WHAT IS THE PLACEBO IN PSYCHOTHERAPY?

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Abstract. Although there is an extensive literature on the placebo effect in psychotherapy, the distinction between the placebo and other elements of the therapeutic process has not been clear. This paper analyzes the therapeutic relationship in terms of separating the placebo elements and the specific actors. The so-called nonspecific elements, often equated with the placebo, are proposed as the specific factors. It is contended that those variables focused upon by those studying the social psychological factors are actually part of the placebo.

Nearly twenty-five years ago I titled a chapter in *Counseling and Psychotherapy: Theory and Practice* (Patterson, 1959) "Common Elements in Psychotherapy: Essence or Placebo?" At that time I suggested a division of the common elements in all psychotherapies into those which were essentially specific treatment variables and those which were essentially placebos. In the first edition of *Theories of Counseling and Psychotherapy* (Patterson, 1966) the suggestion was repeated. The suggestion has been ignored in the literature on psychotherapy and the placebo effect. In this paper I shall develop this suggestion further, in the light of more recent discussions of the psychotherapy relationship, particularly the attention to social psychological variables.

THE PLACEBO EFFECT

The most extensive discussion of the placebo effect is that of Shapiro and Morris (1978) (28 pages and 523 references). A placebo is defined as: "any therapy or component of therapy that is deliberately used for its nonspecific, psychological, or psychophysiological effect, or that is used for its presumed specific effect, but is without specific activity for the condition being treated. A placebo, when used as a control in experimental studies, is defined as a substance or procedure that is without specific activity for the condition being evaluated. The placebo effect is defined as the psychological or psychophysiological effect produced by placebos."

These authors consider placebo effects in both medical treatment and psychotherapy. They note that "the placebo effect may have greater implications for psychotherapy than any other form of treatment because both psychotherapy and the placebo effect function primarily through psychological mechanisms.... The placebo effect is an important component and perhaps the entire basis for the existence, popularly, and effectiveness of numerous methods of psychotherapy." It perhaps should be noted here that the placebo as an inert substance does not exist in psychotherapy. All the variables in the psychotherapy relationship are psychological and all are active, having some direct or specific effects on the client or patient. By the placebo in psychotherapy is meant non-specific effects, that is, though the placebo may have some specific effects, these effects are not those which are the objectives the therapist is attempting to achieve.

Placebo elements may promote such effects, but they presumably are not used *deliberately* to achieve such effects. The word deliberately presumably is used because, as will be noted later, there are those who, viewing psychotherapy as nothing but the placebo, propose deliberately using the placebo.

In his earlier chapter in the first edition of the *Handbook of Psychotherapy and Behavior Change* Shapiro (1971) stated that the chapter would be "an examination of psychotherapy as a placebo effect," thus suggesting that psychotherapy is nothing more than a placebo. Shapiro and Morris don't go quite so far. However, they view the total psychotherapy relationship as a placebo. They refer to a review by Luborsky, Singer, and Luborsky (1975) which found, after a comparison of the effectiveness of several types of psychotherapy, that all were about equally effective, and which concluded that this improvement was related to the presence of the therapist-patient relationship in all forms of psychotherapy. Shapiro and Morris refer to this as a demonstration of the placebo effect.

Rosenthal and Frank (1956) much earlier came to much the same conclusion. Referring to the placebo effect as a nonspecific form of psychotherapy, they continue: "The similarity of the forces operating in psychotherapy and the placebo effect may account for the high consistency of improvement rates found with various therapies, from that conducted by physicians to intensive psychoanalysis." Most recently Pentony (1981), in his extensive analysis of the placebo as a model of psychotherapy, suggests that "the placebo effect constitutes the most parsimonious explanation that would account for the apparently equal success achieved by each of the diverse collection of therapies practiced."

There are many writers of diverse origin who view the total psychotherapeutic relationship as nonspecific, and therefore, at least by implication, a placebo. Frank (1961, 1973) has long maintained this position. Bergin (1978) and Strupp (1978) also have emphasized the nonspecific nature of the relationship. They repeatedly emphasize that specific techniques are necessary in addition to the nonspecific relationship, without being clear just what these techniques are. Bergen (Bergin & Lambert, 1978) however, perhaps unintentionally, implies that techniques themselves are placebos: "Technique is crucial to the extent that it produces a believable rationale and congenial modus operandi for the change agent and the client."

Behaviorists also view the therapeutic relationship as nonspecific, and the techniques of behavior therapy as specific. Wolpe, (1973, p. 9) for example, claims that his method of reciprocal inhibition, as well as other behavioristic techniques, increase the improvement rate over that of the relationship alone, stating that "the procedures of behavior therapy have effects additional to those relational effects that are common to all forms of psychotherapy." Such claims have been disputed, and do not seem to be supported; indeed, it appears that many, if not most, of the specific techniques in the various approaches to psychotherapy, including behavior therapy, operate through the placebo effect--that is they are themselves placebos.

It has been noted, for example, that systematic desensitization, which specifies certain conditions for its effectiveness, is effective when none of the conditions are present, which suggests that it is the placebo element in the persuasive ritual which gives the method its effectiveness.

Paraphrasing Pentony we would say that the therapy relationship is the most parsimonious explanation of the relatively equal success of the diverse approaches to psychotherapy, since all approaches share the relationship. If the relationship is entirely a placebo, this statement and Pentony's are equivalent. But it is the thesis of this chapter that the complex therapy relationship may be separated into two major components, or classes of variables, the nonspecific and the specific. Moreover, in speaking of the relatively equal success of various therapies, we must be concerned about the definition of success, that is, the goal or goals of the treatment process. The success, or outcome, of those therapies that are mainly placebo may differ from the outcomes of therapy focusing on the specific variables in the therapy relationship.

SOCIAL PSYCHOLOGY AND PSYCHOTHERAPY

While recognizing the client's important contributions to the placebo effect, in the discussion to follow we will concentrate on the therapist's contribution, in effect hypothetically considering the client's contributions equivalent or constant across therapists and therapies.

In 1961 Jerome Frank suggested that psychotherapy is a process of persuasion. In 1966 Goldstein (1966) proposed that research in psychotherapy should be directed toward study of variables derived from research in social psychology, particularly the psychology of interpersonal attraction, and he, with Heller and Sechrest (1966), provided an analysis of relevant research in social psychology. There was a considerable literature on the process of persuasion in social psychology (Hovland, Janis Kelley, 1953) which was drawn upon.

In 1968 Strong (1968) proposed applying the social psychological concept of cognitive dissonance to the interpersonal influence process in counseling or psychotherapy. He suggested that the greater the extent to which counselors are perceived as expert, attractive, and trustworthy, the greater would be their credibility, and thus their power to influence clients.

There are three main therapist variables in the concept of psychotherapy as a social influence process. The first is actually a loose cluster of variables designated as perceived expertness, or credibility. It also appears to include respect and perceived competence. Contributing to this perception by the client of expertness are indications of status (degrees, diplomas, office decor, and furnishings); prestige (reputation); power and authority. While trustworthiness is often considered a separate variable, it is also included with expertness in the concept of credibility.

The second variable is perceived attractiveness. Included In this are therapist-client similarities in opinions, attitudes, beliefs, values and background; therapist liking for the client; therapist likability, friendliness and warmth; and therapist self-disclosure.

The third variable is therapist expectancy. Therapist self-confidence in the methods and techniques used, leads to expectation of change or improvement in the client. This expectancy is communicated to the client through various subtle, unintentional ways as well as through direct expressions of optimism, suggestions, and reassurance.

Strong's article stimulated a series of research studies. The research has been reviewed by Beutler (1978), Strong (1978), and Corrlgan, Dell, Lewis and Schmidt (1980). Almost all of the

studies (68 out of the 70 reviewed by Corrigan, et. al.) were analogue studies, involving the presentation of audiotapes or videotapes, or a single contrived interview with nonclients, usually college students, as subjects. Most of the studies were concerned with correlates of or cues for expertness and attractiveness. The measures or criteria used in outcome studies included subject reports or self-ratings of changes in attitudes or opinions, of improvement or satisfaction, or of likelihood of self-referral. The results of these studies have been varied, inconsistent within and between studies and even directly contradictory. Beutler (1978) concludes that "it is not clear from these findings that credibility consistently produces attendant attitude change in psychotherapy....These persuader variables serve only as a basis for facilitating a therapeutic relationship and are not necessarily a direct contributor to therapeutic change." In other words, they are nonspecific variables.

Strong (1978), in spite of the mixed results and the fact that the studies reviewed were analogue studies and did not include outcome studies, states that "as a whole, these studies show that therapist credibility is an important variable in psychotherapy." This would seem to be an unjustifiable conclusion. In regard to perceived therapist attractiveness he concludes that "studies of the effect of client attraction to the therapist on the ability of the therapist to influence the client have obtained mixed and generally pessimistic results."

Corrigan et al (1980) conclude that "The effects of expertness and attractiveness on counselors' ability to influence client are, at best, unclear.... Those studies that successfully manipulated attractiveness failed to find differential effects on client change." Yet these authors recommend further research on these social influence variables in counseling as "interesting and reasonable," though they admit that "the question of the utility of considering counseling as a social influence process remains."

These conclusions, as negative as they are, would appear to be too optimistic. It is difficult to understand the continued enthusiasm for this line of research. The reviewers have all been among the major researchers in the field, however, and this commitment and identification with the area probably influences their conclusions. A study published after these reviews were written should be noted. This study, by LaCrosse (l980) was not an analogue study, but involved 36 clients in a drug counseling program whose counseling ranged from 4 to 31 sessions. Clients rated their counselors at the beginning and end of counseling on an instrument devised to measure client perceptions of expertness, attractiveness, and trustworthiness. They also rated themselves on change following counseling. There was a highly significant relationship between the clients' ratings of their counselors and their self-ratings of outcome. However, not only is there questionable validity of the self-ratings of outcome, there is the distinct possibility of a spurious element in the correlations, since both variables were ratings by clients. In addition, only two of the clients came to counseling voluntarily, so there is a real question about the relevance of the research for the usual situation in counseling or psychotherapy, where clients come voluntarily for help.

These mixed and inconsistent results are exactly what would be expected if the variables operating were placebos. Placebo effects are highly varied and unreliable--not all subjects respond to the placebo--and are usually temporary in nature. It is interesting that Shapiro and

Morris discuss these variables, including expectancy, among others, as methods by which the placebo operates.

Related to or an element in the therapist's expectations of positive results are his/her belief and faith In himself/herself and in his/her methods or techniques, factors which Shapiro emphasizes as important elements in the placebo effect. These factors appear to be the same factors which Orne (1962) has called the "demand characteristics" in psychological experiments. Rosenthal (1966), among others, has demonstrated the influence of the experimenter's beliefs, expectations and desires on the outcome of psychological experiments both in and outside the laboratory. In psychological research these are unwanted, or placebo, effects. It would seem that they should be regarded as such in psychotherapy, as indeed they are by Shapiro and Morris.

These variables appear to constitute the "good guy" factor in psychotherapy (Muehlberg, Pierce & Drasgow, 1969). LaCrosse and Barak (1976) suggest that the common factor in expertness, attractiveness, and trustworthiness is the "influence" of Strong, or the "persuasiveness" of Frank and LaCrosse, or the "power" of Strong and Matross, and Dell. They then note that "these terms are also related to what might be described as 'charisma' or 'impressiveness."' All of this suggests an image of the counselor or therapist as a person exuding or projecting self-confidence, self-assurance, competence, power and persuasiveness--a charismatic snake-oil salesman.

If psychotherapy is nothing but a placebo, then it would appear to be desirable to maximize the effect. As Krasner and Ullmann(1965, p. 230) note: "Whereas the problem had previously been conceptualized in terms of eliminating 'placebo effects', it would seem desirable to maximize placebo effects in the treatment situation to increase the likelihood of client change. The evidence is growing that 'placebo effect' is a euphemism for examiner influence variables." This is exactly what Fish (1973) attempts to do in his systematic development of what he calls placebo therapy.

In this approach, the therapist does everything possible to establish himself/herself as an expert and an authority in the eyes of the client. Then this is used as a power base to influence the client. Recognizing that "the social influence process has been considered the active ingredient in the placebo," Fish states that placebo therapy "denotes a broad frame of reference for considering all forms of human interaction, especially psychotherapy, in terms of social influence process" (p. vi). It also refers to "a method of conducting psychotherapy based on social influence principles" (pp. vi-vii). The therapist fosters the client's belief in the potency of the therapeutic intervention by an impressive and detailed interrogation and exploration of the client's history and current behaviors. This process itself sets the therapist up as an authority, using a thorough "scientific" approach. It also assesses the client's susceptibility to influence and persuasion. The process implies to the patient that "Once I know what is wrong with you I can cure you." A treatment strategy is formulated and communicated to the client in a plausible manner, tailored to the individual client's belief system. The major techniques used are those of behavior modification, together with suggestion and hypnosis "Placebo therapy is a strategy for getting the maximum impact from such techniques regardless of their validity" (p. vii). The placebo formulation and communication "is designed to activate one powerful set of the patient's beliefs (his faith) to change another set of beliefs (his problems). Placebo therapy can thus be seen as a form of spiritual judo in which the therapist uses the power of the patient's own faith to force him

to have a therapeutic conversion experience" (p. 16). "The patient must be persuaded that it is what he does, not what the therapist does, which results in his being cured .... Thus a therapist must encourage his patient to believe that he is curing himself, whether or not the therapist believes it" (p. 17)

Placebo communications are used not because they are true but because of their effect. It is the patient's faith or belief in psychotherapy and in whatever methods or techniques the therapist uses that is the source of cure. Thus, the validity of the techniques, or the therapeutic ritual, to use Fish's term, is important only as it enhances the patient's faith--that is, how persuasive, believable, intriguing or impressive it is to the patient. "The therapist's role in placebo therapy involves acting in ways which inspire faith because he believes that the patient's faith cures him" (p. 30).

The therapist "says things for the effect they will have rather than for his belief that they are true. Thus, instead of speaking empathically because he believes that empathy cures, he does so because he sees that such statements add to his credibility in the patient's eyes" (p. 32).

The patient's expectations of help tend to result in some improvement, producing increasing pressure in him/her for further change. The knowledge-or belief--that he/she is receiving expert treatment is likely to increase this improvement. The patient has faith in the truth of "high status sources, such as the therapist.... One of the strong points in the therapist's role as a socially sanctioned healer is his status as an agent in psychotherapy" (pp. 45, 46).

Whether or not Fish's presentation is a tour de force is a question that might be raised. Someone has suggested that the author may have been writing with tongue in cheek. Yet the presentation seems to be sincere, though doubts may be raised by some statements such as that placebo therapy is a nonschool of persuasion whose therapeutic title is intended ironically" (p. vii). It may be viewed as carrying the social influence approach to an absurd extreme. For example, "lying to a patient is desirable if the lie furthers the therapeutic goals, is unlikely to be discovered (and hence backfire), and is likely to be more effective than any other strategy" (P. 39).

A number of questions or objections may be raised about placebo therapy. First, of course, is the fact that there is little if any research support for it. Fish, who claims that it works, urges that the reasons need to be researched. The unreliability of the placebo effect--that not all subjects respond to the placebo, also is a limiting factor. Fish notes that many are called but few are chosen. It is not possible to predict who will respond--who are placebo reactors. Fish refers to the problem client who expects and desires a (different) relationship with the therapist. Pentony (1981) writes that "it seems questionable whether a treatment procedure based on suggestion (persuasion) alone will be universally applicable," given the existence of strong resistance to change. "The placebo model would seem to be most appropriate for clients who are disposed to accept the therapist's message. Such clients typically have relatively specific problems, often involving low self-esteem, lack of self-confidence, and anxiety. Their disabilities range from physical symptoms to inability to assert themselves in social contexts. Their life goals are relatively realistic and attainable once they gain confidence in themselves. But not all cases which come to the attention of therapists fall into such a category" (p. 8). Nor is it necessarily true that placebo therapy is the most appropriate therapy even for them.

And there are other objections that must be raised against placebo therapy. The placebo effect is often, if not usually, temporary. No studies of the social influence process in psychotherapy have gone beyond the evaluation of immediate or short term effects.

Pentony raises three other questions about placebo therapy. "1. Is it ethical to mislead the client in regard to the therapeutic strategy? 2. Will the therapist be convincing when he is not a true believer in the ritual he is carrying through? 3. If placebo therapy becomes general and clients become aware of its nature, will they lose faith in the healing ritual and hence render these ineffective?" (pp. 63-64). Fish's attempts to handle these questions are less than convincing.

Placebo therapy--and the social influence model of psychotherapy-assumes not only that psychotherapy is an influencing process, which few would deny, but that it is a process of influencing through persuasion. The therapist is concerned only with those actions or techniques which enhance his persuasability. Having achieved a power base from which to operate, the therapist then uses whatever methods or techniques are necessary to influence the client toward goals chosen by the client and the therapist. It becomes a situation where the ends justify the means. Moreover, there is no consideration of unintended outcomes or side effects, such as increase in client dependency. Reading the procedures considered by Fish, one has a *deja vu* experience of being regressed to the practices of counselors and psychotherapists in the 1930s and 1940s, before the influence of Rogers began to be felt.

THE THERAPEUTIC RELATIONSHIP

If perceived expertness, attractiveness, and trustworthiness are essentially placebos, that does not mean that the entire therapy relationship is a placebo. There is more to the therapeutic relationship than these three variables. Three other variables have been extensively studied: empathic understanding, warmth or respect, and genuineness, all in terms of client perceptions. These variables, or core conditions as they have become known, are defined and described in many places (e.g., Patterson, 1974). The evidence for the specific effects of these conditions has been accumulating for over twenty-five years. This research has been evaluated elsewhere (Patterson, 1984).

On the basis of this research, it is proposed that these variables are the specific conditions for certain client behaviors in the counseling or therapy process and for certain outcomes of the process. In the process, the client responds to these conditions with self-disclosure, self-exploration, and self-understanding. The client assumes responsibility for himself/herself in the process, engages in problem solving, and makes choices and decisions. The client becomes more understanding, respecting, and accepting of others, more honest and genuine in relationships with others. These behaviors continue outside and after the therapy process ends, and are thus also outcomes of the process. They constitute aspects of self-actualizing persons, which is the ultimate goal of counseling or psychotherapy.

These conditions and the social influence variables are probably not entirely independent. LaCross (1977) found significant correlations between the Counselor Rating Form, measuring client perceptions of counselor expertness, attractiveness, and trustworthiness, and the Barret-

Lennard Relationship Inventory, measuring client perceptions of counselor empathic understanding, congruence, level of regard, and unconditional positive regard. Observer ratings were also highly correlated, though ratings by the counselors themselves were not, raising some question about the presence of an artifact, such as the halo effect, in the client and observer ratings.

The presence of relationships between these two groups of relationship variables poses the question of which is primary, or which causes or leads to the others. That the core conditions are primary is suggested by the fact that they have been shown to be related to various therapy outcomes in numerous studies, while this has not been done for the social influence variables. Krumboltz (l979) has indicated the direction of the relationship when he suggests, after his review of the research, that "counselors who want to be seen as attractive should be empathic, warm and active..." It also would appear, from LaCrosse's research, that counselors who want to appear to be experts should also be empathic, show respect and warmth, and be congruent or genuine. Similarly, it might be suggested that counselors who want to be perceived as trustworthy should show respect and warmth and be genuine or congruent. And if the therapist really respects clients, he/she will expect the best from them, and will probably find that clients respond in expected ways, that is by assuming responsibility for the conduct of therapy, making choices and decisions, and solving problems.

It thus appears that the complex therapeutic relationship cannot be prevented from being "contaminated" by placebo elements. The client perceives the therapist, to some extent at least, as an authority and an expert. He/she puts trust in the therapist. The therapist's belief in his/her methods or approach is inextricable from the methods or techniques used. If the therapist did not have confidence in them, he/she would use other methods or techniques. Similarly, if he/she did not have confidence in himself/herself as a therapist, he/she would not continue to practice.

But if the placebo elements cannot be eliminated from psychotherapy, they can be either minimized or maximized. If they are maximized, then the therapist is engaging in placebo therapy, with the possibility that results may be limited, superficial, or temporary. When the placebo elements are minimized, as in client-centered or relationship therapy, the therapist is focusing on those conditions which appear to be specific for the outcomes which are the goals of this approach to psychotherapy.

SUMMARY

In this paper the question, What is the placebo in psychotherapy? has been considered. Since in psychotherapy there is no inert substance comparable to the placebo in medicine, the discussion has concerned the specific versus the nonspecific elements in psychotherapy. Many, if not most, of the writers on psychotherapy, including the behaviorists, view the entire therapy relationship as nonspecific, and thus as essentially a placebo. The behaviorists have been almost the only ones who have been clear in proposing specific factors, claiming that the various techniques of behavior therapy are specific. However, this claim has been increasingly disputed. Not only does behavior therapy depend on the relationship between the therapist and the client, but the specific methods and techniques of behavior therapy may be essentially placebos.

During the last 15 years, increasing attention has been given to what has become known as the social influence model of psychotherapy, derived from the social psychological research on the nature of the persuasive process. The three variables which have been emphasized are perceived expertness, attractiveness, and trustworthiness. The research on these variables, almost entirely analogue research, is inconsistent and contradictory in its results. It is suggested that this is consistent with the hypothesis that these variables are essentially placebos. Fish (1973) has systematically developed an approach which includes these variables, particularly perceived expertness, as its central focus, which he calls Placebo Therapy.

There are other variables in the psychotherapy relationship which have received considerable support from extensive research not involving analogue situations. Three of these variables are empathic understanding, respect or warmth, and therapeutic genuineness. It is proposed that these are specific conditions for certain desirable outcomes in counseling or psychotherapy.

It appears to be impossible to separate out or to eliminate placebo elements from psychotherapy, since the client attributes a certain degree of expertness, authority, and attractiveness to the therapist, and the therapist's belief or confidence in himself and his methods lead to certain expectations for favorable response in the client, which are communicated to the client in various ways. The therapist, however, has the choice of maximizing or minimizing the placebo elements. It is suggested that maximizing the placebo elements, which is essentially placebo therapy, has the disadvantages of the placebo effect. That is, it is not reliable or consistent in that not all clients are strong placebo reactors, and its effects can be limited and temporary in nature.

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