What is the place for placebo in the management of psychogenic disease?

‘Placebo’ was used to describe fake substances or rituals used by medieval physicians to ‘please’, or assuage discomfort, in patients for whom no cure was available. This placatory perception of placebos led many to regard them as obsolete, permissible only as a comparator agent in clinical trials. Yet, placebo use by healthcare workers is relatively common, mainly to distinguish between organic and functional disease, identify malingering, establish the psychological origin of a condition (to both physician and patient alike) and placate patients who insist on potentially harmful measures when the physician believes that no treatment is indicated.

Psychogenic disorders are somatic complaints for which there is no apparent physiologic cause. Features consistent with psychogenic conditions include: (1) presence of associated psychiatric disorders; (2) lack of concern (la belle indifference) or an exaggerated emotional response; (3) disease manifesting only when observed, and not when alone or thought to be unobserved; (4) bizarre or inconsistent signs; (5) presence of emotional or situational triggers; (6) multiple inexplicable physical symptoms; (7) failure to respond to therapy; (8) presence of a medical background; and (9) disease is triggered or ameliorated by placebo.

Management of psychogenic disorders is difficult, as these patients often have an underlying organic disease. Prognosis for functional recovery is generally poor, and successful management requires a multi-disciplinary approach featuring the psychiatrist in a pivotal role. Empathy and a non-judgemental manner should be used, and it is often helpful to invoke a neurobiological explanation of the symptoms in order to foster trust, acceptance, understanding and recovery.

Should placebos be used in managing psychogenic disease? In its favour are the potential salutary effects and absence of side effects, coupled with the low success rate of psychotherapy and potential adverse effects of psychopharmacotherapy. On the other hand, many are uncomfortable with the ethics of administering an inert substance purporting to be ‘active’, on the basis that it smacks of deception.

Placebos have opposing roles in clinical and research settings. A meta-analysis concluded that giving placebo equals ‘no treatment’, but there is physiologic evidence demonstrating the power of the placebo effect, which refers to perceived health benefits from prescription of medically inert substances. Studies in depressed patients have demonstrated similar metabolic responses to placebo and fluoxetine, just as positron emission tomographic (PET) studies in parkinsonian patients have shown robust dopamine release in response to placebo. It can be seen how the placebo effect can confound in clinical trials. In fact, the perceived benefits from sham surgery in surgical trials in osteoarthritis and surgery for Parkinson’s disease, have resulted in the move to include a sham surgery control arm in surgical trials.

Thus, in clinical practice, the physician prescribes a placebo in the hope that it will produce a therapeutic effect: such an effect is anathema to research. Ethicists have coined the term, ‘knowledge framing’, to describe desirable treatment effects arising from proper presentation of information to patients during the clinical encounter, distinct from the placebo (unwanted) effect in clinical trials.

Whilst debate rages about whether it is permissible to harness the placebo effect to treat psychogenic disease, few would condone placebo use to treat organic diseases for which appropriate therapy is available. Purists maintain that any practice involving deceit of patients is inappropriate, and that they must be informed of the inert nature of the placebo when it is administered. Unfortunately, complete disclosure is liable to decrease the utility of the placebo as treatment or diagnostic test (in which placebo is administered to trigger or halt psychogenic disease). Disallowing use of placebo because it is considered to be unethical would remove from the physician’s armamentarium an important tool to diagnose and potentially treat psychogenic disease. As a result, such patients would be susceptible to the adverse effects of medications which would otherwise prove unnecessary.

One of the criticisms levied against placebo therapy is that it reflects a paternalistic attitude—that of an omniscient doctor who is the best judge of what is right for the patient, making decisions for the patient without need for patient consultation or agreement. It is feared that an erroneous judgement on the part of the physician would lead to his withholding appropriate treatment for the patient who is adjudged psychogenic or less serious. This scenario is, unfortunately, not as far fetched as one would hope. Disorders such as cervical dystonia and writer’s cramp, now accepted as organic diseases, were once thought to be unobserved; (4) bizarre or inconsistent signs; (5) presence of emotional or situational triggers; (6) multiple inexplicable physical symptoms; (7) failure to respond to therapy; (8) presence of a medical background; and (9) disease is triggered or ameliorated by placebo.

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With the development of the field of medical ethics, we have evolved from the principles of paternalism and beneficence to embracing respect for patient autonomy, i.e. the right or freedom of individuals to make decisions on their own behalf. As doctors, we must be mindful of the dictum, primum non nocere, and strive to do right for our patients. Several questions remain: is the patient afflicted with psychogenic disease composes mensae? If not, can a relative or guardian make the decision to proceed with the placebo test or placebo therapy? It is likely that, however beneficent the intent, it can be argued that knowingly deceiving a
patient by declaring placebo to be an active drug is an unethical act. It would be far better, perhaps, to practise knowledge framing and provide a neurobiological explanation, describing the placebo as a harmless agent, whose administration is meant to bring about improvement in the disorder.

To summarize, there is a place for placebo therapy, as long as: its use is transparent and the patient’s autonomy and right-to-know is respected; it builds on and respects the patient-doctor relationship; it tolerates and even encourages the patient’s right-to-choose, whilst developing an appropriate therapeutic concept for the patient; and it is engendered by care and concern for the patient. Thus, we would submit that the placebo is useful as a diagnostic test to distinguish between psychogenic and organic disease. Upon exclusion of organic pathology and confirmation of diagnosis, a trial of placebo therapy may avoid the need for harmful psychopharmacotherapy, though it may instead be used as an adjunct to psychiatric counselling and drug treatment. Of course, we would not recommend the placebo as standard therapy for all psychogenic disease, but would argue for acceptance of its place in the physician’s pharmacopoeia.

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Many clinicians may be faced with the dilemma of what is a reasonable amount of concern for a patient to have with regard to their appearance. Physical perfection is now seen as achievable by the general population, with ideals of aesthetic beauty becoming increasingly uniform. This makes it difficult to follow the DSM–IV criteria with regards to whether a defect is imagined or slight. If unclear, clinicians should focus on other aspects of the criteria such as degree of distress and functional impairment. They should also look at what actions patients have taken to rid themselves of the defect (for example, ‘do it yourself [DIY]’ surgery). A thorough history may reveal previous unsuccessful contacts with plastic surgery or dermatology due to concern over other body areas. Psychiatric comorbidity or a past psychiatric history should also increase the index of suspicion for BDD. The number of cosmetic procedures is likely to continue to rise and raising awareness of BDD is vital in order to provide expedient diagnosis and appropriate further management for these patients.

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