

Deception as treatment: the case of depression

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Received 27 July 2010

Revised 7 September 2010

Accepted 17 September 2010

Published Online First

20 October 2010

ABSTRACT

Is it ever right to prescribe placebos to patients in clinical practice? The General Medical Council is ambivalent about the issue; the American Medical Association asserts that placebos can be administered only if the patient is (somehow) 'informed'. The potential problem with placebos is that they may involve deception: indeed, if this is the case, an ethical tension arises over the patient's autonomy and the physician's requirement to be open and honest, and the notion that medical care should be the primary concern. This paper examines the case of depression as an entry point for understanding the complexities of the prescription of placebos. Recent important meta-analyses of antidepressants claim that they are not significantly more effective in a clinical setting than placebos. Given that antidepressants have numerous adverse side effects and are hugely expensive, this provocative research has serious potential ethical and practical implications for patients and medical providers. Should placebos be prescribed in place of antidepressants? The case of depression highlights another important issue which medical ethical codes have hitherto overlooked: well-being is not synonymous with being realistic about oneself, one's circumstances and the future. While severely depressed individuals are unduly pessimistic about themselves and the world around them, treatment of depressed individuals can be deemed successful when patients have successfully attained those positive illusions that are indicative of psychological health. This is exactly what successful psychological treatments of depression seem to achieve. It is therefore possible that there may be a limited unavoidable role for deception in medicine.

Gone are the days of 'therapeutic privilege' whereupon the physician was at liberty to withhold information from a patient. Today, patients' autonomy and openness in patient–doctor relationships are regarded as imperatives in clinical practice. The idea that a physician is permitted to deceive a patient about his or her prognosis is now deemed out of the question. The General Medical Council's (GMC's) code of ethics asserts that physicians must be satisfied that they have 'consent or other valid authority' before undertaking any examination or providing treatment.¹ Similarly, the American Medical Association (AMA) asserts that 'withholding medical information from patients without their knowledge or consent is ethically unacceptable'.² What, then, of the case of placebos? Placebos are those substances given to patients that produce no pharmacological effect (ie, no effect as a result of their specific physical composition); rather, they produce a therapeutic effect via the expectation of recovery in the patient. Given that there is evidence of significant clinical benefit of placebos—they are especially

beneficial in cases of analgesia—how should physicians proceed?³ Does the administration of placebos breach existing ethical codes in medicine? The GMC instructs physicians to 'make the care of your patient your first concern', so does placebo usage compromise other directives on honesty?⁴

I argue that current ethical guidelines about placebo use are equivocal: medical codes explicitly rule out deception yet (doubtless because of their efficacy), placebos are not proscribed; in addition, the nature of placebo deception needs to be established. The importance of understanding the role of deception in medicine is highlighted by examining the case of depression, drawing on recent provocative research which indicates that antidepressants are not significantly more effective in a clinical setting than placebos. These findings have important repercussions for physicians; they indicate that physicians ought to weigh up the relative effectiveness of placebos with important palliative concerns about the use of antidepressants given their common side effects.

Indeed, is there any way to circumvent the problems with antidepressants by employing alternative treatments that might avoid the issue of side effects and deception? Before addressing the issue of successful alternatives, I contend that medical bodies such as the GMC and AMA need to pay much closer attention to the very nature of mental health. Well replicated evidence from social psychology indicates that positive illusions are indicative of well-being; more than this, it seems that individuals who are very mildly depressed exhibit a higher degree of realism about their lives. While it certainly appears that severely depressed individuals display highly negative illusions (ie, they are pessimistic about themselves and the world around them), it seems that *any* successful form of therapy necessarily involves some degree of deception in order to restore full health. In short, if medical bodies accept that placebos involve some form of deception and, as a result, decide to prohibit their usage, this will also rule out the successful treatment of depression, *tout court*. In fact, the current most successful forms of treatment for depression appear to involve methods which instil those optimistic illusions that are lacking in patients. In conclusion, by unwittingly ruling out the possibility of treatment for depression and by prevaricating over the usage and character of placebos, current medical ethics codes appear to be inconsistent and (dare I say it) self-deceiving.

CURRENT GUIDELINES ON PLACEBOS

At the outset we can note that, in practice, physicians are not resistant to prescribing placebos. A recent survey of US internists and rheumatologists,

for example, indicated that around 50% of respondents regularly prescribed placebo treatments and 62% believed that the practice was 'ethically permissible'.⁵ In addition, 68% of those physicians who used placebos described them to patients as 'potentially beneficial medicines which were not typically employed in treatment'; in only 5% of cases did physicians explicitly describe the form of treatment as a placebo. This suggests a sort of intuitive moral sensibility and/or pragmatic stance on the issue among physicians, regardless of stipulated medical codes.

The GMC proffers no specific guidelines on placebo use, rendering this a predicament which physicians must resolve on their own. The AMA, however, attempts to clarify the issue, but its statement provokes more questions than it answers. It stipulates that 'the use of a placebo without the patient's knowledge may undermine trust' and 'compromise the patient-physician relationship'.⁶ What can it mean to request consent before employing a form of therapy that is inherently illusory? The AMA guidelines continue (and this is the rub): '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'. This raises two issues: (1) the question of how a placebo can be a 'placebo' if it doesn't deceive; and (2) whether suppressing details of placebo use can be consistent with those resolute stipulations which speak against withholding information.

Turning to the latter issue, it seems clear that there is an irresolvable tension in the AMA's guidelines: deceiving patients about placebo use seems, on any level, to be a flagrant dismissal of the imperative that physicians be wholly honest. *Prima facie*, the first issue presents a way to resolve this: if placebos do not involve deception, then there is no such ethical dilemma. However, this is curious: if placebos *don't* involve deception, why can the physician not identify the placebo and the timing of its use? More to the point, what can it mean for a patient to expect treatment from a form of 'medication' that is not in itself curative but for this *not* to involve deception?

The notion of 'non-deceptive placebos' draws on limited and controversial research that indicates that divulging to a patient that he is receiving a placebo need not lessen its effectiveness.⁷ This research appears to show that patients are responding to placebos as a result of conditioning: taking pills or being injected with medication are acts which we are strongly conditioned to associate with recovery. Indeed, other well-supported studies reveal that the type of placebo medication even has an impact on the size of the response: smaller sugar pills are less effective than larger ones⁸; pills taken four times a day are more effective than those taken twice a day⁹; and pills make for less effective placebos than saline injections.¹⁰ However, the 'non-deceptive placebo' theory is problematic for at least two reasons. First, no control was employed in the original study in 1965 (and this work has never been replicated); second, it is not clear whether subjects today would not be more sophisticated (ie, sensitive) in response to the revelation that they were being administered a 'placebo'. It seems that the AMA is drawing on insubstantial research in order to 'licence' clinical and ethical employment of placebos.

In summary, more robust research is needed to ascertain whether it is somehow possible to prescribe placebos without deception. Given that placebos are deemed to be effective (to varying degrees) in the treatment of various conditions, how should ethics committees and physicians proceed? There are two choices available, given current (reliable) research. In the interests of consistency, ethical bodies can either counsel that placebos *do* involve deception and therefore should never be

employed,¹¹⁻¹⁴ or admit that deception is involved but assert that placebos are too important to be eliminated from clinical practice.¹⁵⁻¹⁷ In the following sections I further investigate the nature of deception in clinical practice by examining the treatment of depression.

DEPRESSION AND PLACEBOS: EMERGING CONCERNS

In this section I argue that the limited efficacy of antidepressants is a serious issue but one that has started to gain the attention of the medical community. I argue that nascent but highly significant research adds further importance to responding carefully to the issue of deception.

Depression is deemed to be the most prevalent mental disorder in the world: in the USA alone, diagnostic rates are estimated at around 10% of the adult population per annum.¹⁸ Antidepressants (such as Prozac, Effexor, Zoloft and Citalopram) are the treatment of choice among physicians in the USA; in any month 10% of women and 4% of men are prescribed antidepressant medication¹⁹ and more than 31 million prescriptions were written for antidepressants by physicians in the UK in 2006.²⁰ Clearly, any research that questions the effectiveness of these drugs demands serious attention by medical professionals.

In fact, recent work reveals disquieting statistics on the efficacy of antidepressants. In noteworthy meta-analyses of antidepressant usage, it has been argued that any difference between placebos and antidepressants in clinical settings is due to the significant side effects of antidepressants—that is, patients and physicians are able to intuit that sugar pills have not been administered and this, it is argued, undermines the requisite research standard of 'double blind' trials.²¹⁻²² Indeed, the greater the number of side effects experienced by patients in such trials, it has been observed, the more patients improved. Furthermore, when trials included 'active' placebos (placebos which induce similar antidepressant side effects), no clinically significant disparities in the effectiveness of placebos and antidepressants were seen to occur.²³⁻²⁴ This research is singularly important because, with respect to National Institute for Health and Clinical Excellence (NICE) criteria, it indicates that antidepressants are not more effective in a clinical setting than placebos.²⁵

While it should be reiterated that further research is needed to ascertain whether the mechanism of action of antidepressants is the same as for placebos, these findings raise potential issues of concern for medical ethicists and physicians. Should it be discovered that antidepressants function as placebos, then it is possible that they have already (unwittingly) been employed as a form of 'deception medication'. On the other hand, if antidepressants are not in fact, placebos, given the well-documented severity of side effects associated with them, should physicians be prescribing sugar pills instead? Although this latter scenario may involve deception on the part of the patient and physician, is this preferable to treatments with extensive common side effects (drowsiness, low sex drive, weight gain, and so on), more especially when there is a possible link between suicidal ideation and such medication (notably in the case of paediatric treatment)?²⁶⁻²⁸ Research into the effectiveness and mechanisms of action of antidepressants highlights the importance of resolving the tension between patient deception, on the one hand, and provision of the utmost medical care, on the other; indeed, there is a pressing need for more studies in this area. However, before I address the issue of alternative treatments and how they might work, we need to consider the issue of precisely what it is we want our treatments to achieve.

POSITIVE ILLUSIONS AND 'DEPRESSIVE REALISM'

Is deception an irrevocable part of life? Well-replicated evidence shows that positive illusions—that is, positive unrealistic self-evaluations, an inflated perception of one's control over events and an exaggerated optimism about the future (what psychologists dub the 'Pollyanna principle')—are characteristic of good mental health.^{29–31} The health-promoting effects of these positive illusions include an increased capacity to care for others and an enhanced aptitude for creative and productive work. Indeed, individuals who display the positive illusion that they are better off than others are less likely to develop depression.³² This research is fundamental to how we conceive of mental health. If individuals deviate from these illusions—that is, these forms of positive deception—it seems that it is the job of medical treatment to restore them.

Indeed, the notion that depressives exhibit realistic cognition when it comes to self-evaluation and their mastery of events is one that has been mooted in the psychological literature.^{33–34} Assuming the correctness of such a hypothesis, and in the interests of upholding current medical ethical guidelines, it would appear that physicians ought not even to treat depression. Clearly, this is an absurd consequence, but it further underscores the importance of a more penetrating revision of prevailing views on excluding deception from medical treatment.

In fact, growing evidence supports the view that depressives display illusions on the opposite end of the spectrum from the mentally well (they appear to exhibit negative illusions about themselves and their future prospects^{35–36}); it would appear that the onset of depression involves a swing towards pessimistic biases from normal positive cognitive biases.³⁷ However, regardless of the standing of these hypotheses on depression, neither hypothesis affects the prevailing consensual view held among social psychologists that mental functioning involves deception. Counterintuitive as it may seem, research indicates that it is the job of physicians to redress this imbalance by restoring positive illusions in patients.

CONCLUSION: A SPOONFUL OF DECEPTION HELPS THE MEDICINE GO DOWN?

Returning to the issue of successful treatment, what are the alternatives to antidepressants? Meta-analyses show that cognitive behavioural therapy (a form of psychotherapy) is the most successful long-term treatment for depression.^{38–39} This is a form of therapy which encourages patients to identify negative thought patterns and subsequent behaviour and to consider whether such thought patterns and responses are useful or helpful to them. Over a long period of time (many months), patients are persuaded to adopt thoughts which are more 'realistic' (but which are, in fact, moderately positive) and which induce different behavioural responses to their usual course of action.^{40–41} Individuals who successfully complete such forms of treatment end up endorsing positive illusions about themselves and the world around them. They often consider that their illness has 'happened for a reason' and that it has given them an opportunity to 'grow' as individuals; indeed, the notion that they are fortunate to have suffered appears to extend to a downward comparison with those who have not had the chance to experience such things.³⁰ More than this, these psychological therapies involve a more prolonged form of deception than placebos; any deception about the efficacy of prescribed sugar pills pales when contrasted with the promotion of highly personal deep-seated illusions about oneself that are induced in the successful treatment of a patient with depression. In short, by finding meaning in misfortune and integrating it

with positive views on oneself and the benevolence of the world, individuals heal.⁴² One psychologist has dubbed this form of therapy the 'ultimate placebo'.²⁴

In conclusion, given the intrinsic importance of positive illusions to psychological well-being, medical ethics committees need to be more candid about the importance of placebos in clinical practice. We await robust research to the contrary of the current prevailing view that placebos involve deception. Moreover, treatment for depression cannot even be undertaken without the active endorsement of positive illusions on the part of the medical community. Medical bodies need to accept that a spoonful of deception may be fundamentally (and unavoidably) therapeutic.

Acknowledgements The author thanks Irving Kirsch and one anonymous reviewer for very helpful comments.

Competing interests None.

Provenance and peer review Not commissioned; externally peer reviewed.

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J Med Ethics 2011 37: 13-16 originally published online October 20, 2010

doi: 10.1136/jme.2010.039313

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