

Psychology of Consciousness: Theory, Research, and Practice

Go Open: A Plea for Transparency in Psychotherapy

Jens Gaab, Charlotte Blease, Cosima Locher, and Heike Gerger

Online First Publication, October 19, 2015. <http://dx.doi.org/10.1037/cns0000063>

CITATION

Gaab, J., Blease, C., Locher, C., & Gerger, H. (2015, October 19). Go Open: A Plea for Transparency in Psychotherapy. *Psychology of Consciousness: Theory, Research, and Practice*. Advance online publication. <http://dx.doi.org/10.1037/cns0000063>

Go Open: A Plea for Transparency in Psychotherapy

Jens Gaab
University of Basel

Charlotte Blease
University College Dublin

Cosima Locher and Heike Gerger
University of Basel

The debate on the clinical, scientific as well as ethical implication of the placebo and its effects is important, but has mainly focused on placebos with a medicinal and somatic meaning, such as pharmaceutical, surgical, or so called alternative medicinal interventions. However, this perspective omits the role of placebo processes in interventions with a psychotherapeutic meaning, such as psychotherapy. Based on a theoretically derived differentiation of the placebo concept we argue that although it is difficult to prove that psychotherapy is verum, it is possible to use it as placebo and that it can best be described as either a superplacebo or a superverum. Because these conceptualizations of psychotherapy have ethical consequences, the nature of psychotherapy as anything other than a verum needs to be actively addressed by research and practice.

Keywords: ethics, placebo, psychotherapy

Psychotherapy has gone through a tremendous transformation from an eminence-influenced to an evidence-based intervention, with proven effectiveness and efficacy for an array of psychological disorders as well as somatic symptoms and syndromes across all ages (Goldfried, 2013). However, despite its impressive scientific and clinical track record, psychotherapy has to grapple with the fact that the cause(s) of its actions elude understanding. Thus, where

medicine can escape the post hoc ergo propter hoc fallacy by simply conducting double-blind placebo-controlled trials, the “use of placebo in studies of psychotherapy . . . is fraught with both conceptual and practical problems” (Herbert & Gaudiano, 2005, p. 893), which in consequence disables or at least hinders to identify specific treatment components of otherwise effective psychotherapy interventions. Interestingly, the lack of valid explanatory models for the wealth of effective interventions has been mooted as an explanation for the reluctance of clinicians to employ empirically supported treatments (Tryon, 2005) and that “even though understanding mechanisms may well be the best long-term investment for improving clinical practice and patient care . . . , (t)he study of mechanisms of change has received the least attention” (Kazdin, 2008, p. 151).

Similar to psychotherapy, the placebo—which is often understood as the deceptive administration of an otherwise inert or less effective intervention—has been subject to thorough changes. For a long time the placebo was seen as a harmless and commonly used pacifier for the hopeless and ignorant (Kaptchuk, 1998), but since the 1950s the placebo effect has also gone from being viewed as powerful and needing to be controlled in trials (Beecher, 1955) to the

Jens Gaab, Clinical Psychology and Psychotherapy, Department of Psychology, University of Basel; Charlotte Blease, School of Philosophy, University College Dublin; Cosima Locher and Heike Gerger, Clinical Psychology and Psychotherapy, Department of Psychology, University of Basel.

Charlotte Blease is now with the Ireland & Research Affiliate, Program in Placebo Studies & Therapeutic Encounter, Harvard Medical School.

The authors acknowledge and thank Sebastian Hasler (Clinical Psychology and Psychotherapy, Department of Psychology, University of Basel, Switzerland) for his thoughtful and accurate comments and correction of the manuscript.

Correspondence concerning this article should be addressed to Jens Gaab, Clinical Psychology and Psychotherapy, Department of Psychology, University of Basel, Switzerland. E-mail: jens.gaab@unibas.ch

depreciation of being clinically powerless, while still being necessary to be controlled in trials (Hróbjartsson & Gøtzsche, 2001). However, this uniform disposal of placebo effects has been relativized (Wampold et al., 2005), and the placebo and its various effects as well as biological and psychological processes have thus rightfully been the subject of a scientific research program with promising clinical potential (Enck, Bingel, Schedlowski, & Rief, 2013), besides ruining big pharma's high hopes (Enserink, 1999).

The motivation for examining a possible relationship between placebo and psychotherapy can be justified by at least two observations: First, both interventions yield large and clinically relevant effects on symptomatic, emotional, cognitive, and behavioral variables as well as on biological processes (e.g., Goldapple et al., 2004; Mayberg et al., 2002) and second, both interventions are nonpharmacological. It is because of the latter assumption, that is, that both placebo and psychotherapy interventions are psychological interventions or that at least placebo is some sort of psychotherapy, that the relationship between these two concepts as well as the examination of the provocative *argumentum e contrario*, namely that psychotherapy is placebo, warrants consideration and empirical scrutiny. In this article, the relationship between the concepts of placebo and psychotherapy will be delineated conceptually, historically, as well as empirically on the basis of Grünbaum's conceptualization of placebo (Grünbaum, 1981, 1986), before the scientific, clinical, as well as ethical implications of this are discussed. We want to emphasize that the aim of this article is not to discredit the importance of psychotherapy as a clinical intervention; rather, it is to highlight potential threats to its ethically sound application. Also, it is not the ambition to meddle in or even settle the great psychotherapy debate (Wampold & Imel, 2015) or to recapitulate the state of affairs in psychotherapy research (i.e., Lambert, 2013), but rather to propose the need to clearly and openly describe and communicate the factors responsible for psychotherapy's effects. In short, if there is a possibility that psychotherapy *can be* or *is* something other than verum, we argue that

there is an obligation on the profession to take action.

Current Ethical Guidelines on Placebos

Ethical discourse on the use of placebos in clinical practice is usually premised on the notion that placebos necessitate deception; the debate then pivots on whether such deception is ever justified. On a rule-based or deontological normative ethical framework, it is argued that placebos infringe patient autonomy—regardless of potential therapeutic gain, on this view, it is always unethical to lie to patients (Brody, 1980; Kleinman, Brown, & Librach, 1994). Consequentialist normative ethics provides a different and differing range of justifications for and against placebo use. Some philosophers and researchers have argued that the therapeutic benefits to patients of deception are in some circumstances justified (Blease, 2011, 2015; Foddy, 2009; Lichtenberg, Heresco-Levy, & Nitzan, 2004; Rawlinson, 1985; Raz, Harris, de Jong, & Braude, 2009). Others have argued that any positive therapeutic consequence of lying to patients, and administering placebos, is offset by the distrust that is likely to emanate from such deceptions (Bok, 1974; Kanaan, 2009; Schwab, 2009; Shah & Goold, 2009).

The placebo clearly comprises components that are unproblematic in any regard, such as and most notably the therapeutic alliance (Kaptchuk et al., 2008), because it is acceptable and advocated (and effective) in clearly nonplacebo interventions (Kelley, Kraft-Todd, Schapira, Kossowsky, & Riess, 2014). Accordingly, "it is ethically acceptable, not to mention clinically relevant, to provide a supportive clinical encounter that relieves anxiety and promotes positive expectations along with honest disclosure of the expected benefits of a medically indicated treatment" (Finness, Kaptchuk, Miller, & Benedetti, 2010, p. 692).

However, clinical practice must steer the Scylla and Charybdis of averting harm and avoiding paternalism. Health professionals are expected to respect patient autonomy and informed consent procedures while also delivering the utmost clinical care to patients. In short, the days of therapeutic privilege are (in principle, at least) over: health professionals do no longer have the professional entitlement to divulge what they perceive to be harmless non-

sense to their patients. Respect for informed consent and the provision of adequate disclosure about treatments is codified in medical ethics guidelines. The ethical dicta that are most relevant in placebo interventions are respect for patient choice and medical beneficence. Besides these philosophical considerations, the use of placebo in clinical trials is also constricted (Enserink, 2000a), although its use is still warranted in psychiatric trials (Enserink, 2000b).

Before we begin our theoretical analysis of the placebo concept and how it relates to psychotherapy, it is important to examine how medical ethics codes typically conceive of placebos. An excellent place to look for such insights is clinical ethics guidelines. What do contemporary medical ethics codes say about the use of placebos in clinical practice? The American Medical Association (2007) is explicit in the rule-based ethical guidance which it provides to physicians: “In the clinical setting, the use of a placebo without the patient’s knowledge may undermine trust, compromise the patient-physician relationship, and result in medical harm to the patient. Physicians may use placebos for diagnosis or treatment only if the patient is informed of and agrees to its use” (American Medical Association, 2007).

As one might expect, these recommendations are consistent with the ethical dictum that “withholding medical information from patients without their knowledge or consent is ethically unacceptable” (American Medical Association, 2007: Opinion 8.082). However, the American Medical Association goes on to stipulate that “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.” Similarly and according to a consensus statement of the German medical chamber, the use of “pure placebo or so-called “pseudo-placebo” is warranted in clinical practice” under some preconditions, that is, no other treatment options exist, minor illnesses, explicit wish for treatment and known efficacy for the given illness (Bundesärztekammer, 2011, translation by J.G.).

As Blease (2015) has argued, these guidelines bring to mind the proverbial case of having one’s cake and eating it too. On the one hand, these guidelines intimate that doctors should be

open about placebos and obtain consent before they are administered, and on the other hand, the American Medical Association appears to embrace the view that deception is a necessary requisite in placebo use. Given that deception is forbidden in medical practice, the American Medical Association appears to have inserted an additional patient authorization clause as something of an afterthought. As we will shortly see, when we examine Grünbaum’s account of placebos, the underlying assumption that placebos are (by definition) mere dummy pills or sham interventions that can only be effective if deception is involved is theoretically naïve. Moreover, at this juncture, we can also note that the claim that sugar pills necessitate deception to elicit therapeutic effects cannot be decided a priori. Indeed, some recent research has attempted to investigate the possibility of (fully) open placebos (Kaptchuk et al., 2010; Kelley et al., 2012; Sandler, Glesne, & Bodfish, 2010). Although more research is needed to establish whether open placebos are as effective as deceptive placebos, this is a matter that (at least in principle) can only be resolved empirically.

As one might expect, the American Psychological Association—like the American Medical Association—has a code of ethical conduct which also stipulates respect for patient autonomy in clinical encounters; psychologists should, “(O)btain the informed consent of the individual” and, “inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy.” Interestingly, however, the American Psychological Association provides no specific guidelines on placebos—at least the ethical code of conduct for psychologists (American Psychological Association) does not explicitly deal with this issue. But it is worth noting in this context that the American Psychological Association does call “for treatment(s) for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation” (American Psychological Association, 2010, Standard 10.01, p. 13).

If one narrowly (and simplistically) conceives placebos as physical interventions which are pharmacologically inert then it would seem

as if psychotherapy (and other psychological interventions) are somehow immune from the placebo problem. The lacuna in any ethical consideration of placebos by the American Psychological Association appears to intimate an underlying assumption that the term placebo is unfeasible or inapplicable when it comes to psychological treatments.

In this article we argue that the term placebo is certainly relevant in psychotherapy; in what follows, we find that the term placebo is in principle applicable to psychological treatments and controlled testing of such treatments, even if in practice placebos are difficult to discern. Moreover, we contend that the continued use of placebos in its different appearances in psychotherapy settings poses a threat to patient autonomy (and to trust in health care professionals). In short, this article asserts that it is time for psychotherapy to go open to avoid placebos and to live up to its own ethical dicta. However, before we can provide an ethical justification for this conclusion, we first need to provide a robust theoretical framework for the term placebo. Therefore, in the next sections we examine Grünbaum's model of placebo and show how it can be applied to psychotherapy before revisiting the clinical and ethical repercussions of this framework.

A Theoretical Taxonomy of Placebogenic Elements in Psychotherapy

According to Grünbaum (1981, 1986), the nature of an intervention or a treatment process, that is, as either being placebo or verum, cannot be deduced by its effects, but rather is defined "by a given therapeutic theory . . . as having (characteristic) constituents . . . , but also possessing other, perhaps unspecified incidental constituents" (Grünbaum, 1986, p. 24). Central to the question at hand is whether the characteristic and incidental constituents of a treatment rely on an underlying therapeutic theory and that "the generic distinction between placebos and non-placebos has nothing whatsoever to do with the contrast between nonspecificity and specificity, but only with whether the characteristic treatment factors do play a therapeutic role for (a given disorder) . . . or not" (Grünbaum, 1986, p. 33). Put otherwise, to equal placebo effects with unspecific effects is illogical, because placebos do have specific effects.

The qualification of these treatment components in medicine is at least facilitated by both the possibilities to test theory-driven definitions of characteristic and incidental treatment components in double-blind placebo-controlled trials as well as to scrutinize etiological models by objective parameters, but matters are more complicated in psychotherapy. Although this is also attributable to the methodological and practical impossibility of constructing and conducting an indistinguishable placebo condition in psychotherapy (Borkovec & Sibrava, 2005), an additional obstacle is that the definition of what is incidental and what characteristic is defined theoretically (Critelli & Neumann, 1984). To illustrate this, Freud considered "overcoming the analysand's resistance to their conscious recognition in the context of resolving his or her transference behavior towards the doctor" as a characteristic effector of the "educative and affect-discharging lifting of the patient's presumed repressions," while the "patient's faith in the analyst, and the derivation of emotional support from that authoritative figure, as . . . incidental, because they are avowedly quite incapable of extirpating the pathogenic causes" (Grünbaum, 1986, p. 24). Although the latter disqualification of expectations and emotional support as epiphenomena is disproved by current empirical observation, because expectancy-related phenomena as well as therapies based on emotional support are effective and sustainable (e.g., Cuijpers et al., 2012; Dour, Chorpita, Lee, Weisz, & Research Network on Youth Mental Health, 2013; Leichsenring et al., 2014), Freud's classification exemplifies the theoretical basis of defining what is to be considered characteristic or incidental.

Psychotherapy is rife with rival and contrasting theoretical models, which both differ in their definition of incidental and characteristic treatment components and—to make things even more complicated—differ negligibly in their effects (e.g., Marcus, O'Connell, Norris, & Sawaqdeh, 2014; Barth et al., 2013). On the basis of (a) Grünbaum's definition of theory defining the characteristic and the incidental components of a treatment and (b) because "it is not only the patient who can be unaware that the treatments they are receiving are just placebos for their disorders; the physicians as well may mistakenly believe that they are administering nonplacebos for patients' ailments, when they

are actually dispensing placebos, while further enhancing the patients' credulity by communicating their own therapeutical faith" (Grünbaum, 1986, p. 19) the following definitions can be derived:

- First, any treatment can be classified as intentional *placebo* when its characteristic constituents are not remedial for a given disorder, but the therapist knowingly administers the treatment in expectation that the incidental factors will have an effect on the patients disorder.
- Second, any treatment can be classified as inadvertent placebo when the characteristic constituents are not remedial for a given disorder, but both the therapist and the patient believe that the treatment effects are due to its characteristic constituents. Because this double-blindness to the placebo-genic nature of the intervention will likely increase its effects, this will be labeled as *superplacebo*.
- Correspondingly, Grünbaum defines a *verum* (which he prefers to call nonplacebo) as a treatment whose characteristic constituents are remedial for a given disorder (Grünbaum, 1981). It needs to be noted that according to this definition, treatments whose—in case of more than one—assumed characteristic constituents are not all remedial for a given disorder are still seen as nonplacebos. For example, if a given treatment consists of several characteristic constituents, whose removal with an exception of one treatment constituent does not compromise the effects of the treatment, this treatment would still be considered as nonplacebo/verum. However, any observation of some/not all characteristic constituents being remedial would call for a revision of the underlying therapeutic theory. Also and interestingly, this definition implies that any treatment working through their characteristic constituents, for example, otherwise inert substance working through response expectancy, is a verum by definition. In this understanding, the open-label administration of placebo would be seen as a case of verum, as long as the characteristic treatment constituents are remedial for a given disorder. Similarly, any psychotherapeutic treatment containing treatment constituents that are also

characteristic constituents of placebo (e.g., expectancy) is not to be considered placebo as long as it defines and communicates these constituents as characteristic.

- Also, when effects of the characteristic constituents of a given treatment are substantially augmented or exceeded by the effects of its incidental constituents, we will use label *superverum*. This term captures the superimposition of nonplacebo by placebo effects. Note that these treatments have hitherto been labeled impure placebos (Fellner, 1958). It needs to be noted that the concept of superverum differs from the concept(s) of impure placebos. There are at least two different definitions of impure placebos, either being defined as “treatments that have specific components but exert their effects primarily through non-specific mechanisms.” (Shapiro & Morris, 1978, p. 372) or as “medical interventions that have a pharmacological or physical activity, but not for the actual disease or its symptoms” (Meissner et al., 2012, p. 79). However, according to Grünbaum (1981) and our adoption, both definitions of the term impure placebo are misleading since the former would be best be seen as verum (see above), whereas the latter in our understanding would qualify as placebo, because they do not possess any characteristic constituents remedial for the given disorder (see above). Here, the term superverum has a wider grasp, because it also includes instances of clearly nonplacebo treatments, whose effects are augmented or exceeded by incidental constituents.

Conceptual Relationships Between Placebo and Psychotherapy

Having identified four possible classes of interventions by the effects of their characteristic and incidental constituents, these classes will be examined with regard to their status in psychotherapy. It needs to be noted that by creating these classes neither intervention, that is, placebo or psychotherapy, is to be simplified as being one single entity or being caused by one single mechanism, which is clearly not the case for both interventions. Also and importantly, the processes and mechanisms of placebos in the context of medical interventions are not to

be automatically equaled to processes and mechanisms of incidental constituents, that is, unspecific/common factors, in the context of psychotherapeutic interventions. Instead and according to the aforementioned classification, the classification of incidental and characteristic constituents (and their processes and mechanisms) rests on an underlying treatment theory, which could be either medical or psychotherapeutic.

Psychotherapy as Placebo

Although the equation of (some forms of) psychotherapy with placebo has—usually intended—negative connotations, there have been several benevolent approaches to identify shared mechanisms between the two interventions. As early as 1936, Rosenzweig footnoted in his seminal paper on the Dodo verdict that “complete or absolute truth (of the theory of personality upon which a method of therapy is based) is by no means necessary for therapeutic success” (Rosenzweig, 1936, p. 414, footnote 4). Following a similar line of reasoning, Rosenthal and Frank concluded that characteristics of the psychotherapeutic relationship are comparable with those responsible for the placebo effect and that the latter “may be thought of as a nonspecific form of psychotherapy” (Rosenthal & Frank, 1956, p. 300). In 1973, Jefferson Fish made a clear statement for the clinical importance and feasibility of the placebo by proposing the placebo therapy as “the therapeutic transaction (that) can be seen as taking place between two believers” (Fish, 1973, pp. 8–9). With this, he not only highlighted that psychotherapy rationales should be plausible for patients, it is possible that he introduced the first plea for an open handling of placebo in psychotherapy. Although the placebo model of psychotherapy, defined as “a strategy of therapy that is designed to maximize the placebo effect in the cause of the patient’s welfare” (Pentony, 1981, p. 55), seemingly passed to oblivion it was at one time considered to be one of the main explanatory models of psychotherapy (Pentony, 1981).

Since its introduction in 1936 (Rosenzweig, 1936), the assumption of incidental constituents, which are typically referred to as common or unspecific factors, underlying psychotherapy effect has been a constant in psychotherapy

research. Interestingly, this has not had the same aftertaste as it has in medicine, where these are seen as synonymous with placebos and therefore unethical (Justman, 2011a). This difference in connotation is most clearly seen in the (empirically well-deserved) popularity of common factors in psychotherapy research (Norcross, 2011), practitioners (Duncan, Miller, Wampold, & Hubble, 2011; Tasca et al., 2015), as well as in patients (Swift & Callahan, 2010). In this respect, it is informative that both interventions have been proposed as relying on meaning (Frank, 1986; Moerman & Jonas, 2002; Wampold, 2007) and thus that “most psychotherapy is a placebo by definition; it is an effective treatment because of its psychological properties (i.e. meaning) rather than its physical properties” (Kirsch, 2005, p. 797).

However, equating psychotherapy with placebos is not feasible, because “a placebo is something that is sham, fake, false, inert, and empty. Psychotherapy is none of these” (Kirsch, 2005, p. 797). According to Grünbaum’s definition, psychotherapy could only qualify as placebo in circumstances in which psychotherapists knowingly administer treatments with characteristic treatment constituents, which are not remedial for a given disorder. Although the use of *superverum* in medical practice is frequent, the use of placebos by this definition is rare in medical practice (Fässler, Meissner, Schneider, & Linde, 2010) and similarly, the intentional use of placebos in psychotherapy seems (in the main) restricted to research. Here, because the design of indistinguishable placebo treatments is impossible in psychotherapy research, other designs have been employed. Two general approaches are identifiable, which both rely on manipulating the meaning of the given interventions:

First, two different treatments can be administered with the same meaning. For example, Kim and colleagues (Kim, Wollburg, & Roth, 2012) randomly assigned patients with panic disorder to a wait-list group and two breathing therapies. The latter two were identical regarding treatment duration, patient-therapist interaction, direction of attention to bodily sensations, and use of scientific equipment, but were based on two opposing treatment theories for panic disorder (false-suffocation alarm and hyperventilation theory of anxiety). Thus, both therapies differed in

their characteristic, but shared their incidental constituents, most importantly a convincing therapeutic myth and ritual: “The therapy rationale communicated the ideas that panic symptoms are part of a normal stress response rather than a physiologic collapse, that a cause for panic attacks had been identified scientifically, and that this cause could be controlled by learning to breathe in a certain way.” (Kim et al., 2012, p. 937). Because “evidence for and against the two respiratory theories has been inconclusive” (Kim et al., 2012, p. 931) and treatment rationales diametrically differed, at least on of these interventions could be seen as an instance of intentional placebo from the perspective of the opposing treatment theory. Assessing panic disorder severity at baseline as well as 1 and 6 months after the five weekly sessions of biofeedback-assisted breathing therapies, treatment groups did not differ in their response at any assessment and both groups experienced significant, clinically relevant and large reductions (Cohen’s $1.34 < d < 1.53$) in their symptom severity.

Second, a treatment can be administered with different meanings. For example, in a randomized trial healthy subjects underwent 10 weeks of aerobic training, with three training sessions per week (Desharnais, Jobin, Coté, Lévesque, & Godin, 1993). Participants were assigned either to two experimental groups, of which one group received instructions that the aerobic training improves both aerobic capacity as well as psychological well-being, while the other group were only told that the training benefits the former. The results clearly indicated a significant and large effect (Cohen’s $d = 1.10$) for the “aerobic capacity plus psychological well-being” group, whereas the “aerobic capacity only” group did not experience a significant change in self-esteem.

Although differing in their experimental approach, these studies are clear instances of interventions, where therapists (or in the described cases: researchers) knowingly administer treatments in expectation that the incidental, but not the characteristic constituents elicit the reported effects. Thus, although there would be understandable objections in employing placebos in psychotherapy there is also evidence that intentional placebos with a psychotherapeutical meaning are both possible and effective.

Psychotherapy as Verum

Clearly, the main perception of psychotherapy—at least among psychotherapists—is that psychotherapy is a verum intervention. In this perspective, a given psychotherapy treatment theory defines characteristic as well as incidental treatment constituents and when a given psychotherapy intervention is effective, this is seen as affirmation of its verum nature—post hoc ergo propter hoc or as Steven D. Hollon puts it, “saying that something works means that it has a causal effect” (Hollon & Wampold, 2009, p. 637). Thus, anything that has an effect is perceived as characteristic.

However, the case that distinct psychotherapy treatment theories with distinct definitions of their constituents show similar effects (e.g., Leichsenring et al., 2014) does not only spark academic debates (e.g., Clark, 2013; Leichsenring, Salzer, & Leibing, 2013), but also speaks against a ready acceptance of the post hoc ergo propter hoc-assumption. Although the equivalence of treatment effects in direct comparisons could also be attributable to one of these interventions being in fact a verum, whereas the other is a (super-) placebo (e.g., Eysenck, 1994), simultaneous comparisons between several—and equally effective—interventions make this possibility rather unlikely (Barth et al., 2013).

Borrowing from biomedical designs, psychotherapy outcome research made use of control groups to establish proof for its definition of characteristic and incidental constituents. Although these so-called passive/unspecific/common factor controls are intended to control for theoretically defined incidental constituents, these attempts in psychotherapy clearly lack the persuasiveness of their kin in biomedical research. Control conditions in medical trials ought to be indistinguishable from their active comparators to both those received and those administering treatments. But this requirement is not borne out in psychotherapy trials. For example, in a study of depressed older people in primary care, Serfaty et al. (2009) compared cognitive-behavioral therapy with a talking control condition. Cognitive-behavioral therapy outperformed the talking condition significantly, albeit effect size differences between the two conditions were small (baseline to 10-month follow-up differences in Cohen’s $d =$

0.16) and comparable with results of meta-analyses controlling for structural equivalence between comparators (Baskin, Tierney, Minami, & Wampold, 2003). The authors concluded that the “inclusion of a (talking control) arm is a strength of the study, as this suggests nonspecific factors such as warmth and attention are not the mediators of change” (Serfaty, Csipke, Haworth, Murad, & King, 2011, p. 1338). However, the talking control condition was clearly distinguishable for patients as well as therapists, because patients were encouraged “to discuss neutral topics such as hobbies, sports, and current affairs . . . and there was little focus on emotional issues. . . . So for example, if the patient said, “My daughter does not like me as she never comes to visit me,” the therapist would ask, “How many children do you have?” (Serfaty et al., 2009, p. 1334).

This unblinding opens the door for bias and may thereby reduce patients’ satisfaction with regard to active help through the intervention (Serfaty et al., 2011). It may also lead to a reduction in allegiance of researchers and therapists (see below). For example and with regard to the latter, a comprehensive meta-analysis on the specific and nonspecific effects of psychotherapies for the treatment of depression found that researcher allegiance is an important moderator of reported differences between bona fide and nondirective supportive control treatments, that is, differences between comparators vanished after controlling for researcher allegiance (Cuijpers et al., 2012).

We should also bear in mind that Grünbaum’s original contention is that treatments that comprise at least one effective characteristic constituent are to be considered as nonplacebo, that is, verum. This contention is not unproblematic. Consider for example Eye Movement Desensitization and Reprocessing, an effective and recognized treatment for posttraumatic stress disorder (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013; Foa, Keane, Friedman, & Cohen, 2009; American Psychological Association/Society of Clinical Psychology), which could be seen as verum treatment, because it encompasses factors that have been identified as important for the successful treatment of posttraumatic stress disorder, for example, exposure, the opportunity to talk about trauma as well as making sense of traumatic

event and patient’s reaction to the event (Wampold et al., 2010). However, because psychotherapy treatments usually comprise a multitude of foci, techniques, and methods this could easily lead to the so-called purple hat problem (Rosen & Davison, 2003), whereby “adding one or more functionally inert components (such as a purple hat containing a band of magnets) to an existing intervention based on sound psychological science can . . . be perceived as a new therapy (Tryon, 2005, p. 68) or as Rosen and Davison put it “if one takes eye movements out of EMDR (the first two letters), one is left with the previously known and empirically supported treatment components of exposure and cognitive therapies (the last two letters)” (Rosen & Davison, 2003, p. 303).

Thus, the ability to find evidence for the characteristic constituents and in consequence establish a psychotherapy treatment as nonplacebo/verum is seriously hampered by the inability to control for its incidental constituents. Adopting the—admittedly rather weak—alternative of accepting at least one proven characteristic constituent as sufficient for a verum status, runs the risk of putting old wine in new bottles: it allows entrepreneurial influences to “ride piggyback on established principles of change” (Rosen & Davison, 2003, p. 306). A more fruitful approach to this problem would be a clarity over what we theorize to be the characteristic and incidental constituents of psychotherapy treatments. For example, the elevation of present-centered therapy from a nonspecific and nontrauma focused control condition to an now empirically supported treatment (American Psychological Association, Society of Clinical Psychology, n.d.), which not only fares comparably well in comparison with trauma-focused approaches, but also has lower dropout rates (Frost, Laska, & Wampold, 2014), could serve as a reminder that the perception of what is characteristic or incidental can and should change under scientific scrutiny.

Psychotherapy as Superverum

Interventions have been given the label “extra strength” or “super” when expectancies for the efficacy of these treatments have been augmented due to breaking the blind in clinical trials or attributable to a shared understanding of the intervention by patients and practitioners

(Kirsch, 2010; Nuhn, Lüdtke, & Geraedts, 2010). However, referring to Grünbaum's definition, the superaffix could have different meanings in the case of placebo and verum. Although the former is defined as a placebo, which is inadvertently believed to be nonplacebo by both patient and therapist/practitioner, the latter is seen as a verum intervention, whose characteristic effects are outperformed by its incidental effect. How could this concept of *superverum*, which so far has been used to explain high placebo responses in placebo-controlled homeopathy trials (Walach, 2001), be applied to psychotherapy?

Here, research on the allegiance effect is instructive. Simply put, the allegiance effect refers to the observation that intervention's effects increase when researchers as well as therapists have a strong belief in the effectiveness of the intervention. Given that researchers' and therapists' allegiance are not—by definition—characteristic components of the intervention, the allegiance effect can be regarded as incidental to most, if not any treatment theories.

There is good evidence for the presence of an association between allegiance and outcome. Therapists' allegiance has for instance been shown to explain 19% of variance in the effects of applied behavioral analysis for autism spectrum disorders (Klintwall, Gillberg, Bölte & Fernell, 2012). Similarly, a meta-analysis showed that the researchers' allegiance explained 12% of the variance in the relative effects between two trauma-focused treatments for PTSD (Munder, Flückiger, Gerger, Wampold, & Barth, 2012). Notably, the allegiance-outcome association does not simply mirror true differences in the effectiveness of two different interventions, but rather seems to be a causal factor that contributes to intervention effects (Munder et al., 2012; Munder, Gerger, Trelle, & Barth, 2011). Both, the allegiance of the therapist as well as the researchers' allegiance, thus contribute to an intervention effect.

Several mediators have been proposed as possible sources of the allegiance outcome association (Leykin & DeRubeis, 2009; McLeod, 2009). In order to illustrate how allegiance effects may affect outcome via incidental intervention components and how incidental and characteristic components may even interact we will briefly outline two of the suggested medi-

ators: First, a researcher's allegiance to a particular intervention under investigation may affect the decisions a researcher has to take in the course of an outcome study. These decisions may include methodological decisions with respect to data analysis, for example, handling of outliers, choice of primary outcome. Methodological quality has indeed been shown to partly mediate the allegiance outcome association (Munder et al., 2011). But it may also affect the decision whether or not to publish results in case they are not supporting the effectiveness of the preferred treatment (e.g., Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008). Finally, depending on their allegiance researchers may also interpret a given effect differently (e.g., Clark, 2013; Leichsenring et al., 2013). It is important to note that all outlined mediators are not defined as characteristic components, while still affecting intervention effects. Second, allegiance is defined as greater enthusiasm for a treatment. Such bias might motivate researchers to implement the interventions under investigation in a way that favors the preferred intervention, for example, selecting highly skillful therapists or implementing better training and supervision for the preferred intervention. Baskin and colleagues (2003) provided evidence that smaller differences occurred between psychotherapeutic interventions and control interventions in studies that—among other variables—kept training and supervision of therapists equal in both conditions. But greater allegiance may also affect the therapists' behavior, which in turn may lead to better outcome, for example, more convincing presentation of intervention rationale or stronger adherence to the intervention manual. Barber, Crits-Christoph, and Luborsky (1996) have shown that the therapists' adherence to use the characteristic techniques of the intervention predicted symptomatic improvement. In short, a stronger adherence to an intervention manual may enhance the effects of characteristic constituents of an intervention, if delivered with more rigor and more competence. Again, all outlined mediators of the allegiance-outcome association are not characteristics of the intervention. However, besides directly being associated with outcome, they also contribute to the effects of the characteristic intervention components.

In this sense, research on the allegiance effect illustrates how incidental constituents may con-

tribute to the effectiveness of psychotherapy interventions. Considering that the explained variance of allegiance effects, which are incidental to treatment theories, are either equivalent to or exceeding the differences between treatments and thus the effects of the characteristic constituents, for example, in treatment of youth disorders (Miller, Wampold, & Varhely, 2008), depressive disorders (Cuijpers et al., 2012), or posttraumatic disorders (Munder et al., 2012), the allegiance effect is a clear example of supervenience in psychotherapy, understood as a presumably nonplacebo treatment, whose effects are augmented or exceeded by incidental constituents.

Is Psychotherapy a Superplacebo?

It is instructive to look back on the development and the course of psychotherapy as a clinical as well as scientific endeavor, because there is a steady succession of psychotherapy interventions that have been assumed to be “little more than elaborate psychosocial placebos” (McNally, 1999, p. 234), but which are or have been administered with the full conviction that they are indeed verum.

The interventional ideas of Franz Anton Mesmer (1743–1815) rather accidentally revealed the great power of psychosocial placebos (Justman, 2011b) and thus built ground for following founders of psychotherapy (Shapiro & Shapiro, 1997). While on a long retreat in the wild, Mesmer “held that a subtle, undetectable fluid (that) pervaded nature” (McNally, 1999, p. 226), whose blockage gave rise to all sorts of ailments. While the hence deduced therapy was effective and attracted strong interest, “an experience so charged with ambiguous suggestion and so potentially subversive incurred the suspicion . . . (of) the king of France” (Justman, 2011b, p. 18). The subsequently appointed royal commission led by Benjamin Franklin employed a rather elegant placebo-controlled study design, showing that mesmerism was nothing more than mesmerizing *bona fide* sufferers.

Interestingly, mesmerism was discredited despite reports that it was effective, while (what we might dub) its modern counterpart—Eye Movement Desensitization and Reprocessing—has so far been spared this fate, because it too has been found to be effective (McNally, 1999). Interestingly, the use of the assumed force be-

hind mesmerism—“(the) touching . . . the imagination set in action & . . . this involuntary imitation that brings us in spite of ourselves to repeat that which strikes our senses” (Franklin et al., 2002, p. 362)—was taken up by medical practice and experienced many upheavals until its revival in France as hypnotherapy at the end of the 19th century. One of the most prominent representatives of the theory that hypnotizability is an instance of hysteria was Jean-Martin Charcot (Shorter, 1997, p. 137). It has been argued that mesmerism involuntarily gave way to the Freudian psychoanalysis and other psychodynamic methods (Kihlstrom, 2002), as Freud was reportedly inspired to use hypnosis after studying at Charcot’s clinic (Auerback, 1961). Interestingly, contemporary hypnotherapy is rightfully far from sharing the same fate or perception as its historic progenitor and could be considered a fine example of the argument at hand, because its mediators have been elucidated (Kirsch, Mazzoni, Montgomery, 2007) and thus has been considered a “nondeceptive placebo” (see Kirsch, 1994).

The idea that some forms of psychotherapy not only were influenced by placebo, but also are nothing—or little—more than placebos can also be traced across recent history. This includes the infamous claim that psychotherapy, that is, any nonbehavioral treatment, not only fares worse than spontaneous remission (Eysenck, 1952), but that its effects are little more than those of placebo treatment (Eysenck, 1994), the likening of—notably American Psychological Association-approved—Eye Movement Desensitization and Reprocessing with mesmerism (Justman, 2011b; McNally, 1999), the placebogenic nature of insight-orientated therapies (Jopling, 2001), the statement that cognitive reappraisal—the cornerstone of cognitive and cognitive-behavioral therapies—“has the force of a good story, and does not ask us to believe in any cognitive mechanism beyond those that have been familiar to playwrights and novelists for centuries” (Lang, 1988, p. 221, in McNally, 2001, p. 515) and the assumption “that the bottom line is that if the Food and Drug Administration was responsible for the evaluation of psychotherapy, then no current psychotherapy would be approvable” (Klein, 1996, p. 84, in Wampold et al., 1997, p. 211) because of its lack of superiority over placebo conditions. The problem here is not that

these interventions are not effective or efficacious, but that the underlying theory is seen as false or unproven, so that its definition of what is to be seen as characteristic or incidental is fundamentally flawed. For example, picking up Popper's critique of psychoanalysis as unfalsifiable, Roth, Wilhelm, and Pettit (2005) examined current theories of panic attacks and found these theoretical backbones of the efficacious cognitive-behavioral treatment of panic disorders—catastrophic cognitions, vicious circle and hyperventilation—to have heuristic value, but not to be falsifiable in their current form. Accordingly Roth et al. argue that “proponents of the theories will and should try to rescue them with modifications and addenda” (Roth et al., 2005, p. 189).

A possible example of superplacebo, understood as an intervention which does not significantly exceed credible placebo conditions, while still being defined as “efficacious and specific” by its proponents (Arns, de Ridder, Strehl, Breteler, & Coenen, 2009, p. 180), could be seen in bio- and neurofeedback. For example, both interventions were found to be equally effective as credible placebos in chronic low back pain (Kapitza, Passie, Bernateck, & Karst, 2010) and attention deficit and hyperactivity disorder (Lansbergen, van Dongen-Boomsma, Buitelaar, & Slaats-Willemse, 2011), which interestingly did not prevent the authors of one of the former publication from concluding that “(respiratory biofeedback) can be used as a useful, safe, and effective adjunct in multimodal pain therapy” (Kapitza et al., 2010, p. 215).

Discussion

This article set out to delineate the relationship(s) between placebo and psychotherapy. We examined four different conceptualizations of psychotherapy derived from Grünbaum's theory of the placebo concept. First, placebos with a psychotherapeutic meaning are possible (and effective), but require the intentional deception of the patient. On the other hand, it is experimentally challenging to prove that psychotherapy is verum. Here, the lack or exiguity of differences between different psychotherapy treatments (e.g., Marcus et al., 2014), the absence of indistinguishable conditions to control for incidental treatment factors as well as the small to nonexistent differences between treat-

ment and (more or less distinguishable) control conditions (e.g., Cuijpers et al., 2012; Cuijpers et al., 2014) hinder the identification of verum treatments. Psychotherapy might thus at best or at worst be conceptualized as either superverum or superplacebo. The evidence suggests that its effects are unintentionally and to varying extent—substantially for superverum and totally for superplacebo—driven by its incidental constituents. If psychotherapy wants to fulfill its claim not to be “sham, fake, false, inert, and empty” (Kirsch, 2005, p. 797), the following implications and recommendations are important.

Implications for Research

The described exemplifications for the four classes of interventions clearly need to be subjected to further scientific scrutiny. Although the association between placebo and psychotherapy has received ample theoretical consideration—of which this article is a case in point—there is a scarcity of empirical studies, at least when compared with the large number of psychotherapy outcome and process studies as well as empirical investigation of placebos in the context of medicinal interventions. However, there are exceptions, which are also informative for the problem at hand. Consider for example the case of systematic desensitization. Here, to address the role of credibility and expectancy for improvement of systematic desensitization various control strategies were implemented (Kazdin & Wilcoxon's, 1976), including attention placebo group (e.g., Kirsch & Henry, 1977; Marcia, Rubin, & Efran, 1969; Paul, 1967), the treatment element control group (e.g., Borkovec & Nau, 1972; Brown, 1973; Tori & Worell, 1973), and the empirically derived control conditions (D'Zurilla, Wilson, & Nelson, 1973; McReynolds, Barnes, Brooks, & Reagen, 1973; Steinmark & Borkovec, 1974). The results of these studies were sobering: “In short, the present state of desensitization research allows for the rival interpretation that nonspecific treatment effects rather than specific therapeutic ingredients account for change. Moreover, when this rival interpretation is ruled out, the evidence does not strongly support the efficacy of desensitization as a specific treatment strategy” (Kazdin & Wilcoxon's, 1976, p. 753); or with the words of Kirsch and

Henry (1977): “The results of desensitization may be duplicated by at least some equally credible “placebo” procedures” (p. 1059). Whether these findings have contributed to the downfall of systematic desensitization (see McGlynn, Smitherman, & Gothard, 2004) is speculative, but systematic desensitization is still considered a second line research-supported treatment option for specific phobias (American Psychological Association, Society of Clinical Psychology, n.d.).

There are several possible avenues to address this issue, such as the design and empirical testing of credible placebos with a psychotherapeutic meaning (e.g., Espie et al., 2014), the manipulation of the meaning of already established interventions either by giving different meanings to otherwise identical interventions (Desharnais et al., 1993) or giving identical meaning to otherwise different interventions (Kim et al., 2012). Furthermore, there is a multitude of experimental designs in placebo research, such as blinded balanced designs (Lund, Vase, Petersen, Jensen, & Finnerup, 2014), open/hidden paradigms (Colloca, Lopiano, Lanotte, & Benedetti, 2004), and open-label placebo trials (Kaptchuk et al., 2010; Kelley et al., 2012), which are to be explored in the context of psychotherapy and which would help to clarify the status of theoretically defined characteristic and incidental treatment constituents. For example, supposedly characteristic treatment constituents, such as stimulus exposure and response prevention, cognitive reappraisal, expressive writing, insight-generation interpretations of intra-/interpersonal conflicts or a warm, empathetic and unconditionally regarding attitude toward the patient, could be administered openly as a therapeutic interventions as well as covertly, for example, described as a purely diagnostic or distractive procedure. With this open and hidden administration the relevance of assuming incidental constituents, such as providing a treatment rationale, could be examined and, if warranted, underlying treatment theory could be revised regarding the definition of its characteristic and incidental constituents.

Furthermore, keeping in mind that the effectiveness and the efficacy of a given treatment is no direct proof for the validity of its underlying definition of characteristic constituents as well as considering the wealth of data supporting the

significant, that is, characteristic, role of treatment constituents, which are at large considered to be incidental (Norcross, 2011), there is the need to revise treatment theories. For example, if a psychotherapeutic treatment or method has proven to be effective independently of its assumed incidental constituents, such as a treatment rationale or a trusting and empathetic relationship, it could be considered a *verum*. However, if this were not the case, these previously incidental constituents would best be reconsidered as characteristic. To illustrate this, a recent meta-analysis showed that irrespective of allegiance to the role of the therapeutic relationship in psychotherapy, the therapeutic relationship had a significant and clinically relevant impact on treatment outcome (Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012). Thus, the therapeutic relationship would need to be defined as characteristic and the underlying treatment theory of the respective treatment would benefit from the incorporation of why and how the relationship exerts its effects. On the other hand, treatment constituents, which usually are considered as characteristic, such as so-called specific treatment methods, would need to be reconsidered as incidental when they fail to explain variance in treatment outcome in direct or fair comparisons (e.g., Barth et al., 2013; Cuijpers et al., 2012; Leichsenring et al., 2014). Also, it needs to be noted that the described revisions of treatment theories could then be as disorder or patient specific as possible. With regard to the latter, a recent meta-analysis reported different effects for characteristic and incidental treatment constituents for patients with more circumscribed or more complex problems (Gerger, Munder, & Barth, 2014). It needs to be noted that our position should not be mistaken as to prove or disprove any school of thought in psychotherapy, but rather be seen as a quest for specificity in terms of understanding, employing, and communicating the driving forces of psychotherapy’s effects. The revisions of treatment theories would not only enable a valid definition of characteristic and incidental treatment constituents, but also facilitate the development and description of evidence-based principles of change in psychotherapy (Rosen & Davison, 2003), help to avoid the genesis of purple hat therapies, and facilitate the identification of noneffective or even harmful therapies (Lilienfeld, 2007).

It would also be beneficial for scholars to expand the placebo research program to encompass investigations into processes in longer lasting and nonmedicinal interventions. So far, research into psychological processes of placebo effects and responses to a large extent relies on acute laboratory or clinical studies, such as conditioned or expectancy-induced analgesia. Here, it is informative that long-term therapeutic changes might to a lesser extent be caused by expectancy and conditioning, but rather be the result of motivational goal satisfaction (Hyland, 2011). Furthermore, it has been noted that placebo research mainly focuses on psychobiological models. Although this has its merits in its own rights, it has been argued that a “concerted empirical effort to clarify the psychological models underlying placebo effects could integrate with the neurobiological models to fulfill the promise that placebo effects have for improving patient outcomes” (Geers & Miller, 2014, p. 330).

Implications for the Ethical Practice of Psychotherapy: Go Open!

For too long the ethical repercussions of research into psychotherapy—including the possibility that psychotherapy may be a placebo—has received scant attention (however see Blease, 2015, in press; Jopling, 2008). Just as with other kinds of mental health interventions—such as psychopharmacology—psychotherapists have a duty to ensure respect for patient autonomy, while also providing the utmost care to patients. In short, psychotherapy has a professional obligation to meet its own (codified) ethical standards (Blease, 2015). In light of the foregoing discussion we assess the prevailing ethical problems with psychotherapy. We argue that psychotherapy needs to anchor practice in its ethical duties to patients—the profession needs a wake-up call. The ethical analysis of current practice also raises the challenging issue of balancing beneficence with patient autonomy. Although this raises difficult questions, we contend that psychotherapy cannot continue to ignore them.

As we have seen, on Grünbaum’s theoretical framework there are four ways to conceive of psychotherapy: verum, placebo, superplacebo, or superverum. Although it is impossible to analyze every version of psychotherapy against

these conceptualizations, our goal is to show, very broadly, what ongoing research implies about the ethical clinical practice of psychotherapy within this overarching theoretical framework. In particular we shall be concerned with psychotherapy as a verum, placebo, or superplacebo because these conceptualizations pose the most significant questions for ethical practice.

Consider the first conceptualization: psychotherapy as verum. We take it that—in line with medicine—this should be the goal of psychotherapy. Given our survey of current psychotherapy research, there are serious and reasonable doubts that psychotherapy is verum. When the theories that underpin how psychotherapy works are not truth-tropic (that is to say, when there is no strong evidence that their theoretical underpinnings track the truth) this has important repercussions for both the training of psychotherapists and for informed consent procedures. Only when the profession keeps up-to-date with the scientific research program in psychotherapy can therapists’ training and understanding be properly anchored to science. And only when psychotherapy is verum are therapists well-placed to provide adequate information about the nature of psychotherapy to their patients. In so doing, therapists, and psychotherapy as a discipline, can be said to respect patient autonomy.

It might be argued, however, that these comments are already too heavy-handed: that there is no conflict between adequate and truthful disclosure about psychotherapy and patient autonomy. On this view, if a therapist informs a patient that the process of therapy works via exposure techniques, or eye-movement techniques and cognitive restructuring, for example, these are legitimate and honest responses. On this defense, the therapist is entitled to interpret the patient as asking, “What goes on in these helpful sessions?” and the information that the therapist is disclosing can be construed as truthful since the therapist (it might be argued) is thereby describing the vehicles for the underlying causal processes which do the real therapeutic work. In short, on this view, when we differentiate vehicles from causal processes, it might be argued that the therapist has furnished the patient with an accurate account of why therapy works. Indeed, according to the contextual model of psychotherapy, it is the contextual

factors (the collaborative sessions, the focus on the tasks or rituals involved, the expectations of the therapist and the patient, and so on) that are causally relevant in outcome. Therefore, the techniques (even if they are based on pseudo-scientific principles) are nonetheless the vehicles of treatment.

But this is an evasive response. The first thing to note (before we even address the issue of patient disclosure) is that therapists are overwhelmingly trained to take these techniques at face value—their training involves instruction in the specific techniques and models of distinct versions of therapy. These are not presented as the vehicles for the real causal tokens that effect therapeutic outcome. Therapists are trained into specialist forms of therapy and informed consent procedures relate to disclosure about the processes in which they have been trained. To deny this is wishful thinking. Second, even if a therapist is educated about common factors research and has some scientific knowledge that therapy does not work according to its theorized, specific techniques, why should he or she assume that the patient will also understand that these techniques are mere vehicles for the genuine causal processes to get to work? If a patient asks, “How does EMDR work?” it seems clear that this is a direct question about causal processes; “What is the real engine of treatment here?” When a therapist responds, “EMDR works because of its specific techniques which include eye movements, and cognitive restructuring” but, in fact, believes that specifying such techniques is something of a sleight of hand—that the techniques are not in themselves causally responsible for therapeutic gains but one of many possible vehicles of them—then he or she has not directly answered the patient’s question. Moreover, it is only in light of the scientific facts that the patient would be justified in believing that the therapist had sidestepped the question. If we choose to sanction such oblique responses, we unwittingly endorse medical paternalism with the understanding that therapists are within their rights to tell their patients phony stories about how psychotherapy works. Notice that if we wish to support this stance we need to back it up with explicit argumentation. Furthermore, if we take this tack, we are then obliged to endorse the view that psychotherapy is a placebo or superplacebo, rather than *verum*. As such, we need to ask: What ethical arguments

can be marshaled in support of these conceptualizations of psychotherapy? Is it ever ethically acceptable for psychotherapy to be a placebo or superplacebo?

Consider, then, the first view: psychotherapy as placebo. It might be contended that there is nothing wrong with therapists intentionally providing false information to patients. There are two ways to interpret this argument. One line of reasoning (a weaker argument) is to assert that we can justify psychotherapy as a placebo because doing so has no harmful consequences. On this perspective, it might be contended that doctors frequently talk what is normally assumed to be harmless nonsense to patients—for example telling them that antidepressants work by addressing a neurochemical imbalance. Similarly, we know that the idea that EMDR works because of eye movements may be seen as just as daft and surely to worry about these matters makes rather heavy ethical weather of the actual practice of referring someone to this or that treatment. It works, it might be argued, so it doesn’t matter what we explain to patients about how it works. A second line of reasoning is more substantive and recognizes the importance of the ethical debate. On this view it is argued that patients have much to gain if they are furnished with inaccurate accounts about how psychotherapy works: if psychotherapy is a placebo, it might be argued, the deception is ethically justified on the grounds of beneficence. Hence, if patients expect a particular version of psychotherapy to be effective, it is argued, their beliefs will induce (a morally defensible) self-fulfilling prophecy. In short, this strand of argumentation proposes that the provision of truthful informational disclosure undermines the magic of therapy—it denies patients the very effectiveness of psychotherapy.

We reject both lines of reasoning as ethically and empirically naïve. The first argument is especially problematic because it suggests that ethical issues are ignorable on the grounds of expediency (Bleas, 2013, 2014, 2015). This is flagrantly to ignore the duty of health professionals to provide information to patients. Certainly, it is correct to contend that medicine is something of a practical science. It is the effectiveness of a treatment that is the priority in medical research: the explanation for a treatment can (and, often does) come later. However, this fact does not free doctors or psycho-

therapists to disclose what they like to patients. Doctors (and other health care professionals) cannot simply peddle false information to patients and justify this on the grounds of practicality or convenience. Advocating the promotion of false information—information that the medical and scientific community deem to be nonsense but which lay patients may accept as true—is tantamount to giving a hand-waving gesture to the importance of patient choice and self-determination. It is to be professionally remiss—to disengage with the debate about the significance of patient autonomy, and honesty and transparency in consent procedures (of which more, shortly).

But it is also to ignore some significant findings in behavioral health care: we know, for example, that what is *prima facie* trifling or harmless nonsense can, in fact, lead to negative health behaviors. In respect of this, the comparison with psychopharmacology is worth dwelling on because it raises issues about the health ramifications of the content of disclosed information. A growing body of research shows that bio-babble can be harmful: for example, the pop-scientific idea that depression is caused by low serotonin can induce behavior that is detrimental to the patient's health; "patients who embrace the view that depression is wholly caused by a biochemical imbalance tend to expect a worse prognosis: they also embrace the belief that non-pharmacological interventions and lifestyle changes are ineffective. . . . There is also evidence that, far from benignly eradicating health stigmatization by presenting it as a brain disease caused by a chemical imbalance this theory appears to promote stigmatization among the non-depressed public" (Bleese, 2014, p. 227). In summation, the hegemony of the biochemical imbalance explanation for depression has profound implications on patients' knowledge of their illness, thereby leading to a harmful (false) essentialist understanding among patients that they are innately depressive (Bleese, 2014). There are not only ethical implications in providing false information (which threaten patient autonomy and trust in doctors), it is possible that there are long-term health implications that result from reporting the wrong information to patients. Indeed, it is worth recalling the controversy (and lawsuits) that have arisen when psychotherapy has been challenged in the recent past: in particular the

hiatus over false memory syndrome and the fallout and distrust about therapy that emerged from accusations of malpractice. However, before we examine indirect evidence for the claim that misinformation may jeopardize patient outcome in psychotherapy, we need to examine the second, more substantive argument, which directly attempts to justify misinformation on ethical grounds.

On this second perspective, it is argued that the beneficence that accrues from benign lies outweighs any putative harm to patients—psychotherapy is best characterized as a placebo, the argument goes, (and we are justified in maintaining this status) because, in the final analysis, it benefits patients. In line with this view, we earlier cited research which shows that versions of therapy with plausible rationales are more effective than forms of sham therapy with no cogent theory (Krupnick et al., 1996; Wampold et al., 2005); and when patients are offered the choice of their favored version of therapy, significantly fewer patients drop out of treatment (Swift, Callahan, & Vollmer, 2011). On the basis of this evidence it might seem that we should present to the patient whatever kind of rationale for psychotherapy makes sense to them, rather than concern ourselves with the validity of that rationale.

However, there are major problems with this line of reasoning. First, according to this logic, we should not only dupe patients, we are ethically obliged to dupe therapists too: psychotherapy is a superplacebo and patient beneficence is the best reason for maintaining its superplacebo status. As we have seen, psychotherapists who show strong allegiance to a particular version of therapy appear to enhance the therapeutic outcome for patients. Certainly, the notion that therapists intentionally deceive patients is questionable: thus the notion that psychotherapy is (in general) best characterized as a placebo is doubtful. In short, psychotherapy is not merely a placebo, it works best as a superplacebo and patient beneficence is the best reason for maintaining its superplacebo status. As we have noted, psychotherapists are not routinely trained in scientific explanations for therapy. It would seem, then, that inculcating therapists into particular theories (even when those theories are not truth-tropic or scientifically informed) accrues potent therapeutic effects. Once again, the justification for this kind of professional and

patient double-blinding is that it elicits significant treatment outcomes. In short, it would seem that psychotherapy as placebo is not an accurate generalization of psychotherapy—it is more plausible to characterize current practice as a superplacebo. But how ethically sound is this justification of psychotherapy as placebo or superplacebo? We argue that the rationale for a *laissez-faire* attitude toward current clinical practice is neither justified on ethical grounds nor on the basis of supposed patient beneficence.

The first problem is the consequentialist claim that beneficence outweighs the deception to both patients and to therapists. This is problematic because it places professional psychotherapy in a precariousness position: as we have already argued in respect of psychotherapy as placebo, what appear to be white lies may incur distrust in the profession from both therapists and patients, and this may have a domino effect in terms of patient outcome. The seed of doubt or distrust may thereby threaten the professional reputation of psychotherapy, and this may incur reduction in both therapist allegiance, and (as a knock-on effect) patient adherence to treatment.

More to the point, the justification on the grounds of beneficence has not yet conclusively been made: it is a claim that is underdetermined by the evidence. Research shows, for example, that adherence to protocols and manualized accounts of psychotherapy may diminish therapeutic outcome, negatively effecting the therapeutic alliance between therapist and patient. One study found that therapists who rigidly adhered to treatment manuals displayed less approval and more authoritarian behavior toward their patients (Henry, Schacht, Strupp, Butler, & Binder, 1993). Thus, maintaining a shroud of misinformation in psychotherapy training is a risky strategy. Further problems may arise when patients are not adequately informed about how to select therapists, or how to make judgments about the progress of therapy. We know, for example, that patients are better judges of the therapeutic alliance than therapists (Horvath & Symonds, 1991). Yet the drop-out rate for psychotherapy stands at around 20% (Swift & Greenberg, 2012): if patients were furnished with better understanding of the importance of the therapeutic alliance (and the knowledge that (arguably) nobody is to blame if the alliance is unsatisfactory), this information

may work not only to keep more patients in treatment, but may even improve their outcome.

Finally, the argument that beneficence is depreciated when patients are given scientifically representative facts about how treatments work (such as being informed about the importance of their own expectations, and the therapeutic alliance) is being challenged in new ways. Recent open placebo trials show the intriguing result that patients can be informed that they are receiving a placebo yet they still derive placebo-genic effects (Kaptchuk et al., 2010). Although such studies are still in their infancy (Kelley et al., 2012), contrary to received wisdom, it may be possible to harness placebo effects without deception.

In summation: the ethical justifications for maintaining psychotherapy as a placebo or as a superplacebo on consequentialist grounds are unconvincing. We recommend that the profession of psychotherapy goes open. No health care profession is entitled to gloss the rights of patients, nor the professional standards of adequate information and training provided to therapists (Bleas, 2012). We concede that there are many unanswered questions about what should be communicated to patients, and how therapy will be affected by transparency (see Bleas, 2015 for some tentative ideas). Our point in this article is that there is not sufficient ethical justification to dismiss scientific research into how psychotherapy works as unimportant (Bleas, 2015). Therapists have a duty to be candid about the state of knowledge about psychotherapy: we know that it works (and indeed, that it may even work as a prophylaxis; Hollon, Stewart, & Strunk, 2006). We also know something about how it works even if that knowledge is incomplete—we have made much progress in recent decades in understanding the common factors that are significant in psychotherapy. Even when we do not yet have a full understanding of how a treatment modality works, it is the duty of health care professionals to communicate this to patients; indeed, as we have noted, it is even possible that more patients will fare even better when openness is respected. Finally, as it has already been argued in respect of medical disclosure, “(P)atients should be given adequate and relevant information to reach a treatment decision—and the medical community should be *seen* to provide that information” (Bleas, 2013, p. 4). The same is

true of psychotherapy. Although it needs to be acknowledged that the identification of placebo or ill-defined characteristic or incidental constituents in psychotherapy is not only hindered by the lack of indistinguishable and credible control conditions, but also by the fact that most psychotherapies consist of more than one active ingredient, this should not automatically exempt psychotherapists from disclosing the uncertainty about the scientific validity of psychotherapy models. This uncertainty does not seem to be restricted to certain psychotherapy schools or models, because the critique of the scientific validity of treatment theories is not restricted to the usual suspects, (e.g., Jopling, 2001), but also comprises cognitive-behavioral therapies (McNally, 2001; Roth et al., 2005). This need not lead to therapeutic nihilism, if treatment theories are revised.

Future research into psychotherapy must fully incorporate ethical issues into its agenda, thereby aligning itself with the strictures of good psychotherapy practice. Up until now this has largely been ignored. We conclude that it would be more appropriate for patients and therapists to be informed about how therapy actually works (given that we have some good ideas about what is effective), rather than conservatively preserving the status quo, thereby ossifying current practices.

Conclusion

Although this seems impossible at first sight, since the so-called common/unspecific factors are both important for *and* incidental to most psychotherapy treatment theories, a feasible remedy is to incorporate these so-called common/unspecific into existing treatment models or to revise treatment theories substantially. It needs to be noted that the formulations of how these so-called common factors are characteristic might differ between treatment approaches, for example, the therapeutic bond is important for cognitive-behavioral and psychodynamic therapies, but operates differently in these treatments (Ulvenes et al., 2012).

Psychotherapy research is often said to be divided into two camps—the medical model stressing the need to use specific/active ingredients, and the contextual model, which sees psychotherapy as a cultural healing practice—and clearly, the need to revise treatment theories

is inevitable for both approaches. Differences between different psychological treatments are small and effects for so-called common/unspecific factors are substantial (e.g., Cuijpers et al., 2012; Marcus et al., 2014), so that the definition of what is characteristic and what incidental needs to be put in the right order. Likewise, as noticed by Grünbaum “it would, of course, be entirely natural to label as characteristic just those treatment factors that (the respective model) deems remedial, even though these same ingredients count as merely incidental within each of the psychotherapeutic theories rejected by (the respective model)” (Grünbaum, 1981, p. 162). Thus, although needed and important, it does not suffice to identify and list empirically supported common factors (e.g., Norcross, 2011), but these should be defined as characteristic constituents in the respective treatment theory. Both the medical as well as the contextual model might be considered meta-models, but while the former has transcended in different treatment theories, the contextual model still lacks this practical and disorder/problem-specific operationalization. However, important first steps seem to have been taken (Hofmann & Barlow, 2014; Wampold & Budge, 2012).

On a practical level, it might be difficult to tell the difference between characteristic and incidental constituents for practitioners. However, it is feasible and possible to inform patients about the personal treatment theory of psychotherapists, her/his definition of characteristic and incidental constituents, and to include the patient in important treatment decisions. Also, it is also expectable that psychotherapists are knowledgeable about the scientific status as well as the conceptual and methodological problems in establishing verum status for psychotherapies. Thus, our recommendations for psychotherapists are to be knowledgeable about determinants, processes, and effects of placebo *and* psychotherapy, to go open about the certainties *and* their uncertainties regarding the incidental and the characteristic constituents of their treatment in each patient as well as to get informed consent for their actions by their patients. In the light of the aforementioned ethical repercussions this stance should be employed even when causing a reduction of treatment effects. However, it needs to be noted that possible consequences of going open are a matter

of empirical studies to come and furthermore (as we have noted) these could also be positive.

Although it is imaginable as much as ethically acceptable that these efforts to theoretically as well as practically “go open” reduce the effectiveness of a given psychotherapeutic treatment, it is also possible that this will not occur or even enhance psychotherapy’s effects. Open placebo administration has been shown to have promising effects in different patient and age populations (Kaptchuk et al., 2010; Kelley et al., 2012; Sandler, Glesne, & Bodfish, 2010) as much as congruence of psychotherapists have been found to be a significant predictor of outcome (Kolden, Klein, Wang, & Austin, 2011).

If indeed “psychotherapy is nothing more than a good human interaction between patient and therapist” (Benedetti, 2009, p. 141), then this should be transparent for both psychotherapists and patients.

References

- American Medical Association. (2007). *The Code of Medical Ethics: Opinion 8.082 & 8.083 - Placebo use in clinical practice*. Council on Ethical and Judicial Affairs. Retrieved October 30, 2014, from <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8083.page?>
- American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct, informed consent to therapy*. Retrieved October 30, 2014, from <http://www.apa.org/ethics/code/index.aspx>
- American Psychological Association, Society of Clinical Psychology. (n.d.). *Research-supported psychological treatments*. Retrieved March 15, 2014, from http://www.div12.org/PsychologicalTreatments/disorders/ptsd_main.php
- Arns, M., de Ridder, S., Strehl, U., Breteler, M., & Coenen, A. (2009). Efficacy of neurofeedback treatment in ADHD: The effects on inattention, impulsivity and hyperactivity: A meta-analysis. *Clinical EEG and Neuroscience*, *40*, 180–189. <http://dx.doi.org/10.1177/155005940904000311>
- Auerback, A. (1961). The place of hypnosis in medicine. *California Medicine*, *94*, 252–256.
- Barber, J. P., Crits-Christoph, P., & Luborsky, L. (1996). Effects of therapist adherence and competence on patient outcome in brief dynamic therapy. *Journal of Consulting and Clinical Psychology*, *64*, 619–622. <http://dx.doi.org/10.1037/0022-006X.64.3.619>
- Barth, J., Munder, T., Gerger, H., Nüesch, E., Trelle, S., Znoj, H., . . . Cuijpers, P. (2013). Comparative efficacy of seven psychotherapeutic interventions for patients with depression: A network meta-analysis. *PLoS Medicine*, *10*, e1001454. <http://dx.doi.org/10.1371/journal.pmed.1001454>
- Baskin, T. W., Tierney, S. C., Minami, T., & Wampold, B. E. (2003). Establishing specificity in psychotherapy: A meta-analysis of structural equivalence of placebo controls. *Journal of Consulting and Clinical Psychology*, *71*, 973–979. <http://dx.doi.org/10.1037/0022-006X.71.6.973>
- Beecher, H. K. (1955). The powerful placebo. *Journal of the American Medical Association*, *159*, 1602–1606. <http://dx.doi.org/10.1001/jama.1955.02960340022006>
- Benedetti, F. (2009). *Placebo effects. Understanding the mechanisms in health and disease*. New York, NY: Oxford University Press.
- Bisson, J. I., Roberts, N. P., Andrew, M., Cooper, R., & Lewis, C. (2013). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. *Cochrane Database of Systematic Reviews*, *12*, CD003388.
- Bleasé, C. (2011). Deception as treatment: The case of depression. *Journal of Medical Ethics*, *37*, 13–16. <http://dx.doi.org/10.1136/jme.2010.039313>
- Bleasé, C. (2012). The principle of parity: The ‘placebo effect’ and physician communication. *Journal of Medical Ethics*, *38*, 199–203. <http://dx.doi.org/10.1136/medethics-2011-100177>
- Bleasé, C. R. (2013). Electroconvulsive therapy, the placebo effect and informed consent. *Journal of Medical Ethics*, *39*, 166–170. <http://dx.doi.org/10.1136/medethics-2012-100955>
- Bleasé, C. (2014). The duty to be well-informed: The case of depression. *Journal of Medical Ethics*, *40*, 225–229. <http://dx.doi.org/10.1136/medethics-2012-101122>
- Bleasé, C. R. (2015). Talking more about talking cures: Cognitive behavioural therapy and informed consent. *Journal of Medical Ethics*. Advance online publication. <http://dx.doi.org/10.1136/medethics-2014-102641>
- Bleasé, C. (in press). Informed consent, the placebo effect, and psychodynamic psychotherapy. In T. Schramme (Ed.), *New perspectives on medical paternalism*. London, UK: Springer-Verlag. http://dx.doi.org/10.1007/978-3-319-17960-5_11
- Bok, S. (1974, November 24). Deceptive use of placebos challenges medical ethics. *Los Angeles Times*, J1.
- Borkovec, T. D., & Nau, S. D. (1972). Credibility of analogue therapy rationales. *Journal of Behavior Therapy and Experimental Psychiatry*, *3*, 257–260. [http://dx.doi.org/10.1016/0005-7916\(72\)90045-6](http://dx.doi.org/10.1016/0005-7916(72)90045-6)
- Borkovec, T. D., & Sibrava, N. J. (2005). Problems with the use of placebo conditions in psychotherapy research, suggested alternatives, and some strategies for the pursuit of the placebo phenome-

- non. *Journal of Clinical Psychology*, 61, 805–818. <http://dx.doi.org/10.1002/jclp.20127>
- Brody, H. (1980). *Placebos and the philosophy of medicine: Clinical, conceptual, and ethical issues*. Chicago, IL: Chicago University Press.
- Brown, H. A. (1973). Role of expectancy manipulation in systematic desensitization. *Journal of Consulting and Clinical Psychology*, 41, 405–411. <http://dx.doi.org/10.1037/h0035382>
- Bundesärztekammer. (Ed.). (2011). *Placebo in der Medizin*. Köln, Deutschland: Deutscher Ärzte-Verlag. http://www.bundesaerztekammer.de/downloads/Placebo_LF_1_17012011.pdf
- Clark, D. M. (2013). Psychodynamic therapy or cognitive therapy for social anxiety disorder. *The American Journal of Psychiatry*, 170, 1365. <http://dx.doi.org/10.1176/appi.ajp.2013.13060744>
- Colloca, L., Lopiano, L., Lanotte, M., & Benedetti, F. (2004). Overt versus covert treatment for pain, anxiety, and Parkinson's disease. *Lancet Neurology*, 3, 679–684. [http://dx.doi.org/10.1016/S1474-4422\(04\)00908-1](http://dx.doi.org/10.1016/S1474-4422(04)00908-1)
- Critelli, J. W., & Neumann, K. F. (1984). The placebo. Conceptual analysis of a construct in transition. *American Psychologist*, 39, 32–39. <http://dx.doi.org/10.1037/0003-066X.39.1.32>
- Cuijpers, P., Driessen, E., Hollon, S. D., van Oppen, P., Barth, J., & Andersson, G. (2012). The efficacy of non-directive supportive therapy for adult depression: A meta-analysis. *Clinical Psychology Review*, 32, 280–291. <http://dx.doi.org/10.1016/j.cpr.2012.01.003>
- Cuijpers, P., Turner, E. H., Mohr, D. C., Hofmann, S. G., Andersson, G., Berking, M., & Coyne, J. (2014). Comparison of psychotherapies for adult depression to pill placebo control groups: A meta-analysis. *Psychological Medicine*, 44, 685–695. <http://dx.doi.org/10.1017/S0033291713000457>
- Desharnais, R., Jobin, J., Côté, C., Lévesque, L., & Godin, G. (1993). Aerobic exercise and the placebo effect: A controlled study. *Psychosomatic Medicine*, 55, 149–154. <http://dx.doi.org/10.1097/00006842-199303000-00003>
- Dour, H. J., Chorpita, B. F., Lee, S., & Weisz, J. R., & the Research Network on Youth Mental Health. (2013). Sudden gains as a long-term predictor of treatment improvement among children in community mental health organizations. *Behaviour Research and Therapy*, 51, 564–572. <http://dx.doi.org/10.1016/j.brat.2013.05.012>
- Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2011). *The heart and soul of change* (2nd ed.). Washington, DC: American Psychological Association.
- D'Zurilla, T. J., Wilson, G. T., & Nelson, R. N. (1973). A preliminary study of the effectiveness of graduated prolonged exposure in the treatment of irrational fear. *Behavior Therapy*, 4, 672–685. [http://dx.doi.org/10.1016/S0005-7894\(73\)80159-5](http://dx.doi.org/10.1016/S0005-7894(73)80159-5)
- Enck, P., Bingel, U., Schedlowski, M., & Rief, W. (2013). The placebo response in medicine: Minimize, maximize or personalize? *Nature Reviews Drug Discovery*, 12, 191–204. <http://dx.doi.org/10.1038/nrd3923>
- Enserink, M. (1999). Can the placebo be the cure? *Science*, 284, 238–240. <http://dx.doi.org/10.1126/science.284.5412.238>
- Enserink, M. (2000a). Bioethics. Helsinki's new clinical rules: Fewer placebos, more disclosure. *Science*, 290, 418–419. <http://dx.doi.org/10.1126/science.290.5491.418>
- Enserink, M. (2000b). Psychiatry. Are placebo-controlled drug trials ethical? *Science*, 288, 416. <http://dx.doi.org/10.1126/science.288.5465.416a>
- Espie, C. A., Kyle, S. D., Miller, C. B., Ong, J., Hames, P., & Fleming, L. (2014). Attribution, cognition and psychopathology in persistent insomnia disorder: Outcome and mediation analysis from a randomized placebo-controlled trial of online cognitive behavioural therapy. *Sleep Medicine*, 15, 913–917. <http://dx.doi.org/10.1016/j.sleep.2014.03.001>
- Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, 16, 319–324. <http://dx.doi.org/10.1037/h0063633>
- Eysenck, H. J. (1994). The outcome problem in psychotherapy: What have we learned? *Behaviour Research and Therapy*, 32, 477–495. [http://dx.doi.org/10.1016/0005-7967\(94\)90135-X](http://dx.doi.org/10.1016/0005-7967(94)90135-X)
- Fässler, M., Meissner, K., Schneider, A., & Linde, K. (2010). Frequency and circumstances of placebo use in clinical practice—A systematic review of empirical studies. *BMC Medicine*, 8, 15. <http://dx.doi.org/10.1186/1741-7015-8-15>
- Fellner, C. H. (1958). Tranquilizing drugs in general practice or the triumph of the impure placebo. *American Practitioner and Digest of Treatment*, 9, 1265–1268.
- Finniss, D. G., Kaptchuk, T. J., Miller, F., & Benedetti, F. (2010). Biological, clinical, and ethical advances of placebo effects. *Lancet*, 375, 686–695. [http://dx.doi.org/10.1016/S0140-6736\(09\)61706-2](http://dx.doi.org/10.1016/S0140-6736(09)61706-2)
- Fish, J. M. (1973). *Placebo therapy—A practical guide to social influence in psychotherapy*. San Francisco, CA: Jossey-Bass.
- Flückiger, C., Del Re, A. C., Wampold, B. E., Symonds, D., & Horvath, A. O. (2012). How central is the alliance in psychotherapy? A multilevel longitudinal meta-analysis. *Journal of Counseling Psychology*, 59, 10–17. <http://dx.doi.org/10.1037/a0025749>
- Foa, E., Keane, T., Friedman, M., & Cohen, J. (2009). *Effective treatments for PTSD: Practice guidelines from the International Society for Trau-*

- matic Stress* (2nd ed.). New York, NY: Guilford Press.
- Foddy, B. (2009). A duty to deceive: Placebos in clinical practice. *The American Journal of Bioethics*, *9*, 4–12. <http://dx.doi.org/10.1080/15265160903318350>
- Frank, J. D. (1986). Psychotherapy—The transformation of meanings: Discussion paper. *Journal of the Royal Society of Medicine*, *79*, 341–346.
- Franklin, B., Majault, Le Roy, Sallin, Bailly, J. S., D'Arcet, . . . Lavoisier, A. (2002). Report of the commissioners charged by the King with the examination of animal magnetism. *International Journal of Clinical and Experimental Hypnosis*, *50*, 332–363. <http://dx.doi.org/10.1080/00207140208410109>
- Frost, N. D., Laska, K. M., & Wampold, B. E. (2014). The evidence for present-centered therapy as a treatment for posttraumatic stress disorder. *Journal of Traumatic Stress*, *27*, 1–8. <http://dx.doi.org/10.1002/jts.21881>
- Geers, A. L., & Miller, F. G. (2014). Understanding and translating the knowledge about placebo effects: The contribution of psychology. *Current Opinion in Psychiatry*, *27*, 326–331. <http://dx.doi.org/10.1097/YCO.0000000000000082>
- Gerger, H., Munder, T., & Barth, J. (2014). Specific and nonspecific psychological interventions for PTSD symptoms: A meta-analysis with problem complexity as a moderator. *Journal of Clinical Psychology*, *70*, 601–615. <http://dx.doi.org/10.1002/jclp.22059>
- Goldapple, K., Segal, Z., Garson, C., Lau, M., Bieling, P., Kennedy, S., & Mayberg, H. (2004). Modulation of cortical-limbic pathways in major depression: Treatment-specific effects of cognitive behavior therapy. *Archives of General Psychiatry*, *61*, 34–41. <http://dx.doi.org/10.1001/archpsyc.61.1.34>
- Goldfried, M. R. (2013). What should we expect from psychotherapy? *Clinical Psychology Review*, *33*, 862–869. <http://dx.doi.org/10.1016/j.cpr.2013.05.003>
- Grünbaum, A. (1981). The placebo concept. *Behaviour Research and Therapy*, *19*, 157–167. [http://dx.doi.org/10.1016/0005-7967\(81\)90040-1](http://dx.doi.org/10.1016/0005-7967(81)90040-1)
- Grünbaum, A. (1986). The placebo concept in medicine and psychiatry. *Psychological Medicine*, *16*, 19–38. <http://dx.doi.org/10.1017/S0033291700002506>
- Henry, W. P., Schacht, T. E., Strupp, H. H., Butler, S. F., & Binder, J. L. (1993). Effects of training in time-limited dynamic psychotherapy: Mediators of therapists' responses to training. *Journal of Consulting and Clinical Psychology*, *61*, 441–447. <http://dx.doi.org/10.1037/0022-006X.61.3.441>
- Herbert, J. D., & Gaudiano, B. A. (2005). Moving from empirically supported treatment lists to practice guidelines in psychotherapy: The role of the placebo concept. *Journal of Clinical Psychology*, *61*, 893–908. <http://dx.doi.org/10.1002/jclp.20133>
- Hofmann, S. G., & Barlow, D. H. (2014). Evidence-based psychological interventions and the common factors approach: The beginnings of a rapprochement? *Psychotherapy*, *51*, 510–513. <http://dx.doi.org/10.1037/a0037045>
- Hollon, S. D., Stewart, M. O., & Strunk, D. (2006). Enduring effects for cognitive behavior therapy in the treatment of depression and anxiety. *Annual Review of Psychology*, *57*, 285–315. <http://dx.doi.org/10.1146/annurev.psych.57.102904.190044>
- Hollon, S. D., & Wampold, B. E. (2009). Are randomized controlled trials relevant to clinical practice? *Canadian Journal of Psychiatry*, *54*, 637–643.
- Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *The Canadian Journal of Psychiatry / La Revue canadienne de psychiatrie*, *38*, 139–149. <http://dx.doi.org/10.1037/0022-0167.38.2.139>
- Hróbjartsson, A., & Gøtzsche, P. C. (2001). Is the placebo powerless? An analysis of clinical trials comparing placebo with no treatment. *The New England Journal of Medicine*, *344*, 1594–1602. <http://dx.doi.org/10.1056/NEJM200105243442106>
- Hyland, M. E. (2011). Motivation and placebos: Do different mechanisms occur in different contexts? *Philosophical Transactions of the Royal Society of London Series B, Biological Sciences*, *366*, 1828–1837. <http://dx.doi.org/10.1098/rstb.2010.0391>
- Jopling, D. A. (2001). Placebo insight: The rationality of insight-oriented psychotherapy. *Journal of Clinical Psychology*, *57*, 19–36. [http://dx.doi.org/10.1002/1097-4679\(200101\)57:1<19::AID-JCLP4>3.0.CO;2-Z](http://dx.doi.org/10.1002/1097-4679(200101)57:1<19::AID-JCLP4>3.0.CO;2-Z)
- Jopling, D. A. (2008). *Talking cures and placebo effects*. Oxford, UK: Oxford University Press. <http://dx.doi.org/10.1093/med/9780199239504.001.0001>
- Justman, S. (2011a). From medicine to psychotherapy: The placebo effect. *History of the Human Sciences*, *24*, 95–107. <http://dx.doi.org/10.1177/0952695110386655>
- Justman, S. (2011b). The power of rhetoric: Two healing movements. *The Yale Journal of Biology and Medicine*, *84*, 15–25.
- Kanaan, R. (2009). When doctors deceive. *The American Journal of Bioethics*, *9*, 29–30. <http://dx.doi.org/10.1080/15265160903234102>
- Kapitza, K. P., Passie, T., Bernateck, M., & Karst, M. (2010). First non-contingent respiratory biofeedback placebo versus contingent biofeedback in patients with chronic low back pain: A randomized, controlled, double-blind trial. *Applied Psychophys-*

- iology and Biofeedback*, 35, 207–217. <http://dx.doi.org/10.1007/s10484-010-9130-1>
- Kaptchuk, T. J. (1998). Powerful placebo: The dark side of the randomised controlled trial. *Lancet*, 351, 1722–1725. [http://dx.doi.org/10.1016/S0140-6736\(97\)10111-8](http://dx.doi.org/10.1016/S0140-6736(97)10111-8)
- Kaptchuk, T. J., Friedlander, E., Kelley, J. M., Sanchez, M. N., Kokkotou, E., Singer, J. P., . . . Lembo, A. J. (2010). Placebos without deception: A randomized controlled trial in irritable bowel syndrome. *PLoS ONE*, 5, e15591. <http://dx.doi.org/10.1371/journal.pone.0015591>
- Kaptchuk, T. J., Kelley, J. M., Conboy, L. A., Davis, R. B., Kerr, C. E., Jacobson, E. E., . . . Lembo, A. J. (2008). Components of placebo effect: Randomised controlled trial in patients with irritable bowel syndrome. *BMJ: British Medical Journal*, 336, 999–1003. <http://dx.doi.org/10.1136/bmj.39524.439618.25>
- Kazdin, A. E. (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American Psychologist*, 63, 146–159. <http://dx.doi.org/10.1037/0003-066X.63.3.146>
- Kazdin, A. E., & Wilcoxon, L. A. (1976). Systematic desensitization and nonspecific treatment effects: A methodological evaluation. *Psychological Bulletin*, 83, 729–758. <http://dx.doi.org/10.1037/0033-2909.83.5.729>
- Kelley, J. M., Kaptchuk, T. J., Cusin, C., Lipkin, S., & Fava, M. (2012). Open-label placebo for major depressive disorder: A pilot randomized controlled trial. *Psychotherapy and Psychosomatics*, 81, 312–314. <http://dx.doi.org/10.1159/000337053>
- Kelley, J. M., Kraft-Todd, G., Schapira, L., Kosowsky, J., & Riess, H. (2014). The influence of the patient-clinician relationship on healthcare outcomes: A systematic review and meta-analysis of randomized controlled trials. *PLoS ONE*, 9, e94207. <http://dx.doi.org/10.1371/journal.pone.0094207>
- Kihlstrom, J. F. (2002). Mesmer, the Franklin Commission, and hypnosis: A counterfactual essay. *International Journal of Clinical and Experimental Hypnosis*, 50, 407–419. <http://dx.doi.org/10.1080/00207140208410114>
- Kim, S., Wollburg, E., & Roth, W. T. (2012). Opposing breathing therapies for panic disorder: A randomized controlled trial of lowering vs raising end-tidal P(CO₂). *Journal of Clinical Psychiatry*, 73, 931–939. <http://dx.doi.org/10.4088/JCP.11m07068>
- Kirsch, I. (1994). Clinical hypnosis as a nondeceptive placebo: Empirically derived techniques. *American Journal of Clinical Hypnosis*, 37, 95–106. <http://dx.doi.org/10.1080/00029157.1994.10403122>
- Kirsch, I. (2005). Placebo psychotherapy: Synonym or oxymoron? *Journal of Clinical Psychology*, 61, 791–803. <http://dx.doi.org/10.1002/jclp.20126>
- Kirsch, I. (2010). *The emperor's new drugs: Exploding the antidepressant myth*. New York, NY: Basic Books.
- Kirsch, I., & Henry, D. (1977). Extinction versus credibility in the desensitization of speech anxiety. *Journal of Consulting and Clinical Psychology*, 45, 1052–1059. <http://dx.doi.org/10.1037/0022-006X.45.6.1052>
- Kirsch, I., Mazzoni, G., & Montgomery, G. H. (2007). Remembrance of hypnosis past. *American Journal of Clinical Hypnosis*, 49, 171–178. <http://dx.doi.org/10.1080/00029157.2007.10401574>
- Klein, D. F. (1996). Preventing hung juries about therapy studies. *Journal of Consulting and Clinical Psychology*, 64, 81–87. <http://dx.doi.org/10.1037/0022-006X.64.1.81>
- Kleinman, I., Brown, P., & Librach, L. (1994). Placebo pain medication: Ethical and practical considerations. *Archives of Family Medicine*, 3, 453–457. <http://dx.doi.org/10.1001/archfami.3.5.453>
- Klintwall, L., Gillberg, C., Bölte, S., & Fernell, E. (2012). The efficacy of intensive behavioral intervention for children with autism: A matter of allegiance? *Journal of Autism and Developmental Disorders*, 42, 139–140. <http://dx.doi.org/10.1007/s10803-011-1223-z>
- Kolden, G. G., Klein, M. H., Wang, C. C., & Austin, S. B. (2011). Congruence/genuineness. *Psychotherapy*, 48, 65–71. <http://dx.doi.org/10.1037/a0022064>
- Krupnick, J. L., Sotsky, S. M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., & Pilkonis, P. A. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology*, 64, 532–539. <http://dx.doi.org/10.1037/0022-006X.64.3.532>
- Lambert, M. J. (2013). Outcome in psychotherapy: The past and important advances. *Psychotherapy*, 50, 42–51. <http://dx.doi.org/10.1037/a0030682>
- Lang, P. J. (1988). Fear, anxiety, and panic: Context, cognition, and visceral arousal. In S. Rachman & J. D. Maser (Eds.), *Panic: Psychological perspectives* (pp. 219–236). Hillsdale, NJ: Erlbaum.
- Lansbergen, M. M., van Dongen-Boomsma, M., Buitelaar, J. K., & Slaats-Willemse, D. (2011). ADHD and EEG-neurofeedback: A double-blind randomized placebo-controlled feasibility study. *Journal of Neural Transmission*, 118, 275–284. <http://dx.doi.org/10.1007/s00702-010-0524-2>
- Leichsenring, F., Salzer, S., Beutel, M. E., Herpertz, S., Hiller, W., Hoyer, J., . . . Leibing, E. (2014). Long-term outcome of psychodynamic therapy

- and cognitive-behavioral therapy in social anxiety disorder. *The American Journal of Psychiatry*, *171*, 1074–1082. <http://dx.doi.org/10.1176/appi.ajp.2014.13111514>
- Leichsenring, F., Salzer, S., & Leibing, E. (2013). Response to Clark. *The American Journal of Psychiatry*, *170*, 1365–1366. <http://dx.doi.org/10.1176/appi.ajp.2013.13060744r>
- Leykin, Y., & DeRubeis, R. J. (2009). Allegiance in psychotherapy outcome research: Separating association from bias. *Clinical Psychology: Science and Practice*, *16*, 54–65. <http://dx.doi.org/10.1111/j.1468-2850.2009.01143.x>
- Lichtenberg, P., Heresco-Levy, U., & Nitzan, U. (2004). The ethics of the placebo in clinical practice. *Journal of Medical Ethics*, *30*, 551–554. <http://dx.doi.org/10.1136/jme.2002.002832>
- Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science*, *2*, 53–70. <http://dx.doi.org/10.1111/j.1745-6916.2007.00029.x>
- Lund, K., Vase, L., Petersen, G. L., Jensen, T. S., & Finnerup, N. B. (2014). Randomised controlled trials may underestimate drug effects: Balanced placebo trial design. *PLoS ONE*, *9*, e84104. <http://dx.doi.org/10.1371/journal.pone.0084104>
- Marcia, J. E., Rubin, B. M., & Efran, J. S. (1969). Systematic desensitization: Expectancy change or counterconditioning? *Journal of Abnormal Psychology*, *74*, 382–387. <http://dx.doi.org/10.1037/h0027596>
- Marcus, D. K., O'Connell, D., Norris, A. L., & Sawaqdeh, A. (2014). Is the Dodo bird endangered in the 21st century? A meta-analysis of treatment comparison studies. *Clinical Psychology Review*, *34*, 519–530.
- Mayberg, H. S., Silva, J. A., Brannan, S. K., Tekell, J. L., Mahurin, R. K., McGinnis, S., & Jerabek, P. A. (2002). The functional neuroanatomy of the placebo effect. *The American Journal of Psychiatry*, *159*, 728–737. <http://dx.doi.org/10.1176/appi.ajp.159.5.728>
- McGlynn, F. D., Smitherman, T. A., & Gothard, K. D. (2004). Comment on the status of systematic desensitization. *Behavior Modification*, *28*, 194–205. <http://dx.doi.org/10.1177/0145445503259414>
- McLeod, B. D. (2009). Understanding why therapy allegiance is linked to clinical outcomes. *Clinical Psychology: Science and Practice*, *16*, 69–72. <http://dx.doi.org/10.1111/j.1468-2850.2009.01145.x>
- McNally, R. J. (1999). EMDR and Mesmerism: A comparative historical analysis. *Journal of Anxiety Disorders*, *13*, 225–236. [http://dx.doi.org/10.1016/S0887-6185\(98\)00049-8](http://dx.doi.org/10.1016/S0887-6185(98)00049-8)
- McNally, R. J. (2001). On the scientific status of cognitive appraisal models of anxiety disorder. *Behaviour Research and Therapy*, *39*, 513–521. [http://dx.doi.org/10.1016/S0005-7967\(00\)00073-5](http://dx.doi.org/10.1016/S0005-7967(00)00073-5)
- McReynolds, W. T., Barnes, A. R., Brooks, S., & Rehagen, N. J. (1973). The role of attention-placebo influences in the efficacy of systematic desensitization. *Journal of Consulting and Clinical Psychology*, *41*, 86–92. <http://dx.doi.org/10.1037/h0035622>
- Meissner, K., Höfner, L., Fässler, M., & Linde, K. (2012). Widespread use of pure and impure placebo interventions by GPs in Germany. *Family Practice*, *29*, 79–85. <http://dx.doi.org/10.1093/fampra/cmz045>
- Miller, S., Wampold, B., & Varhely, K. (2008). Direct comparisons of treatment modalities for youth disorders: A meta-analysis. *Psychotherapy Research*, *18*, 5–14. <http://dx.doi.org/10.1080/10503300701472131>
- Moerman, D. E., & Jonas, W. B. (2002). Deconstructing the placebo effect and finding the meaning response. *Annals of Internal Medicine*, *136*, 471–476. <http://dx.doi.org/10.7326/0003-4819-136-6-200203190-00011>
- Munder, T., Flückiger, C., Gerger, H., Wampold, B. E., & Barth, J. (2012). Is the allegiance effect an epiphenomenon of true efficacy differences between treatments? a meta-analysis. *Journal of Counseling Psychology*, *59*, 631–637. <http://dx.doi.org/10.1037/a0029571>
- Munder, T., Gerger, H., Trelle, S., & Barth, J. (2011). Testing the allegiance bias hypothesis: A meta-analysis. *Psychotherapy Research*, *21*, 670–684. <http://dx.doi.org/10.1080/10503307.2011.602752>
- Norcross, J. C. (2011). *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.). New York, NY: Oxford University Press. <http://dx.doi.org/10.1093/acprof:oso/9780199737208.001.0001>
- Nuhn, T., Lüdtke, R., & Geraedts, M. (2010). Placebo effect sizes in homeopathic compared to conventional drugs - a systematic review of randomised controlled trials. *Homeopathy*, *99*, 76–82. <http://dx.doi.org/10.1016/j.homp.2009.11.002>
- Paul, G. L. (1967). Insight versus desensitization in psychotherapy two years after termination. *Journal of Consulting Psychology*, *31*, 333–348. <http://dx.doi.org/10.1037/h0024855>
- Pentony, P. (1981). *Models of influence in psychotherapy*. New York, NY: Free Press.
- Rawlinson, M. (1985). Truth-telling and paternalism in the clinic: Philosophical reflections on the use of placebos in medical practice. In L. White, B. Turisky, & G. Schwartz (Eds.), *Placebo: Theory, research and mechanisms*. New York, NY: Guilford Press.
- Raz, A., Harris, C. S., de Jong, V., & Braude, H. (2009). Is there a place for (deceptive) placebos within clinical practice? *The American Journal of*

- Bioethics*, 9, 52–54. <http://dx.doi.org/10.1080/15265160903320455>
- Rosen, G. M., & Davison, G. C. (2003). Psychology should list empirically supported principles of change (ESPs) and not credential trademarked therapies or other treatment packages. *Behavior Modification*, 27, 300–312. <http://dx.doi.org/10.1177/0145445503027003003>
- Rosenthal, D., & Frank, J. D. (1956). Psychotherapy and the placebo effect. *Psychological Bulletin*, 53, 294–302. <http://dx.doi.org/10.1037/h0044068>
- Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, 6, 412–415. <http://dx.doi.org/10.1111/j.1939-0025.1936.tb05248.x>
- Roth, W. T., Wilhelm, F. H., & Pettit, D. (2005). Are current theories of panic falsifiable? *Psychological Bulletin*, 131, 171–192. <http://dx.doi.org/10.1037/0033-2909.131.2.171>
- Sandler, A. D., Glesne, C. E., & Bodfish, J. W. (2010). Conditioned placebo dose reduction: A new treatment in attention-deficit hyperactivity disorder? *Journal of Developmental and Behavioral Pediatrics*, 31, 369–375. <http://dx.doi.org/10.1097/DBP.0b013e3181e121ed>
- Schwab, A. P. (2009). When subtle deception turns into an outright lie. *The American Journal of Bioethics*, 9, 30–32. <http://dx.doi.org/10.1080/15265160903234128>
- Serfaty, M., Csipke, E., Haworth, D., Murad, S., & King, M. (2011). A talking control for use in evaluating the effectiveness of cognitive-behavioral therapy. *Behaviour Research and Therapy*, 49, 433–440. <http://dx.doi.org/10.1016/j.brat.2011.05.005>
- Serfaty, M. A., Haworth, D., Blanchard, M., Buszewicz, M., Murad, S., & King, M. (2009). Clinical effectiveness of individual cognitive behavioral therapy for depressed older people in primary care: A randomized controlled trial. *Archives of General Psychiatry*, 66, 1332–1340. <http://dx.doi.org/10.1001/archgenpsychiatry.2009.165>
- Shah, K. R., & Goold, S. D. (2009). The primacy of autonomy, honesty, and disclosure—Council on Ethical and Judicial Affairs' placebo opinions. *The American Journal of Bioethics*, 9, 15–17. <http://dx.doi.org/10.1080/15265160903316339>
- Shapiro, A. K., & Morris, L. A. (1978). The placebo effect in medical and psychological therapies. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (2nd ed.). New York, NY: Wiley.
- Shapiro, A. K., & Shapiro, E. (1997). *The powerful placebo: From ancient priest to modern physician*. Baltimore, MD: John Hopkins University Press.
- Shorter, E. (1997). *A history of psychiatry: From the era of the asylum to the age of Prozac*. New York, NY: Wiley.
- Steinmark, S. W., & Borkovec, T. D. (1974). Active and placebo treatment effects on moderate insomnia under counterdemand and positive demand instructions. *Journal of Abnormal Psychology*, 83, 157–163. <http://dx.doi.org/10.1037/h0036489>
- Swift, J. K., & Callahan, J. L. (2010). A comparison of client preferences for intervention empirical support versus common therapy variables. *Journal of Clinical Psychology*, 66, 1217–1231. <http://dx.doi.org/10.1002/jclp.20720>
- Swift, J. K., Callahan, J. L., & Vollmer, B. M. (2011). Preferences. *Journal of Clinical Psychology*, 67, 155–165. <http://dx.doi.org/10.1002/jclp.20759>
- Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology*, 80, 547–559. <http://dx.doi.org/10.1037/a0028226>
- Tasca, G. A., Sylvestre, J., Balfour, L., Chyurlia, L., Evans, J., Fortin-Langelier, B., . . . Wilson, B. (2015). What clinicians want: Findings from a psychotherapy practice research network survey. *Psychotherapy*, 52, 1–11. <http://dx.doi.org/10.1037/a0038252>
- Tori, C., & Worell, L. (1973). Reduction of human avoidant behavior: A comparison of counterconditioning, expectancy, and cognitive information approaches. *Journal of Consulting and Clinical Psychology*, 41, 269–278. <http://dx.doi.org/10.1037/h0035177>
- Tryon, W. W. (2005). Possible mechanisms for why desensitization and exposure therapy work. *Clinical Psychology Review*, 25, 67–95. <http://dx.doi.org/10.1016/j.cpr.2004.08.005>
- Turner, E. H., Matthews, A. M., Linardatos, E., Tell, R. A., & Rosenthal, R. (2008). Selective publication of antidepressant trials and its influence on apparent efficacy. *The New England Journal of Medicine*, 358, 252–260. <http://dx.doi.org/10.1056/NEJMsa065779>
- Ulvenes, P. G., Berggraf, L., Hoffart, A., Stiles, T. C., Svartberg, M., McCullough, L., & Wampold, B. E. (2012). Different processes for different therapies: Therapist actions, therapeutic bond, and outcome. *Psychotherapy*, 49, 291–302. <http://dx.doi.org/10.1037/a0027895>
- Walach, H. (2001). Das Wirksamkeitsparadox in der Komplementärmedizin [The effectiveness paradox in complementary medicine]. *Forschung Komplementärmedizin und Klassische Naturheilkunde*, 8, 193–195. <http://dx.doi.org/10.1159/000057221>
- Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *American Psychol-*

- ogist*, 62, 857–873. <http://dx.doi.org/10.1037/0003-066X.62.8.857>
- Wampold, B. E., & Budge, S. L. (2012). The 2011 Leona Tyler Award Address: The relationship—and its relationship to the common and specific factors of psychotherapy. *The Counseling Psychologist*, 40, 601–623. <http://dx.doi.org/10.1177/0011000011432709>
- Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: Models, methods, and findings* (2nd ed.). New York, NY: Routledge.
- Wampold, B. E., Imel, Z. E., Laska, K. M., Benish, S., Miller, S. D., Flückiger, C., . . . Budge, S. (2010). Determining what works in the treatment of PTSD. *Clinical Psychology Review*, 30, 923–933. <http://dx.doi.org/10.1016/j.cpr.2010.06.005>
- Wampold, B. E., Minami, T., Tierney, S. C., Baskin, T. W., & Bhati, K. S. (2005). The placebo is powerful: Estimating placebo effects in medicine and psychotherapy from randomized clinical trials. *Journal of Clinical Psychology*, 61, 835–854. <http://dx.doi.org/10.1002/jclp.20129>
- Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. N. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, “all must have prizes. *Psychological Bulletin*, 122, 203–215. <http://dx.doi.org/10.1037/0033-2909.122.3.203>

Received December 5, 2014

Revision received March 27, 2015

Accepted June 2, 2015 ■