims about the curative component of each theory cancel each other out; and, as noted, the evidence so far shows that no one form of psychotherapy is superior to another. Luborsky et al. use the words of the Dodo in Alice in Wonderland to sum up these findings, “everybody has won and all must have prizes” (common factors hypothesis in psychotherapy has since been dubbed the ‘Dodo Bird Conjecture’) (1975; see also: Rosenthal and Frank 1956; Smith et al. 1980; Sloane et al. 1975; Wampold and Imel 2015). Some studies declare that the “therapeutic alliance” or “collaborative bond” between patients is the strongest predictive measure of success in psychotherapy (Brown 2013). These studies assess therapeutic alliance via measurements of patients’ and therapists’ contributions to dialogue in therapy; how freely patients feel able to talk; and patients’ efforts to carry out tasks. However, this measure does not tease apart what causes this therapeutic alliance: it may be that the narrative aspect, for example, brings about this bond, or if the patient considers the therapist to be particularly authoritative or prestigious, that this fosters the alliance. In short, while these studies vindicate the ‘common factors’ hypothesis – that it is the *shared components* of all version of psychotherapy that are therapeutic – the term “therapeutic alliance” is still sufficiently vague as to underdetermine which of the placebo features (if any) is most significant.

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7 Arguably the closest that any study has come to providing a suitable sham comparison was Strupp and Hadley’s study (1979) using a control group of empathetic college professors (with no training in any form of psychotherapy); the study found that there was no difference in patient improvement between “sham psychotherapy” and psychotherapy.

8 Some critics of the explanation that psychotherapy works as a placebo argue that different versions of psychotherapy propose that different so-called placebogenic components are also necessary for successful recovery (Parloff 1986; Kirsch 2005): for example, that creating a secure environment, and the patient’s conviction that the form of psychotherapy works, are important factors in successful treatment. However, it might be countered that the central therapeutic claim of different versions of psychodynamic psychotherapy is that the patient is afforded insights into her life: for this reason, the purported “insight-tracking” of psychotherapy (ideally) needs to be tested.
11.4 Psychotherapy and Disclosure: Current Failings

Given the claim that psychotherapy involves fictional story-construction – what Wilson describes as "literary criticism in which we are the text to be understood" (2002: 163) – we need to consider the circumstances and preconditions in which psychotherapy might be ethically employed. This is no trivial matter. If psychotherapy is as effective as regularly talking through one's problems with a trusted friend, for example, then the mainstream provision of psychotherapy in health services needs to be assessed. On the other hand, it may be that psychotherapy also has negative psychological side-effects (including the forging of false memories).9

At this juncture it is also important to note that the hypothesis that psychotherapy works as a placebo stands in opposition to O'Neil's assertion that placebos are "ancillary or trivial" aspects of medical care (1984): the placebo explanation of psychotherapy renders the placebo effect as the fundamental engine of treatment. It is also important to reiterate that it is not yet known which placebogenic features of psychotherapy are most significant (and perhaps, they are all additively important). This means that the question of patient autonomy and adequate disclosure with regard to psychotherapy cannot easily be sidestepped. In order to tackle the question of informed consent, and to render the problem more manageable, I assume: (a) psychotherapy only works by harnessing placebo effects; and (b) physicians and psychotherapists are currently failing to disclose this information to their patients. With this in mind, we can proceed to evaluate the current failure to disclose relevant information. There may be different reasons and motivations for why physicians and psychotherapists fail to provide adequate treatment disclosure in the case of psychotherapy – each reason warrants separate ethical evaluation.

The first consideration is that it is likely that the majority of physicians and psychotherapists are uninformed of the (growing) literature on psychotherapy and placebos (Raz and Guindi 2008). It might be argued that by ignoring this important empirical literature, health professionals are failing in their duty to keeping themselves up-to-date about research developments in the field of psychoanalysis. This is a significant failing in itself if we expect health professionals to keep medically informed about what is still a frequently used, medically 'orthodox' line of treatment for many mental health conditions, especially those believed to be rooted in childhood trauma (including depression, post-traumatic stress disorder, eating disorders, anxiety disorders). Grünbaum argues, most psychoanalysts consider what they do to have a valid scientific basis (1984). Physicians (certainly in the UK and USA) still recommend psychotherapy to patients but it is likely that they are as ill-informed as psychotherapists with regard to explanations for its effectiveness. Given research into psychotherapy and placebos has been ongoing for some 50 years, the blame for these failings rests both at an institutional and a health agency level. Many patients are not being informed of this.

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9Whilst the problem of the psychological side-effects of psychotherapy is certainly relevant to the ethical use of this treatment, it is an issue that takes us too far from the concerns of this paper (the issue of placebos and informed consent) (see Jopling 2008)


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level. Medical schools and psychotherapy training courses ought to inform students of this research; moreover, the current lack of regulation (and proliferation) of psychotherapists in the UK and USA provides further reason for urgent reform in the professionalization of psychotherapy — as Shapiro and Shapiro conclude, “With more than 250 different types of psychotherapy and hundreds of DSM... diagnoses, it may be necessary to establish a new governmental agency, a ‘Food, Drug, and Psychotherapy Administration’” (1997: 121).

It may even be the case that some physicians and psychotherapists are aware of the psychotherapy-as-placebo explanation for its effectiveness (or at least regard the received view with some cynicism) but singularly fail to provide adequate disclosure to patients or fail to ensure that patients understand this information because they do not consider this to be an important feature of their professional role. This is an issue that may be more prevalent in some healthcare systems than others (and it is also a problem that may be difficult to gauge); it is therefore essential that health professionals perceive the importance of respecting patient autonomy and ensuring that patients have adequate knowledge about how psychotherapy works. Indeed, with regard to the obligation to inform patients about psychotherapy, it has been argued that “practitioners still retain considerable latitude in defining what constitutes informed consent” (Beahrs and Guthiel 2001: 5). Furthermore, some physicians or psychotherapists may be fully cognizant of the importance of informed consent but fail to ensure adequate disclosure wholly out of expediency: this may be a more serious moral failing since apparently these professionals are fully aware that this decision violates patient autonomy (Blease 2014).

If physicians and psychotherapists are aware of the explanation that psychotherapy works as a placebo, should this information be disclosed to patients? And what should be disclosed? Perhaps it is possible to disclose to patients that psychotherapy works as a ‘placebo’. This is a move that has been pioneered by David Jopling (2008). Following the recent evidence for the possibility of successful open placebos (Kaptchuk et al. 2010) Jopling urges that psychotherapy can be ethically employed if patients are adequately informed about how it works; he advises that patients could be informed that therapy involves the creation of “therapeutic fictions”. In light of this, Jopling proposes that psychotherapists invoke the following stipulation:

[This treatment] involves working with psychodynamic explanations, interpretations, and insights concerning your psychology, history, behaviours, feelings and personality that are not literally true, but more like explanatory fictions. It involves making no claims to the psychological and historical truth when exploring your problems and your past. When we work with these interpretations, we are working with the psychological equivalent of a sugar pill. They are not however fanciful, arbitrary or silly; but nor can we say that they are true... (2008: 263).

Jopling’s proposal has much in common with O’Neill’s purview with respect to informed consent and the placebo effect. On O’Neill’s narrow (and problematic) definition of placebos we never need to disclose placebos because they are peripheral to the main therapeutic method of treatment. Similarly, Jopling advocates the disclosure of what he considers to be the fundamental beneficial component of psychotherapy: the therapeutic narrative component (which he also considers to be
a placebo and which is in line with my broader definition of placebos). But whether the narrative feature of psychotherapy is its main therapeutic engine has not yet been determined. It will be recalled that it has been hypothesized that the placebogenic factors in psychotherapy include — not just the construction of therapeutic fictions — but the social status of psychotherapy, the prestige of the therapist, the ‘ritual’ aspects of therapy, the socio-emotional communication style of the therapist, the expense of therapy, the patient’s expectations about the effectiveness of the therapy, and the commensurability of the patient and the therapist’s beliefs about the version of psychotherapy. As noted, research into these component factors is ongoing (Wampold and Imel 2015). If we wish to calibrate our disclosure according to accurate information (and I think that is a given) then Jofling’s proposal for informed consent falls short of adequate disclosure. Therefore, even if we were to concede with O’Neill that only the main method of treatment needs to be disclosed, we have not thereby circumvented the problem when the main course of treatment is placebogenic.

In the case of psychotherapy, the question then becomes: What should we disclose to patients? Should we not inform the patient about all of the placebogenic features of psychotherapy? Perhaps Jofling’s open placebo statement should also include the following: “In addition to the construction of therapeutic fictions, evidence shows that if I speak to you in a positive, empathetic and encouraging tone of voice, if you have a high opinion of me as a health professional, and if I charge you a reassuringly expensive hourly rate, this will lead to therapeutic mind-body effects. Do you consent to these aspects of care?” (Blease 2012a). This may seem somewhat counterintuitive but is that a good enough reason not to disclose this information? One rejoinder is to argue that some of these aspects of care are expected — for example, patients would not embark on psychotherapy if they did not believe it would be effective, and it is only common sense to expect a therapist to adopt a particular demeanour, and for the patient to have a high opinion of the therapist. But we might respond: Do patients routinely expect these features of care to be the engine of therapy per se (Blease 2015b)? We might argue that patients ought to be informed that if they do not have confidence in the therapy, or the therapist, that it is likely that the therapy will be less effective. In the same way, shouldn’t patients have the right to know that their therapy will be more successful if the therapist consistently adopts a particular communication style, or if they don’t feel that they have attained a ‘therapeutic bond’ with the therapist? Shouldn’t patients be informed of the putative therapeutic consequences of the pricing scale for their hourly psychotherapy sessions? What would it mean, for example, to inform patients that the rate per hour is excessively pitched but that this is wholly (or partly?) for therapeutic reasons? As Beauchamp and Childress’ stipulate, “a single false belief can invalidate a patient’s consent” (2009: 130): patients have a right to know how therapy works if they are to make informed choices.
11.5 Conclusion

Ethical discourse on the question of informed consent and questions of patient autonomy need to pay much closer attention to ongoing empirical research. In the case of the placebo effect, when discussion is divorced from current scientific input the discussion floats free of applicable insight. Jopling’s ‘open placebo’ proposal for psychotherapy provides a significant first step in the right direction. However, more detailed attention needs to be given to understanding how psychotherapy works – including whether psychotherapy just is a placebo. It could be that patient understanding of placebos diminishes its therapeutic returns, and we do not yet know whether disclosure in itself threatens (or enhances) patient trust in health professionals. When we have (even preliminary) evidence-based answers to these questions, the debate over the usage of placebos may only then be open to utilitarian challenges. In the meantime, psychotherapy, like any other treatment intervention, should be subject to adequate disclosure – even if this discomfits practitioners of the long tradition of psychodynamic ‘talking cures’.

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