

2. *With reference to relevant empirical studies, discuss the use of placebos in the study of health psychology (20 marks)*

Although medicine has mapped out many mechanisms of the body and psychology many mechanisms of the mind, one remains largely uncharted territory to both: The means by which mind and body interact. This link is most clearly seen in the discussion of placebos in health psychology, treatments believed to be biochemically inert, but still manage to have an effect. Numerous theories have been proposed including spontaneous remission, the role of beliefs and expectations and physical effect, but the jury is still out on which are most adequate. Some researchers (Hróbartsson & Gøtzsche, 2001) have even claimed that the placebo effect is unreal, but others (Kirsch, 2002) maintain its potent role in health psychological research.

Initially, it was believed that the placebo effect might be due to spontaneous remission, that is, the spontaneous healing of the body through self-repair over time. However, this could not explain the fact that a placebo treatment was better than no treatment at all. Further, Assefi & Garry (2003) conducted a naturalistic experiment (set in a bar), in which participants were given placebo vodka shots and responded with drunken behavior. Compared to a control group, they were significantly less inhibited and even displayed memory impairments. This can clearly not be explained in terms of spontaneous recovery as there is no way for the students to “spontaneously” become drunk.

It does, on the other hand suggest a psychological theory of the placebo effect – that it is all a purely mental phenomenon based on expectations and beliefs. Evans (1974) conducted a study on placebo pain-killers and found that placebo morphine had twice the effect of placebo Davon which again had twice the effect of placebo aspirin – clearly illustrating the role of expectations. However, psychological theory cannot explain results such as those reported by Horwitz et al. (1990) who reanalyzed so-called random controlled trials (RCTs) on the use of beta-blockers in prevention of heart disease.

RCTs are a method for comparing the placebo effect with actual treatment effect with regard to some treatment under investigation and have been used extensively in the industry since the 1940s. Patients are randomly assigned to either a treatment or placebo-group without the knowledge of either patients or administrators. The randomization ensures control of participant variables and the double-blind measures control of reactivity and demand characteristics effects. Hence, RCTs are a very controlled way of comparing placebo with conventional treatment effects.

What Horwitz et al. (1990) found was the fact that the most significant predictor of mortality after a year was not the whether the patients received placebos or not, but whether they adhered to the doctor and took any pill at all. If the placebo effect is purely psychological, it should not be able to reduce mortality as was reported in this study. Along with other findings of Luparello et al. (1968) who found that even the lung-volume of asthmatics could be controlled by giving either a placebo bronchoconstrictor or a placebo bronchodilator, Brown (2000) concludes that the placebo effect is a real physical phenomenon.

Yet, a recent meta-analysis by Hróbartsson & Gøtzsche (2001) indicated that the placebo effect might not be as significant as previously reported. They suggested that previous research on placebo treatments had suffered various methodological flaws such as small samples, a lack of no treatment control groups and a reliance on self-report methods for evaluating the effect of placebos which are subjective and might bias the results.

Kirsch (2002) responded that Hróbartsson and Gøtzsche’s (2001) own study was methodologically flawed, because they had used a too broad definition of placebo “we define placebo as what is labelled as such in a clinical trial” along with a too broad spectrum of ailments investigated ranging from marital discord to common cold. Simply taking the average of all these effects is, he argued, too crude a statistic.

This does, however, raise interesting ethical issues – if the placebo effect is not as significant as believed, is it still ethical to cheat patients in the placebo condition in health psychological research for a real, effective treatment? Further, there are no standard procedures for handling the reaction of patients in placebo research, when they are told that all they experienced was ‘in their heads’. If revealed for patients taking anti-depressants, it might, for instance, significantly worsen their condition possibly raising the risk of suicide. Finally, the prescription of placebos cannot be done without deception which is normally regarded as ethically incorrect and doctors and researchers administering placebos must always carefully consider whether it is ethically appropriate to use deception.

In conclusion, the placebo effect is a complex, multifaceted phenomenon that raises ethical as well as methodological and psychological issues. As Fisher & Greenberg (1995) puts it: “Administering a drug is not simply a medical act.”