Maximizing The Placebo Effect
Strategies Founded in Research
By Mark E. Liskey
Here’s a little quiz for you. As a bodyworker, you enhance your client’s healing process because a) your modality is appropriate for the problem, b) you apply the modality correctly, or c) the client trusts you. The answer? All of the above. However, trust—the rapport between bodyworker and client—is sometimes overlooked as part of the healing process. By taking specific steps to build rapport in the therapeutic relationship, you can begin to access your client’s ancient healing response through what is commonly known as the placebo effect.

The placebo effect—any positive, therapeutic response elicited by a non-active substance (sugar pill) or an environmental agent (bodyworker)—was once thought to be a purely psychological phenomenon, meaning the effects were in the mind. To the contrary, a recent brain scan study by Zubieta et al. (2005) revealed association between a placebo intervention and physiological changes in the brain. In this study, pain was produced in the jaws of volunteers by injecting salt water. Concurrently, positron emission tomography was used to monitor brain endorphin activity. At one point, when volunteers received a placebo they were told was a pain killer, nine of fourteen participants reported a reduction in pain. Brain scans of these nine subjects showed increased endorphin activity in areas of the brain associated with pain, and the increase occurred immediately after subjects were told pain relief was on the way.

Despite these findings, many remain ambivalent about the benefits of the placebo response. After all, in drug studies the placebo effect is often seen as an embarrassing misapplication of belief—the participant thought the sugar pill was real medicine. Other times it’s considered a character flaw, as in the case of the person who falls prey to the messianic health expert. But the placebo effect is far more than a nuisance for drug companies and an embarrassment for sugar pill responders. In the words of the late placebo researcher Arthur Shapiro: “When we examine the long history of medicine, it (the placebo effect) is the only common denominator between the Egyptian physician who prescribed crocodile dung and the modern physician who prescribes penicillin. Moreover, its effectiveness has been attested to, without exception, for more than two millennia.” In that light, placebos can be viewed as the basis of our medicinal history and the placebo effect as part of our healing potential.

The Power of Belief

In his essay, “Placebo, Pain, and Belief: A Biocultural Model,” scholar David Morris gives us insight into the workings of the placebo effect. Healing rituals in Native American societies were often elaborate and stakes were high. A shaman could become wealthy if successful, but could also lose his life if his treatment failed. The success of a shaman’s medicine—excluding effective herbs and certain wound care techniques—was largely due to the placebo effect, triggered by the shaman/patient relationship. With both the sick and the healer believing the disease was a product of the supernatural, it would follow that performing rituals with the shaman acting as medium between the material and spiritual world could reverse the disease. Extending this observation back thousands of years, Morris posits that those who had placebo “pathways” made accessible by belief in supernatural causality and ritualistic healing of disease would have a biological advantage in healing over those who did not.

In connection to this idea of the power of belief, placebo theorist Irving Kirsch says the placebo effect is regulated by one’s expectations (expectancy theory), which are formed from one’s beliefs or perceptions.
Expectancy can be informed by a cultural belief and/or acquired through conditioning experiences. For example, JoAnn lives in a culture that values the therapeutic use of pills. When JoAnn takes an aspirin, her headache always goes away. Unconsciously, she observes or perceives the aspirin has worked. If that pill was a sugar pill, she would still expect the headache to go away. Kirsch also contends that expectancies are acquired through daily life experiences, like reading and watching others, and that “the effect of placebos depends on the strength of the person’s expectancies, not on how they were formed.”

The therapeutic relationship is not an expectancy per se, but it can influence the strength of an expectancy, which in turn can influence the placebo response. By applying the latest research to Kirsch’s premise—beliefs inform expectancies and expectancies lead to placebo responses—a practitioner/client schematic rich in placebo response potential can be developed.

**The Effective Therapeutic Relationship**

What bodyworker doesn’t take a deep breath when a chronic-pain sufferer, like our imaginary client Lee, walks through the front door? Lee has formed negative beliefs around his pain—nothing has worked so far and probably nothing will. A study by I.E. Lame has shown the quality of life of a person experiencing chronic pain is affected more by beliefs about pain than by the pain’s intensity. Ultimately, a bodyworker must address a client’s narrative—a story that contains the client’s beliefs about his pain.

Unlike psychologists, bodyworkers are not trained to alter negative narratives, but we can adopt strategies that promote positive placebo responses, in turn altering negative narratives. Howard Brody, MD, offers three such strategies: 1) show care and concern, 2) provide a satisfactory explanation of illness, and 3) provide hope of mastery over symptoms.

**Care and Concern**

To be a bodyworker necessitates a desire to help others. But desire is an impetus, not a means to promote a placebo response. According to research from D.H. Novack, expressing care and concern to a client is one way to provide such means. Though seemingly obvious, this finding shouldn’t be taken lightly, especially when considering that an expression of care that elicits one person’s placebo response may inhibit another’s. Upon first meeting our client Lee, the bodyworker offers encouraging words, and Lee responds with a vacant stare. To Lee, the bodyworker’s positive manner shows a lack of sensitivity to his problem—he hurts. So how might she show care for her client who is weary of a cheery face?

Bodyworkers who facilitate healing don’t just touch, they also listen. Active listening is not only a way to improve comprehension skills; it’s a way to show care. To begin, the active listener must pay attention to what the speaker is saying. One way to focus is to repeat back the speaker’s response. When done ineffectively, this can sound like parroting—a simple and mechanical reiteration. Quality active listening involves the listener paraphrasing, putting into her own words, the essence of the speaker’s comments. Paraphrasing is most effective when the listener concentrates on complete meaning—both content and emotions of what is said. The bodyworker can then react to the emotional component of the speaker’s response when the speaker is trying to convey a feeling, and to content when the speaker is conveying factual information.

For example, Lee says, “My shoulder hurts and so does my back. They always hurt. Well, ever since I fell off the horse two years ago. But it doesn’t matter. I’ve always felt bad, long before that.” Sensing Lee’s exasperation, the bodyworker might respond, “I’m sorry you’ve felt so bad for so long. It must be very frustrating.” However, if Lee says, “My shoulder and back ache. What can you do about it?” the bodyworker might say, “I can lower your discomfort level. Which area hurts the worst, your shoulder or back?”

Shapiro’s research highlights two factors that increase positive expectations and show care and concern: seeing a client on time and giving a client an appointment within a week. A follow-up call to Lee, especially after his first session, is also in order, though possibly humbling to the bodyworker if Lee is no better or feeling worse. Even so, it presents an opportunity for reevaluation and demonstrates to Lee a deeper level of commitment.

**Satisfactory Explanation of the Illness**

In bodywork, a client’s diagnosis is helpful when it identifies a problem and a proven treatment is available to effectively resolve that problem, as with muscle strains and massage. However, a diagnosis can become a negative label (e.g., low-back pain sufferer) when the problem is not adequately defined and/or no one treatment resolves the symptoms. Novack’s study suggests negative labels add to the potential lessening or extinguishing of the placebo response.
When treating a client who identifies with a negative label, a careless practitioner might redefine the label so that the condition is treatable only through her particular discipline. For instance, chronic pain becomes a musculoskeletal disorder, only to be treated by neuromuscular therapy. A more balanced position is not to redefine the label, but rather defang it of negativity by offering the client a supplementary explanation of the condition.

Our client Lee had cortisone injections in his lower back a month ago, but the pain still wakes him up at night. When palpating Lee’s back, the bodyworker, in this case a neuromuscular therapist, finds tightness in the lumbar erectors on both sides. There are also many tender points up and down his back. At the end of the session, she summarizes her findings: “From my perspective, there is a muscular component to your pain cycle that I can help you with.” Pointing to a muscle chart, she says, “For instance, I’ve found tightness in your lower back and tender points in these specific areas.”

“I know the lower back is from my fall, but why the upper back?” Lee asks.

“After your fall, your muscles tightened around your injury. The mid- and upper-back tender points may have developed in compensation for a stiff lower back that no longer moved as it used to.”

Lee objects. “But that’s what I went to physical therapy for—to make my back function better.”

“No one approach works for all musculoskeletal pain problems. I’d like to relax your lower back with gentle massage before I start to concentrate on the tender points.”

The neuromuscular therapist begins by breaking down Lee’s symptoms. She then reins in the negative effect of the label—chronic pain sufferer—by explaining chronic pain as a combination of specific conditions, some treatable through neuromuscular therapy. In effect, she has begun to influence his negative pain narrative. Her concluding comments also keep the door open for other treatments, both alternative and mainstream, that could potentially help if neuromuscular therapy does not.

Hope of Mastery Over Symptoms

An acute-pain sufferer, like someone experiencing a sprained ankle, knows he’s going to get better. Steady improvements—less swelling and more flexibility in the ankle—reinforce the feeling of mastery over symptoms. But for chronic pain sufferers, “better” can seem distant. And for those who catastrophize, better may seem impossible. Lame’s study points to catastrophizing (which can lead to feelings of hopelessness and non-mastery of symptoms) as the number one predictor of quality of life. Negative expectations precipitated by catastrophizing can be offset by establishing incremental and attainable goals for the client.

Chronic pain sufferers may also catastrophize as a result of consistent pain spawning the feeling there will always be more pain. The bodyworker can reinforce feelings of improvement by pointing out when positive gains are made. Client-empowering techniques for relieving pain when massaging, like gently holding a tender point until pain lessens, enforce the idea that pain can go away. Teaching the client ways to self-massage, breathe, and manage pain at home also provide a sense of control. With each attempt successfully demonstrating that pain is manageable, the client is empowered and the therapeutic relationship strengthened. As a result, more placebo potential exists.

The Subtle Enhancer—Humility

A study by Jensen and Karoly suggests patients function better when they believe they are not severely disabled. Unfortunately, showing care and concern, providing a satisfactory explanation of the problem, and promoting hope for mastery over symptoms alone may not curb a client’s feeling of being disabled.

Adding humility can help. For the bodyworker, this may include a realization of her role limitations. If a chronic pain sufferer needs more emotional support than the practitioner/client relationship can provide, a support group with mechanisms in place to protect against an overage of negativity may be helpful, or the client can be referred out for psychological counseling. Contact information for preferred health practitioners, including physicians, physical therapists, chiropractors, and others, will extend the umbrella of personalized care.

It is possible for the health practitioner to maximize the placebo effect in unsafe ways—especially when a temporary placebo effect is thought to be a cure and a more effective course of action is overlooked. For example, a long-time client has developed a relatively new pain just below her scapula and deep into the intercostals. Thinking the pain is caused by poor work posture, the bodyworker massages the area and corrects ergonomic problems. The client has some relief, but it’s temporary. Still convinced she can undo the cause of her client’s pain, the bodyworker continues to treat her client unsuccessfully. For a while, because the therapeutic relationship is well established and the bodyworker was helpful in resolving other soft-tissue problems, non-improvement is overlooked, even
viewed as slow progress. After a year, with the pain undeniably worse, the client sees a physician and is found to have a tumor pressing up into the rib cage. By being connected to a broader community of health professionals, both alternative and mainstream, the body-worker can establish a sounding board of informed perspectives to safeguard against this type of mistake.

**The Placebo Effect in Modern Times**

Nineteenth-century German anthropologist Adolf Bastian sought help from a Guyana medicine man for his headache and fever. The healing ceremony took place at dusk in a lodge with no windows—the room was completely black—in the presence of approximately thirty natives. Bastian felt wind on his face when told spirits were flying. The sounds of various voices attributed to ghosts (the medicine man was a ventriloquist) soon became overbearing. The procedure lasted about six hours and ended dramatically when the medicine man placed his hands on Bastian’s face. Bastian arose, then complained that his headache persisted. At that point the medicine man pronounced him better and produced a caterpillar, the “problem,” that he had extracted from Bastian’s head.

Bastian, the outsider, complained that the healing ceremony didn’t cure his headache, but would a native Guyanan, with thirty fellow villagers witnessing the act, have done the same? It’s possible that ceremonies coupled with the threat of ostracism ensure the placebo effect goes unchallenged, allowing it to remain effective for many. If so, each culture would have a specific way (through its own unique stories, ceremonies, and rituals) to access the placebo effect.

In today’s multicultural society there is no one village, no one system of rules to maximize the placebo effect and discourage the voicing of incomplete or ineffective healing. Instead, the person in pain can choose among villages. The Trager village posits that gentle, rhythmic movements can release ingrained patterns of dysfunction, both mental and physical. The Rolfing village operates on the principle that a body realigned via manipulation of fascia will result in both physical and emotional well-being. The Pfrimmer village holds that precise and specific cross-fiber muscle treatment makes corrective changes at a cellular level.

Representing only one of the many healing modalities, a bodyworker may feel the need to convince the client she has come to the right village. Some come in already convinced, as is the case with a person who has experienced “X” type of bodywork for many years and is looking for an “X” practitioner. Others are far from convinced. Lee ended up in the neuromuscular therapist’s office because he was redeeming a gift certificate his wife won in a raffle, not because he had confidence in neuromuscular therapy. The person who seeks the “X” therapist seems primed for a placebo response since she expects “X” therapy to help her, whereas Lee, the unconvinced client, seems unlikely to have a placebo response. However, a placebo response may be elicited from the unconvinced if the bodyworker temporarily sets aside her belief in the village and embraces the healing potential of the placebo effect.

To expand this idea, we again look back in time. In terms of the therapeutic relationship as an agent of the placebo response, the ancient shaman had it easy because he didn’t have to deal with cultural diversity and varying belief systems. Imagine him treating Lee today, donning ritualistic animal pelts and a mask. Arguably, there could be a placebo effect prompted by the “mystery” of confronting a foreign healing paradigm. But ultimately, Lee isn’t connected to the shaman’s rituals or culture. In a less dramatic but still significant way, Lee isn’t connected to—is skeptical of—the neuromuscular therapist’s healing paradigm. If the therapist attempts to
convert Lee to her village, she risks nullifying therapeutic relationship factors, such as humility, that can lead to a placebo response. In addition, a strong pitch can alienate Lee completely, to the point he may never want to come back. Therefore, initially, the neuromuscular therapist must be very careful not to inhibit a potential placebo response.

At first glance, it seems precepts of solid research methodology would not support this suggestion. A credible, randomized double-blind drug study is one in which both placebo and the active drug are masked to both participant and physician. When a placebo is unmasked (has become known to the participant and/or physician) results can be skewed, more often than not resulting in a decrease in placebo responders. Why? In terms of expectancy theory it could be surmised that both physician and participant view a placebo response as an ineffective and undesired response. So it would seem the bodyworker who knows she is trying to promote a placebo response with her client would tend to bias her client’s response negatively. But what if a placebo response were viewed as a desired outcome? Might the response be even higher? From this perspective, a new healing equation emerges: potential “cure” + placebo effect = the most effective treatment.

Consider Lee who is not yet convinced of the neuromuscular therapist’s potential “cure.” As the therapist explains her treatment procedure, she senses a disconnect. Realizing Lee has heard many explanations before and no treatment has helped so far, she ceases defining the rules of her village and asks him what he wants her to address first (care and concern). After he points to his most painful area, she begins to gently massage a tender point. The pain starts to lessen. Then she explains how to self-massage for pain relief (providing hope for mastery over symptoms). Lee relaxes. She makes him aware the tender points have improved. He then asks her why they are there. The therapist moves into a third component of maximizing the placebo effect—providing a more satisfactory explanation of Lee’s problem. As Lee continues to accept the “cure,” his expectation for a favorable outcome, more likely than not, increases, and the therapist can take satisfaction in knowing she has done everything possible to promote a placebo response while introducing the potential “cure.”

The placebo effect is real. The use of the therapeutic relationship to activate a placebo response connects yesterday’s shaman to today’s health practitioner. Most bodyworkers have capitalized on the therapeutic relationship to elicit a placebo response—without naming it. Now, through consciously applying care and concern, a more satisfactory explanation of the problem, hope for mastery over symptoms, and humility, they can maximize it.

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Notes
5. Ibid.