

**Mother, Magic or Medicine?
The Psychology of the Placebo**

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"Physicians must discover the weaknesses of the human mind, and even condescend to humour them, or they will never be called in to cure the infirmities of the body..."

Charles Caleb Colton, *Lacon*
(1825)

It is not surprising that most contemporary observers and practitioners of medicine assume that drug treatment in medical and psychiatric practice is a kind of "pharmacological engineering". A sample of any text or medical dialogue concerned with this subject is likely to support the notion of the doctor in his role of engineer; his diagnosis locates or defines a malfunction in the body, and his medical treatment is applied as a specific chemical remedy. The practice that follows is guided by purely technical considerations— finding the most specific drug for the problem, working out its route, dose and timing. Explanations as to how drugs work are similarly inclined— replacing depleted chemicals, neutralizing acids, altering proliferation patterns in certain types of cell, inhibiting or catalyzing specific chemical interactions—are common concepts used.

And yet while doctors and medical researchers work painstakingly to refine such scientific theory and its application, the patients themselves often have quite a different way of experiencing the doctor and his medicines. For example, the evidence that most drugs prescribed outside a supervised hospital setting are not taken at all, or not as prescribed (Parkin *et al.*, 1976; Pearson, 1982) strongly implies that the doctor's "scientific" endeavours have quite a different meaning, or lack of meaning, for the patient. For all the technical talk amongst doctors of pharmaco-kinetics, serum concentrations, drug half-life and so on, if there is such a discrepancy between what a doctor assumes and intends and what a patient does, the questions arise "what is this activity, who is it for, and why does it exist?" For the doctor, prescribing in the prescribed manner has a number of functions. It helps him pass the time with the patient in a way that offers him the security of familiarity, and confers on him the mantle of "physician"; a cloak of potency, authority and legitimacy. It legitimatizes, too, his activities with his colleagues and gives him an identified place among them—they act in a similar way and so he is part of their group. It helps him feel helpful, even if this is not the help that is really needed; there are many studies suggesting this is often the case. The act of prescription may

also provide the doctor with the comforting illusion that he is controlling or "managing" the patient's problem.

The foregoing indicates a little of why, for psychological reasons, the doctor may have his own compulsive need to prescribe. The main emphasis of this paper, however, deals with the complementary pattern—the psychology of the patient's need for drugs—which is equally fascinating and important. It is well established that placebos can have a positive therapeutic effect in a very wide range of disease processes in any bodily system (Doongaji *et al.*, 1978). Placebo response to severe injury pain (Beecher, 1955) and angina (Benson and McCalle, 1979) are now classic studies. Severe mental disturbance in those labelled "chronic schizophrenic" often responds to placebos (Silverstone and Turner, 1974).

Some of the fragments of placebo psychology can be deduced from further research. A positive response depends upon an expectation of successful treatment (Lesse, 1962), a trusting and positive attitude to the administering doctors (Black, 1966), and the social status of the "healer" (Silverstone and Turner, 1974). In this latter study, patients with a demonstrated peptic ulcer responded symptomatically to a placebo given by a doctor (70%), but much less with a nurse (25%). The deeper and symbolic meaning of the placebo—which this article discusses later—has received less attention. Among the most interesting studies is that of Balint (1970) who studied, over a period of some years, repeat prescriptions in general practice. He concluded that the repeat prescription often represented less of a treatment than a diagnosis—that the patient was wanting protection and reassurance from the doctor, but not direct contact with him. Such patients were emotionally needy but afraid of a more direct or intimate contact, and so settled for this ritualized "dose of doctor" which represented a symbolic "something" that was "good, reliable, unchanging and always available". Clearly this need is similar, if not the same, to those needs of security and protection that run throughout our infancy and early childhood, and Balint here equated the drug's symbolic protection and goodness with mother, or earlier, the breast. Certainly Balint's notion was supported by the observation of protest, rage or crisis of some kind when the doctor attempted to stop or change the drug, usually with "clinically sound" reasons—the drug for the patient was not a mere "pharmacological agent", it was a symbol of caring, security and regard; its withdrawal seemed threatening to the patient, far beyond any possible medical

implications.

Doctors' training generally does not involve recognition of these important principles, and certainly the skills by which they may be marshalled and used therapeutically have received little attention. The "rational", physical, components of prescribing have been pursued as a legitimate clinical study at the expense of those "irrational", psychological, determinants which, as we have seen, may be decisive, for better or worse. This indifference, or implicit contempt for the placebo, seems to have coincided with the "pharmaceutical explosion" in the 1950s (Doongaji *et al.*, 1978). It seems that the world of medical therapeutics reflected in miniature much wider social processes—a consuming and increasingly exclusive interest in technology, at the expense of psychological and social needs that have been with us since our beginnings. The consequences of over- investment in technology and attention only to the manifest, at the expense of more radical but hidden human needs, is an increasingly pervasive theme in our culture.

The following three cases go back to the "irrational" in treatment for their guiding principles. At first sight it might be easy to dismiss them as in some sense "unscientific" or "quackery", but, on closer inspection, the skilful use of such situations and transactions involves some kind of applied science of the early mind.

Case No 1: A bridge over troubled waters

A 62-year-old woman, Mrs F, was knocked off her moped by a car emerging from a side-turning, driven by a young man, rapidly and without due observation. Mrs F was not seriously injured, but suffered painful bruising and lacerations. More troublesome for her were her symptoms of dizziness, shakiness, headaches and loss of confidence which the first doctor (Dr E) told her was "the shock coming out in you", and for which he prescribed a tranquillizer. A fortnight later she returned to see a second doctor (Dr G) saying she felt worse; she still had the same symptoms, but now she felt "unsteady and tired all the time". Dr G asked about the kind of thoughts and feelings she had toward the young driver, which led Mrs F to talk tentatively of her anger and resentment, which she had not previously expressed; "he was so kind and polite and apologetic . . . and I was too shocked at the time to say anything . . .".

But there was more to her resentment and sense of injury, which Dr G intuited from the little he knew of her. She had recently been made redundant from work, after 20 years with the same employers; they had themselves been "bought-out" by a younger and more aggressive company, which had decided to streamline the old order. At the same time, her husband had recently become ill with angina, following soon after his retirement. Her three children in recent years had married, moved away and become increasingly involved with their young families. In short, she was facing a period of rapid change and loss where the old order, and her familiar roles, were no longer viable or valued. Dr G had acknowledged and shared this dilemma with her, for brief periods, when she had seen him on two previous occasions. On this occasion, behind the miscellany of her physical complaints, Dr G was touched by the tears which kept welling up in Mrs F's eyes, only to be quickly dabbed away with self-disparaging apology. After an intimate pause of a few seconds the doctor said softly "I imagine your whole life at present is a bit like riding your moped. Trying to retain your balance and sense of direction while larger more powerful cars pass you by, often blindly, not aware of your vulnerability. It must have seemed like the last straw when that young man knocked you down. . . Perhaps it's unavoidable that you have strong feelings about this; if that's so, I think you'll need to face and talk about your feelings, rather than take tranquillizers to pretend they're not there."

Mrs F sat and cried for about a minute. Dr G was attentive but silent. This time she did not wipe away her tears, either literally or with apologies. "You've been a great help doctor, helping me express my feelings like that. You're right, they are my feelings and I do feel better just talking about them. I don't want a drug that 'gets into my system' — what about a good old-fashioned tonic?" Dr G's response, a prescription for a multivitamin syrup, was accompanied by his comment: "I think you will feel stronger and more able to cope with this. Come and see me next week."

Mrs F did indeed feel much better with her "tonic". "I know I have to get my confidence back myself, doctor, but that red medicine does me a power of good. I'd like it for just another week and then I think I'll be all right."

Her request complied with, her prediction proved correct.

Comment

What had Dr G done that was different from the first doctor, and can we deduce any scientific principles, even if in embryonic form, to account for his effectiveness?

Dr E had attempted to label and rapidly dispose of Mrs F's feelings by didactic reassurance and tranquillizers. He diagnosed "shock" without, in any way discovering what this shock had meant to her, and thus his verbal help could extend only to sympathy, not empathy. Dr G, however, had entered into her world a little, and understood something of her distress before making any attempt to change it. His intervention, when it came, was an empathic act; Mrs F felt validated and accompanied by Dr G in her hurt and despair. With Dr E, on the contrary, she had felt alone, alienated and discounted. Dr G had offered her, in a symbolic, brief but skilled form, an embracing and protective presence—those elements of successful parenting that all children need successfully, to pass through the many hurts and crises of childhood.

In the words of Guntrip (1964) "we do not grow out of childhood, we grow over it" and it is this Child within us that re-awakens and cries out in times of stress. Dr G sensed that it was not enough to give Mrs F adult reassurance, he had to somehow establish a dialogue with her inner Child, before the panic could be calmed. He knew also that her request for a "good old-fashioned tonic" was Mrs F's primitive need for a symbol of the doctor's concern, protection and understanding which she could take with her, and literally ingest, when he was no longer with her. Balint (1957) talked of patients taking "a dose of doctor" to describe the device of extending, symbolically, the therapeutic relationship. The following two cases explore this theme further.

Case No 2 A balm for grief

Mr D was 78 years old when his wife died. She had suffered a stroke two years previously, which had left her chairbound, dysphasic and dependent on her husband for all her domestic needs and the little contact she had with the outside world. Mr D provided this with great compassion, fortitude and humour, despite his own age and frailty. Her intense dependence on Mr D led to a strength of feeling and an intimacy between the two old people that had previously only existed 50 years before, at the beginning of their marriage. When she died, Mr D, despite his tears of grief, acted with the same courage and independence as before. Two weeks later, after he had completed

all the funeral arrangements, he developed shingles on his chest wall and sought Dr E's advice. The doctor, after explaining the medical nature of the problem and offering a sympathetic warning to Mr D that he would probably experience several weeks of pain, sat back in his chair saying reflectively to Mr D "These must be hard times for you. I'm sorry I can't offer you more." The old man sat silently and sadly for a short while, looking at the floor. Raising his eyes to Dr E he said "I feel there's a big hole inside me—like somebody has taken something away." "Yes," the doctor concurred, "I think losing those we love does leave holes in us which we can never really fill in. Sometimes, though, with time, good new things can grow around the holes." Mr D smiled wistfully at his doctor before leaving with his prescription. "I think the talk with you is my best medicine, doctor. I don't feel so alone now."

Long after any specific medication could affect Mr D's shingles, he was continuing to want "something to rub into my skin" even though his skin was now clear and he had little in the way of residual pain. The doctor had at first resisted prescription, countering Mr D's request with a medical explanation of how it was impossible for a cream to now help his condition, which was largely resolved anyway. The old widower's eyes looked blankly at the doctor during his didactic effort, and then changed to an expression of hurt when he had finished. "I suppose you're right doctor but I feel ever so much better if I have something to rub in ... " Dr E now realized that it was not pharmacology that was required of him, but a kind of symbolic mothering. An inert cream, not recommended in any medical text, brought an expression of relief and seemingly inordinate gratitude from Mr D.

For three years the old man walked slowly round to see his doctor, to collect his prescription for his simple cream. He insisted on seeing the doctor personally; collection from the receptionist was not enough. The medical business of his consultations was perfunctory, the important transactions concerned the sharing, if only briefly, his world and feelings.

Mr D died alone, asleep in his bed, unexpectedly one night. Dr E was summoned by the neighbours to certify his death. Beside his bed were his dentures and spectacles, a glass of water, and a large pot of cream he had collected from his doctor two days earlier.

Comment

Mr D, like Mrs F, was facing a dramatic and painful change in his life. While more concretely-minded sceptics might claim that his outbreak of shingles was coincidental to his wife's death, it seems clear that the "treatment" Mr D wanted from his doctor was of some kind of representation of the doctor's understanding and permissive presence. Dr E had empathised with his aloneness and the grief and hurt that were expressed more by his body than by his words. The cream, for Mr E, was a way for him to have continuous, if symbolic, access to the palliative and nurturing presence of his doctor. The familiar religious symbols of Holy Bread and Water may confer on the believing recipient a sense of purification, forgiveness or strength; the clinical situation here is probably analogous, Mr D receiving from his cream a sense of caring attachment.

Many writers and researchers have stressed the importance of touch in the mental and physical development of the young child (Spitz, 1945; Harlow and Harlow, 1966) and the continuing health of the adult (Berne, 1961). Healing or palliative procedures based upon touch have a long history, and are still prevalent in Eastern medical practice. For the distressed infant, the touch of a protective adult is probably the most effective nonspecific remedy. Even as we grow older, touch remains among the most potent and direct antidotes to pain, panic and distress. Mr D's choice of a "touching" medicine—"something to rub into my skin"—probably indicated a wish for this most basic of comforts, as a balm for the most basic of pains; the loss of a loved person.

Case No 3 Mother's milk

When Mr S, a solitary man of 40 years, became the centre of an angry cacophony in Dr T's waiting room, the doctor became apprehensive, but was not surprised. Mr S, he knew, had a lifelong tendency to violent outbursts, though never before with the doctor or his staff. Most previous contacts with the doctor had been for fairly simple requests, and on these occasions Mr S had had a rather submissive, faltering and lost manner; Dr T had the fleeting mental image of a small boy searching for a (his?) father. Dr T could recall other times when Mr S had come for "tonics" or hypnotics; the preceding events had usually followed a similar pattern: he would react impulsively and sometimes violently to a real or imagined slight or rejection, to be followed by a period of remorse, confusion and despair. Predictably, he was often unemployed, had spent

several short periods in prison, and lived alone, as no partner could tolerate his periodic and explosive violent tantrums. After such episodes Mr S would seek help from his doctor, and would bring with him an air of injured dejection and deflation. It was at these times, in a rather piecemeal way, that Dr T learned something of the life of this hurting and hurt man. Mr S had suffered from the most elementary and early of hurts—the loss of both parents before he could remember. An accidental and illegitimate conception, he had spent his childhood from infancy in a variety of threadbare orphanages and, later, borstals. As far back as he could remember, he had been haunted by the fact of his early rejection, and had developed a primitive and only partially conscious notion of others as being untrustworthy and hurtful; a notion which he would spuriously validate for himself by provocation. Ten years previously, following a depressive reaction to one of his destructively cathartic episodes, a local psychiatrist had referred him to a unit specializing in a therapeutic community approach to "psychopaths". To Mr S's further sense of injury, he was rejected for having "insufficient insight or motivation to make use of the group-therapy approach."

The affray occurring in the waiting room at first involved only the receptionist. Dr T had no appointments left that morning except for "genuine medical emergencies", which did not seem to apply to Mr S, as the receptionist tried patiently to explain to him while offering an appointment that afternoon. The receptionist's positive efforts were rapidly swept away by a rage in Mr S that could not be reasoned with. "I DON'T CARE," he bellowed, "I'VE GOT TO SEE THE F_____ DOCTOR NOW." The doctor, his more routine and polite consultation quickly terminated, and realizing he was dealing with an emergency (even if not "genuinely medical"), entered the waiting room, much to the relief of his rather frightened and confused receptionist. "You seem to be very upset about something, and if you wait for only about half an hour I'll have some time for you . . ." While saying this the doctor looked directly at Mr S while putting a hand firmly but comfortingly on his shoulder; he felt Mr S instantly stiffen at his first touch, and then yield a second later, as if he suddenly found a sense of trust and acceptance in his doctor.

"I have this terrible feeling doctor, I'm afraid I'll explode, go mad and kill somebody . . . I'm afraid of what I may do . . . I didn't know who else to tell." The doctor, asking Mr S to describe recent events, established that he was reacting, again, to an event which Mr S interpreted as being a personal slight and rejection. It was, in reality, more likely to

be the inflexible, but impersonal, bureaucracy of the Social Security Office. After talking for some minutes of the variety and threatening intensity of his feelings, Mr S sat back in his chair exhausted, lost and on the point of tears. Pausing deliberately, Dr T then said quietly: "You know, I imagine that all these feelings you have are the same ones you had when you were a little boy and you felt unloved and that something bad was going to happen to you. I think at those times life really did hurt you in a way you couldn't understand, and all those experiences have led you to thinking that the same kind of things are happening to you now, even when they're not ... and then you get all those old feelings crowding in on you. That desperate and unhappy little boy in you wakes up, and cries out, and starts fighting for his life . . ."

"That's true, that's exactly how I feel . . . But what can I do, doctor?" replied an attentive and thoughtful Mr S.

"Well, what would the 'grown-up you' want to say to the 'little boy you', knowing what he does?"

"I see what you mean ... I've never thought about it like that ... I think I'd like to say to him `You really had it rough and I feel sorry for you ... but you're the past and I mustn't let you run my life now' ... But how can I do that, doctor, I mean when I get upset I just see red and get mad and lose control of myself. I just can't help it ..." Mr S pleaded.

Dr T was insistent, if kindly, in his disagreement of this last statement. "Well, I don't agree that you can't control your actions. You can, but I understand that it's very hard for you and that you may need some help. I have an idea to help you, but it will only work if you want it to, and if you follow my instructions carefully. Will you do that?" he asked, looking at Mr S steadily.

"Yes, I will . . . I do want to try something. . ."

"What I suggest to you is simple but you must do it properly for it to work. When you feel the beginning of one of your strong feelings of panic or anger you must sit down quietly somewhere and suck one of the tablets I'm going to give you. Suck it and don't swallow it whole; you'll find it has a soothing effect as it goes down, first in your throat

and then in your chest and stomach. When you're sitting there I want you to think about what we've been saying, and to have an imaginary talk with that little boy inside you. The tablet will calm you when you're doing this." At this point Dr T reached forward to touch the hand of Mr S briefly but significantly. "I'll give you 40 tablets to begin with and I want you to come and see me at the end of the week to let me know how you are."

Dr T's prescription was simple but thoughtfully chosen—a more uncommon antacid/antiflatulent tablet with a pleasant milky flavour.

Mr S two weeks later claimed that "those tablets have really done the trick. I know that if I've got them with me and do what you say then I won't get so upset or 'blank out' ... " He returned every few weeks to collect some more tablets and to talk with the doctor who would reinforce Mr S's new patterns and help him, in a piecemeal kind of way, with the thoughts and internal dialogues Mr S discovered, often while sucking. Two years later Dr T's unusual therapy had proved its underlying psychological theory. Mr S had not been radically transformed as a personality but he had sustained those important controls which enabled him to hold a single job for longer than at any previous time and remain free of the kind of violent outbursts that had been his previous hallmark. The price of this was a limited psychological dependence on his doctor and his antacid tablets.

Comment and Conclusion

There are a number of principles and metaphors we may use to describe and explain how this doctor made effective and sophisticated use of the most basic therapeutic tools.

He recognized that the disturbance in Mr S was occurring at an early child, even infantile, level of his mind, and that his communications had to be made accordingly. Reasoning, threatening or bargaining with Mr S's "grown up" part had been tried many times before and never with success. On the hypothesis that the outwardly aggressive Mr S harboured an inwardly frightened child reacting to some fantasized danger, Dr T knew that he must quickly make an alliance or rapport in a way that was both age and feeling appropriate. The careful choice of touch, simple words and eye- contact were designed to engender feelings of security and inclusion

in Mr S, who was previously feeling alienated and turbulent.

It was not enough for Mr S to be "tranquillized" in this way only while receiving Dr T's attentions. His life had to be lived outside the consulting room, and Dr T had to find a way of helping his patient take with him an internalized representation of the doctor, which he would re-evoke at crucial times of stress and threat. Common notions of hypnotism usually call to mind formal procedures of trance-formation, but hypnotic suggestions may be made in ways far more various and subtle, as much recent work indicates (Brandler and Grindler, 1975). Dr T's deliberate emphasis of certain words, pausing at certain times and touching Mr S when he wished to make a particular impact, were all ways of "anchoring" his message, of making a lasting hypnotic-association and imprint (Brandler and Grindler, 1979).

Long after the infant has drawn nourishment from his mother's breast, he continues to draw a sense of comfort and security from the use of his mouth, particularly when sucking. The persistence of this need into adulthood is often masked, channelled and ritualized, but remains ubiquitous. Dr T used this most natural of tranquillizers very directly in his choice of a white, sweet "sucking" medicine, and in doing so also took the opportunity to reinforce and anchor his earlier (hypnotic) suggestion.

As we grow into early childhood we have, increasingly, to learn to live without mother's omnipresence and undivided attention. This difficult process of separation is often accompanied by various manifestations of fear, protest and anger on the child's part, and he may often turn to an inanimate object as a source of solace. Teddy-bears, dummies, blankets are all familiar "transitional objects" (Winnicott, 1958), helping the child face the unknown outside world. The child confers on the object special powers that once belonged only to mother. This need, too, persists into adulthood and is likely to become more intense in periods of stress and loss, where those much earlier feelings of peril and aloneness are reawakened. All three cases described illustrate the process where the doctor's medicine had become a kind of transitional object. Mr D (*Case No 2*) faced his last years accompanied, not by a loved-one by his side, but by a tub of cream into which he projected loving qualities; a rather sad substitute, perhaps, but one which brought him great comfort.

In the film *The Wizard of Oz* the young heroine, Dorothy, believing in the Wizard's

powers, finds resources and courage in herself with which to confront the Wicked Witch of the West. She does not know, at first, that the Wizard is only an ordinary man with no more power than she; it is her belief in him which enables her to face those things she would have previously fled from. These principles, too, lay behind the successful placebo-effect in all three cases, and are well substantiated by experimental evidence (Lesse, 1962; Black, 1966; Silverstone and Turner, 1974).

The last principle I wish to outline is quite as important in practice. In the cases described, the practitioners entered into their patients' mental world, in an intuitive and empathic manner, before confidently prescribing the placebo. Recent investigators (Balint and Norell, 1972) described what they termed 'The Flash' in the medical interview where the doctor, leaving behind the usual protocol and ritual, is freer to understand the inner and existential dilemma behind his patient's presenting complaints. While this often seems an essential component of successful placebo prescription so, too, is the skilled application of principles of how the child's mind develops (developmental psychology), and how this "child-residue" is manifest and operating in the adult (psychodynamics and psychopathology). This is particularly so when dealing with the kind of character problems illustrated by Mr S. The other two cases, depicting some kind of life crisis amidst periods of rapid change and loss, but against a background of otherwise stable personality structure, are undoubtedly easier to deal with but involve similar qualities of interest, flexibility, dexterity and genuineness from the practitioner. It is interesting to note that these seem to be the most important elements of effective psychotherapy generally (Truax *et al.*, 1966). Some practitioners might object that such endeavours are too time consuming to be practical. It is noteworthy, however, that even the relatively complex but crucial interview with Mr S took a little over 25 minutes. Dr T would probably have spent more time and energy dealing with the repercussions, had he refused to see his desperate but accessible patient.

Others might balk at the very idea of placebos, all too frequently used ineffectively and crudely as an act of blind, simplistic reassurance or, worse, a cynical and deceptive "quick trick" to get rid of a "troublesome" patient, under the guise of being helpful. However the intention and (lack of) scientific basis lying beneath such patterns of practice are quite different from the three cases described, where the process of diagnosis and selection was of quite a different order; they should not be

confused.

In an age obsessed with increasingly complex technological activity and accompanying official (often vacuous) slogans such as "The Treatment of the Mentally Ill in the Community" it is often a valuable challenge to re-examine and develop those more intimate and human skills that, despite protean fashions in technology, remain a cornerstone of practice. Healing involves far more than physical engineering. The placebo effect serves well as an example.

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British Journal of Holistic Medicine, December 1984