

THE PLACEBO EFFECT: WHAT'S INTERESTING FOR SCHOLARS OF RELIGION?

by Anne Harrington

Abstract. The placebo effect these days is no longer merely the insubstantial, subjective response that some patients have to a sham treatment, like a sugar pill. It has been reconceived as a powerful mind-body phenomenon. Because of this, it has also emerged as a complex reference point in a number of high-stakes conversations about the metaphysical significance of experiences of religious healing, the possible health benefits of being religious, and the feasibility of using double-blind placebo-controlled trials to investigate the efficacy of prayer. In each of these conversations, the placebo effect is always pointing toward some larger issue, serving some larger agenda. The agendas, though, tend to pull in different directions, leading to a situation that feels at once fractured and stalemated. This essay reviews the main areas of interest, and proposes some specific issues where humanistic scholars of religion in particular might be able to introduce constructive and creative new perspectives.

Keywords: health and medicine; placebo effect; prayer studies; religious healing

I begin by painting a word picture of a particular cultural and scientific scene that has become, at least in the United States, quite familiar. It is a scene where monks meditate in brain imaging machines to advance medical scientific research (Hall 2003); where epidemiologists tell us that the health benefits of going to church are comparable to the health benefits of giving up smoking (Comstock & Partridge 1972; Levin & Vanderpool 1987; Strawbridge, Cohen, Shema, & Kaplan 1997; Strawbridge, Shema, Cohen, & Kaplan 2001); where research subjects are given electrical shocks while looking at pictures of the Virgin Mary, so that researchers can see whether activating the “faith” centers of the brain makes it easier for them to bear pain (Wiech et al. 2008); and where prayer is portrayed, not as a private conversation with one’s own hopes and fears, or with God, but as an alternative therapeutic practice comparable to yoga, acupuncture, and homeopathy (Benson 1996; Christy 1998). It is a scene, in short, in which religious practices, spiritual practices, are portrayed as *health practices*, and

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therefore interesting to, and potentially susceptible to, validation from medical and scientific research.

Within this larger scene of research, debate, and discussion there is one element that has not received nearly as much attention as is warranted: the *placebo effect*. We all have a certain understanding of what is meant by the placebo effect: the tendency of patients to report feeling better or otherwise having a response to a drug or treatment that is known or later discovered to be inert or ineffective. Given our understanding, we might think the role of the placebo effect in the larger world of religion and health research will be a negative one: that the concept will almost surely be used to delegitimize whatever phenomenon is under discussion, unmask it as no less fake than a doctor's sugar pills.

It turns out, however, that there is a lot more to say. And the reason is this: today's placebo effect is no longer the medical humbug placebo effect of our grandparents. Today's placebo effect is *real*. It is no longer a form of cheap psychotherapy in pill form; no longer the stock-in-trade of snake oil salesmen and hucksters; no longer just a tool of honorable deception that researchers use to test whether a new drug really works. The placebo effect which we all conjure today has been rehabilitated—embraced as a powerful mind-body phenomenon with a real biology and possible real clinical uses (Talbot 2000). And this fact has given it a role within the religion-health conversation that deserves far more attention from scholars of religion than it has received to date.

SETTING THE STAGE: THE REMAKING OF THE PLACEBO EFFECT

To understand how this is so, we need to know how we got here. The story begins in the 1970s, with two separate developments. The first was an outgrowth of the discovery in the mid-1970s of endorphins: substances in the brain that are chemically similar to opiates like morphine, and that helped to give rise to the idea that the brain has its own "pain medicine cabinet" ("Coast Researchers Find Opiate in Pituitary Gland Stronger than Morphine," 1976). In 1978, researchers Jon Levine, Newton Gordon, and Howard Fields—all at the University of California in San Francisco—published an investigation of the hypothesis that endorphins might have something to do with the reduction in pain often reported by patients who were given placebos (Levine, Gordon, & Fields 1978). Patients recovering from dental surgery were told that they would receive a dose of morphine to help their pain, but in fact they received plain saline solution. A significant number of the patients claimed to feel significant reduction in pain. This was not unexpected.

Then things got more interesting. Having identified a group of placebo responders and a group of non-responders, the researchers covertly gave all the patients a dose of a drug called Naloxone through their IVs. Naloxone

is a drug that is known to block the uptake of opioids into the nervous system, including the uptake of endorphins. If placebo analgesia was in fact mediated by endorphins, then the Naloxone should reverse the analgesia effects.

And this in fact was just what was found. The placebo responders all experienced a spike in pain, while for the non-placebo responders there was no change. This was a blockbuster finding, since it suggested for the first time that there was a knowable biochemistry behind the placebo effect for pain; a biochemistry, moreover, that could be manipulated.

The second relevant scientific development from the 1970s began as a simple conditioning experiment. Psychologist Robert Ader wanted to see if he could condition rats to develop an aversion to saccharine water (that they normally love), and then extinguish the aversion. He did this by first offering them the chance to drink some sweet water, and then injecting them with a powerful drug called cyclophosphamide, a drug that produces gastrointestinal upset and nausea. It worked; after that single trial, the rats avoided the saccharine water.

But how long would it take to reverse the effects? To find out, Ader began force-feeding the rats with saccharine water. At that point, things got strange: large numbers of the rats began to die. More than that, mortality rates varied directly with the amount of saccharine water the rats had drunk during the initial pairing with the real drug.

Why was this happening? Ader now learned that cyclophosphamide was not only a drug that induced nausea but also a powerful immunosuppressant. And this fact suggested a startling hypothesis: maybe the rats had not just learned to associate the taste of saccharine water with nausea; maybe they had also learned to associate the taste of saccharine water with suppression of the immune system.

This was such a startling hypothesis, because at the time the ruling wisdom was that the immune system and the nervous system had nothing whatever to do with each other. But Ader, working now with an immunologist, was able to show convincingly that conditioning of the immune system was possible. The result was a paper (Ader & Cohen 1975) that changed medicine—because it helped launch a new field which Ader himself christened *psychoneuroimmunology* (Ader 2007).

Ader's work also, however, helped to launch a new way of thinking about the placebo effect: as a physiologically potent conditioned response (but see also Herrnstein 1962). Ader reasoned that the sweet water—itsself pharmacologically inactive—had functioned as a kind of placebo version of the real drug. The effects had been real and powerful. What implications, he began to ask, might this have for both pharmaceutical research and medical practice more generally (Ader 1997)?

In the 1970s, however, no one was particularly interested in these kinds of questions or in the new experimental research on the placebo effect more

generally. No one was particularly interested, even though the 1970s was a time that actually saw the first widespread interest in certain alternative mind-body medical practices like biofeedback and meditation for stress reduction (For the history here, see Harrington 2008). The reason for this neglect of the placebo effect lies in the fact that discussion of mind-body techniques in the 1970s was infused with discontent with the supposedly authoritarian and reductionist approaches of mainstream medicine. The appeal of mind-body medicine lay, in no small part, in its potential to empower the patient by putting healing in his or her own hands (Pelletier & Cousins 1979). Meditation seemed to offer that possibility. So did yoga and biofeedback training.

The use of placebos did not. On the contrary, placebo use was so closely associated in people's minds with deception and the "old style" paternalistic medicine that they opposed that they could not, I suggest, make the cognitive shift. Even after the endorphin and conditioning studies were published, most people continued to focus, not on the possibility of a real biology behind placebo responses, but on the ethics of placebo use in any context (Bok 1974; Kapp 1983; Schindel 1978; Simmons 1978).

It was not until the late 1990s that things finally began to change (Brody & Brody 2000; Harrington 1997; Shapiro & Shapiro 2000). They did so, I suggest, because the 1990s saw the emergence of two important new concerns: first, a concern about the alleged demise of the doctor-patient relationship under managed care ("Relationships Are Impersonal" 1990; Verhovek 1993); and second, a concern about the profit-motives and power of what was coming to be known as "Big Pharma" (Specter 1990). It was around these twin concerns in the 1990s that interest began to be taken in the idea of the placebo effect as a genuine force for healing. Maybe, some said, the placebo effect showed that the doctor-patient relationship was a more important factor in the clinical equation than people had thought. Maybe, others said, our bodies have an innate capacity for healing that could be cultivated as an alternative to an increasingly heavy dependence on pharmaceutical drugs.

A third factor that helped shift the focus of attention on the placebo effect in the 1990s was the revolution in brain imaging. New brain imaging techniques demystified the placebo effect in a way that no previous technology had been able to do. By the start of the new millennium, the newly established visual authority of the brain scan had made it possible for arguments about the reality of the placebo effect to be won by simply pointing: "just look at the brain lighting up there!" (Petrovic, 2005; Petrovic, Kalso, Petersson, & Ingvar 2002).

The timing of these developments is important, because the 1990s was also the decade that saw the initially unrelated rise of interest in the physical health benefits of religion and spirituality. Quite quickly, people began to make connections between the two projects. They did not, however,

all make the same kinds of connections. Instead, the conversation here unfolded in at least three distinct ways.

THE PLACEBO EFFECT AND SPIRITUAL HEALING

The first of these focused on the extent to which the new data on the placebo effect demanded that new attention be paid to practices of religious or spiritual healing. For some, the claims took a quite modest form. A 2003 article in the *New York Times*, for example, talked about a resurgence of interest in voodoo in New Orleans. The article described a healer who had immersed himself in the tradition for more than two decades. Deeply committed to his practice, nevertheless his calm conclusion about the meaning of his life's work was this: "Have you heard of the placebo effect? If you have faith, if you truly believe that supernatural powers can intervene in your life, this [voodoo] can help you" (Kinzer 2003).

Put differently, the view here was that it hardly mattered whether there was a real supernatural realm or not. What mattered was that spiritual healing—powered by belief—in fact delivered on its promises.

Others thought that this approach undersold the matter. The placebo effect, they agreed, was the force behind spiritual healing, they said, but that was because it was itself a spiritual force, one that science had now recognized but could not fully explain. One teacher and author affiliated with the Institute of Divine Metaphysical Research (an alternative Christian movement) put the issue this way: "[W]e must look to the spiritual realm for an explanation of the placebo using the evidence assembled by science as a basis. There is no better place to begin this investigation than the Bible" (Warren 1992).

Still others agreed that the placebo effect opened the door to larger spiritual insights, but then argued for a less creed-based take-home message. For so long, they pointed out, medicine and science had told us that we were helpless products of an inflexible set of biological programs. The placebo effect data suggested that, in fact, we are beings capable of transforming our own biology. If science could overlook this amazing fact for so long, what other mental abilities—telepathy, clairvoyance, nonlocal healing, and more—might it similarly have overlooked? For this group, the placebo effect data were exciting because they opened the door to a far more expansive conversation on the true nature of both healing and consciousness (Benor 2005; Lipton 2008; Shealy & Church 2008).

The suggestion that the placebo effect might serve 1970s-style goals of patient empowerment was emphasized by many who took up this particular message. Once, the argument here went, we thought that, to have a placebo effect, we had to put our faith in sugar pills, or doctors or other healers. Now, however, we knew that we could choose instead to have faith in the placebo effect itself; which was to say, in the miraculous power of our own

minds. A 2003 book by Lolette Kuby called *Faith and the Placebo Effect* was clear: “The placebo effect is the good news of our time. It says, ‘You have been cured by nothing but yourself’” (Kuby 2003).

THE PLACEBO EFFECT AND “THE FAITH FACTOR” IN HEALTH

I have suggested that the placebo effect has been claimed by a range of projects interested broadly in spiritual healing and the spiritual powers of the human mind. There is more, however, to say. By the late 1990s, some people also claimed the placebo effect as a critical ingredient in support of a project that was more about religion (and, especially, Christianity) than it was about spirituality. It was also far more about mainstream medical practice than it was about alternative or spiritual forms of healing. Most of the people who were (and still are) at the forefront of this project were physicians, and most of them were also self-identified Christians.

Their interests were to investigate evidence for the claim that religion was not just good for the soul, but also good for the body: evidence that actively religious people were healthier, or more likely to recover quickly from illness, than those who were atheists or who lacked a strong faith (Koenig, McCullough, & Larson 2001). The John Templeton Foundation, founded in 1987 to “pursue new insights at the boundary between theology and science” was an important force behind the emergence of this project in the 1990s. The Foundation funded early extensive literature reviews, encouraged its funded scientists to disseminate the new arguments through popular books (Koenig & McConnell 2001; Levin 2002; Matthews & Clark 1999), and sponsored a series of conferences to discuss the evidence and its implications (Koenig & Cohen 2002).

Few people involved in the early conversations supposed that the connection between religion and health reduced to the placebo effect. Other factors like positive emotions, social support, stress reduction, and being part of a community were also supposed to be important. Nevertheless, everyone in this conversation knew that the placebo effect was likely to be a critical—maybe the critical—ingredient in the mix. Of all those who insisted on this point, no one took the argument further than the Harvard cardiologist Herbert Benson. Benson already had a long track record of influential involvement in mind-body medicine. In the 1970s, he had been active in turning meditation into a practical technique that people might learn as a technique of stress management (Benson 1975). In the mid-1990s, he had been one of the first to urge medicine to take the placebo effect seriously, as a real healing force (Benson & Friedman 1996). By 1997, when he came out with his book *Timeless Healing*, he was ready to go one step further and insist that religious faith itself unlocks those same benefits of healing far more powerfully than faith in a pill or in one’s family doctor ever did or could: “Faith in the medical treatment,”

he wrote, “[is] wonderfully therapeutic, successful in treating 60% to 90% of the most common medical problems. But if you so believe, faith in an invincible and infallible force carries even more healing power. . . . It is a supremely potent belief” (Benson 1997, 208).

What were the implications of this fact, supposing it to be true? This was not always entirely clear; but for many, it led, at minimum, to the conclusion that mainstream medicine needed to find some way to open itself up to the positive therapeutic power of religious faith and spirituality in ways that it had not before. In the 1990s, Benson himself began running continuing medical education courses at Harvard Medical School on “Spirituality and Healing.” Others suggested that maybe medical schools should start teaching students to take a “spiritual case history” of their patients, alongside the medical one, to see how best to help patients cultivate faith for the sake of their health (Koenig 2000; Taylor 2007). Still others suggested that doctors who were themselves people of faith no longer needed to park that faith at the hospital or clinic door; rather, they should share it with believing patients—even offering to pray with them—as part of their overall healing strategy. In the words of a news article entitled “Your Doctor May Be More Religious than You Think,” (2006) and published in *Health Day*, “some prayer or a bit of spirituality can be a welcome addition to the tools available to medical practitioners.”

Predictably, perhaps, not everyone agreed. Beginning in 1999, Richard Sloan, a professor of behavioral medicine at Columbia University, joined forces with colleagues to launch the first of what would become a series of attacks on the entire effort to link religiosity and faith to improved health. First of all, he said, the evidence for a “faith factor” in health and healing was actually weak and unconvincing (Sloan, Bagiella, and Powell, 1999). Even if this were not the case however, for doctors to advocate religious faith to their patients for health purposes was coercive and unethical, and degraded both religion and medicine (Sloan 2006).

Harold Koenig disagreed and insisted that Sloan had misrepresented the project. Even though he himself was a believer, he said, the goal here was not to be coercive or force patients to do anything that made them uncomfortable. It was simply to make health care more compassionate and relevant to the many believers in this country (the United States). As he put it in 2000:

Patients are caught . . . wishing to have their diseases diagnosed and treated competently with the latest technology, yet having social, psychological, and spiritual needs that are being ignored because of an increasingly streamlined health care system that overemphasizes the physical over the spiritual. (Koenig et al. 2001, 5)

This was a battle of words between physicians, but what did the clergy themselves think of all this? Some, it is clear, felt hugely empowered by

what they saw as solid data pointing to the health benefits of religion and faith. In 2003, a Catholic priest wrote of attending a meeting that included a panel of chaplains from a major U.S. children's hospital, where he observed the following scene:

After a review of recent scientific studies linking prayer, faith and physical health, one of the speakers gasped, "When I hear such exciting news, all I can say is: *Wow*." As it turned out, he had more to say, mostly about how clergy now had objective data supporting their role in the "health care team." (Volck 2003)

This particular Catholic priest, however, was troubled. After describing the scene at the meeting, he went on to say:

While I know this particular Lutheran minister to be sincere, conscientious and pastorally astute, I still couldn't help wondering if faith as "wellness technique" was really what Luther had in mind. . .

What did he mean? What might be problematic, from a theological perspective, with the idea of "faith as wellness technique"? For many, one critical answer was this: if the benefits of faith were partly or even primarily caused by some kind of super-placebo effect, then the focus of a person's faith, the *truth* of what a person believed, became irrelevant. All that mattered was *that* he or she believed. In his *Timeless Healing*, Herbert Benson was very clear about this:

I describe "God" with a capital "G" in this book but nevertheless hope readers will understand that I am referring to all the deities of the Judeo-Christian, Buddhist, Muslim, and Hindu traditions, to gods and goddesses, as well as to all spirits worshipped and beloved by humans all over the world and throughout history. In my scientific observations, I have learned that no matter what name you give the Infinite Absolute you worship, no matter what theology you ascribe to, the results of believing in God are the same. (Benson 1997, 200)

And it was, in the end, the instrumentalism of faith implied in passages like these that began to produce the greatest pushback from critics within mainstream religious (especially Christian) communities. Religious people, these critics began to say, make a commitment to a creed, not just to a set of therapeutic practices. They also make a commitment to a community. When we deny or downplay the importance of both creed and community in order to promote a "better health" approach to religion, these people argued, we deeply distort what true religion is all about (Shuman & Meador 2003).

THE PLACEBO EFFECT AND INTERCESSORY PRAYER

We have seen that by the late 1990s the placebo effect had found a place in grassroots and "New Age" discussions about spiritual healing and the spiritual powers of the human mind. We have also seen that it found a rather different place in more mainstream physician-driven discussions

about the health benefits of religious faith. The last conversation in which the placebo effect found a place at this time was distinctly different from the first two in at crucial respect; it functioned, not as the focus but as the foil, not as a positive spiritual force but as a potential spoiler of spiritual meaning.

Here is the background. By the mid-1990s, at least some prominent figures in the religion-health field had taken on a new, radical brief: to investigate the possibility that prayer—especially intercessory prayer, prayer for another—had a positive effect on the prayed-for person's health, but not just by stimulating the body's own endogenous healing capacities through the placebo effect. The idea instead was to investigate the possibility that prayer changed a person's health in ways that operated independently of all known psychological or psychobiological human mechanisms.

How could this possibility be investigated? The answer seemed obvious: by creating a randomized placebo controlled trial, the same kind of study design that is more typically used to study whether new anti-cholesterol or anti-depressant drugs really work in ways that go beyond the placebo effect.

The study that got the ball rolling was carried out by cardiologist Randolph Byrd in 1988. Byrd studied 393 patients who had been admitted to the coronary care unit of the San Francisco General Hospital. The patients were randomly assigned into two groups: one would be prayed for, and the other would not. Both groups knew that prayer was a possibility for them, but they did not know which group they were in. Byrd then recruited a group of intercessors or "pray-ers," who were all self-identified "born again" Christians. Their assignment was to pray daily for a particular patient in the target group (they were just given the first name): the specific task was to ask God for a speedy recovery with no complications.

The results showed no difference in the speed of recovery between the two groups; but Byrd found that, on 6 out of 26 kinds of possible complications, the prayed for patients did better on a statistically significant level than the controls, and the controls did not do better than the prayed for groups on any of the measures (Byrd 1988). In 1999, a group of researchers based at the Mid America Heart Institute at Saint Luke's Hospital in Kansas City, Missouri, claimed to have replicated Byrd's findings with a larger population sample. The replication actually did not find improvement on any of the specific measures of improvement identified by Byrd, but rather found improvement on other measures (Harris et al. 1999).

For some believers, this was enough to declare early victory. Dale Matthews, an internist who taught at Georgetown University School of Medicine in Washington, D.C., had been researching the "faith factor" in medicine since the early 1990s. In 1997, he told a graduating class

of medical students to get ready, because—he said—“the medicine of the future is going to be prayer and Prozac” (Sides 1997, 92). Nevertheless, in 2002 Matthews’s own study on “the effect of intercessory prayer upon the clinical course of patients with rheumatoid arthritis” failed to show any effects (Posner 2002).

Still, there were enough positive claims in the literature to keep interest in the idea of studying prayer alive for some years. In fact, for some, the clinical trials of prayer came to have a metaphysical significance similar to the anthropic principle in physics (the idea that the universe was deliberately constructed to support intelligent life), alleged evidence for Creation, and reports from people who had undergone near-death experiences (Glynn 1997). For others, though, the fact that the studies with the most apparent success had tested the efficacy of Christian prayer felt particularly important. One Christian website from 2002 was quite clear on its position: “No other religion has succeeded in scientifically demonstrating that prayer to their God has any efficacy in healing.” The author went on:

Obviously, science has demonstrated in three separate studies the efficacy of Christian prayer in medical studies. There is no “scientific” (non-spiritual) explanation for the cause [sic] of the medical effects demonstrated in these studies. The only logical, but not testable, explanation is that God exists and answers the prayers of Christians. (Deem 2005)

Other commentators suggested a wholly different way of conceptualizing these data; one rooted less in Christian beliefs in an omnipotent God and more in the innate spiritual powers of the human mind. Maybe prayer worked, it was suggested, not because a personal God responds to a supplication, but because human beings are spiritual creatures with the ability to use their minds to influence others through “nonlocal,” “quantum,” or “distant” healing methods. In the 1990s, the Texas internist Larry Dossey emerged as the most visible advocate of this alternative approach to prayer (Dossey 1993).

A key study for Dossey and others thinking along these lines was a 1998 interfaith report of “distant healing” led by parapsychologists Fred Sicher and Elisabeth Targ at the California Pacific Medical Center in San Francisco. Forty patients with advanced AIDS living in the San Francisco Bay area were recruited for a six month trial, and divided into an active treatment and control group. The interveners for the study consisted of forty practicing healers that self-identified variously as Christians, Jews, Buddhists, Native American shamans, and graduates of “bioenergetic” schools. The healers were given photographs of the AIDS victims, their first names, and their blood counts. Rather than ask God to help the patients, the healers were instead asked to direct an “intention” for health and well-being to the subjects. The authors claimed (though others severely criticized their methods and interpretations) that the twenty AIDS patients

who received the “healing energy” had “fewer and less severe new illnesses, fewer doctor visits, fewer hospitalizations, and improved mood” when compared to the twenty patients in the control group (Sicher, Targ, Moore, & Smith 1998).

Meanwhile, skeptics like Columbia University’s Richard Sloan be-moaned the very existence of these studies as symptomatic of the same kind of trends that result in polls showing that enormous numbers of American believe in angels but do not believe in evolution. It might not matter so much about angels, but when it came to medicine, he said, this kind of irrationalism could be putting human lives at risk (Sloan 2006)

Sloan and others offered multiple criticisms of the methods used by researchers in these studies. A lot of these criticisms had to do with faulty inferences being made from statistics, but one of them also takes us back to the placebo effect. There was some reason to believe, some critics suggested, that the blinding in these trials had been incomplete; that patients knew or suspected that they were in one group or the other. And if that were true, he argued, the studies failed by default. Put another way, if the observed benefits of intercessory prayer were caused by the placebo effect, they could not be caused by God. Again, the placebo effect had no spiritual significance in this part of the territory—it was instead, by definition, the *spoiler* of spiritual significance (Coulter 2003).

For several years, matters remained in this unsettled and somewhat heated state. Then, in 2006, events took a new turn. *The American Heart Journal* published a paper reporting the results of what had been touted as the definitive and methodologically most rigorous study of the effects of prayer on health to date. Headed by Herbert Benson, the study had involved close to two thousand cardiac patients undergoing surgery in six hospital sites (Benson et al. 2006). Strikingly, Benson and colleagues found no difference between the outcomes of subjects who received prayer and subjects who did not receive prayer. In this sense, the study failed; but it failed with an added twist. In the first two arms of his study, Benson and colleagues had controlled for the influence of the placebo effect by not telling the patients whether or not they would be prayed for. But then these researchers did something that none of the other researchers had done: he added a third arm to his study and told patients in that arm that they would be receiving prayer—and then in fact ensured that they did. His idea was to look for an additive effect. He hoped the data might show positive benefits of prayer amplified by further positive benefits resulting from the placebo effect.

However, things unfolded differently than expected. Instead of a positive placebo effect, the patients in the third arm, the ones who knew they were being prayed for, did worse than any of the other groups. It was a small difference, to be sure; but it was statistically significant. From a personal conversation with Benson, I know that this result deeply upset him. I asked



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him: why did he think it had happened? And he said (and would go on to say the same in formal interviews): "I don't know, Anne. Maybe they felt performance pressure and just choked." One of Benson's co-authors, Charles Berthea, had a different suggestion: "Did the patients think, 'I am so sick that they had to call in the prayer team?'" (Knight 2006). The fact is, no one really knew.

But that did not stop others from using the findings to have their fun with the whole thing. Shortly after Benson published his study, the *Guardian* newspaper in England published an article with the following title: "If you want to get better—don't say a little prayer" (Burkeman 2006).

Not too much has been heard on the prayer studies front since Benson's study. By appearing to work perversely—causing patients to get worse rather than better—the placebo effect seems to have taken the wind out of the sails of the whole effort.

WHERE DOES THIS LEAVE US?

I've suggested that, since the 1990s, the placebo effect has been invoked in support of no fewer than three distinct kinds of projects: (1) a project to re-imagine the human capacity for self-healing, not just as a medical but as a spiritual phenomenon; (2) a project to argue specifically for the health benefits of a strong religious—perhaps a specifically Christian—faith; and (3) a project to investigate how far prayer for the healing and health of another really makes a difference in some way that cannot be explained by reference to the power of the mind on the body. In each of these projects, the placebo effect is always pointing toward some larger issue, serving some larger agenda more than itself; even as people disagree as to what that larger agenda is.

The situation, taken as a whole, is notably fractured and increasingly polarized. It cries out for constructive and creative new kind of analyses and interventions. I believe that humanistic scholars of religion are an obvious community from which to seek such interventions. People in this community have not (usually) been players in the various debates, but they bring an obvious range of informed, sympathetic, and critical perspectives to bear on them.

There are certainly enough issues worthy of more attention. To date, the general proposition that religious practice might confer health benefits has attracted the most thoughtful attention, especially from theologians uneasy about its instrumentalist implications (Shuman & Meador 2003). Few, however, have specifically probed the larger issues opened up by the decision—by some—to frame the healing effects of religious faith as a kind of “super placebo effect.” Does this framing act to secularize and medicalize the experience of religious healing, or does it not? The answer seems to be that it depends on how the placebo effect itself is being defined, but all the details after that remain to be worked out.

The recent prayer studies also cry out for more analysis. It seems clear that these studies have tended to be grounded in a kind of eliminative logic: if results cannot be explained in terms of the placebo effect, or any other accepted psychological or psychobiological category, then we are in the realm of unknown forces, either of the human mind or—more usually—of God's ineffable power. *God's power begins (or at least can be witnessed) only where the known powers of the mind leave off*, and only in the abstract space of statistical trends rather than in any specific individual case. What are the theological, ethical, and pastoral implications of thinking about the matter in this way?

Beyond bringing fresh perspectives to existing conversations about religion, health, and the placebo effect, I also imagine ways in which well-developed analytic approaches from religious studies could be used to ask new questions. Consider, for example, the scholarship within religious

studies on ritual healing, on the power of symbols, on the creation of sacred space, and on the acculturated nature of human embodied experience. Perhaps some or all of these analytic perspectives could be tapped to enlarge and enrich the ways that think about the placebo effect. Perhaps some of these analyses could even ask questions about the placebo effect, not just when the context is specifically religious, but also when it is not. Put another way, what might religious studies scholars bring to the analysis of the placebo effect when the setting is a hospital rather than a shrine or church, and involves drugs, syringes, and doctors in white coats?

There is more to say, but I hope the general, and in some ways quite simple point here is clear. The placebo effect is worthy of serious attention by scholars of religion. It is worthy of that attention for at least two reasons: because of what has already happened around this topic, and even more because of what still *could* and, I hope, *will* happen if more attention were to be paid.

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