PhD Thesis

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Removal of Dosing Information to Reduce Withdrawal Symptoms in Drug Reduction Regimens

*“To sum up, I am suggesting that many of the reinforcing consequences and antecedents of drug addiction have no direct pharmacological basis. For a given individual the temporal pattern of drug use may be maintained almost entirely by secondary reinforcers.“*

Valliant, 1988

The context in which a stimulus is presented to us has an enormous influence on the way we perceive and react to that stimulus. Most people however are either unaware of or ignore this fact, as it introduces an uncomfortable element of doubt into their transactions with the world. If we question whether the expensive wine we drink actually tastes better, or if it merely tastes better because it is expensive, we may be forced to admit that all our perceptions are flawed, from the way we think our colleagues interpret what we say to the way we remember pivotal moments in our personal histories. Therefore most of the time we accept our perceptions of both internally and externally generated events as being accurate and in some sense true. These perceptions go on to guide both our volitional and non-volitional responses to the stimuli we encounter. One of the goals of psychology as a science is to measure the gap between what we perceive as the truth and what that truth actually is, and to use this knowledge to help us base our future decisions on reality rather than a view of it that has been distorted by our beliefs, expectations, and predilections.

Expectancies are important moderators of how we perceive and interact with the world. Expectancies can be defined as schemas which are activated based on appraisals of the likelihood of one stimulus predicting the arrival of another. The activation of these schemas by the perception of the first stimulus elicit responses, either volitional or non-volitional, which can alter how we perceive and react to the latter stimulus when it arrives. Thus the context preceding any stimulus gives us cues about what to expect when that stimulus arrives. It provides us with a heuristic that allows us to assimilate novel information into our existing worldview. Expectancies shape both our perception of the stimuli when it finally occurs and our reaction to it after it has occurred. Solomon Asch and effect of labels on perception, Coca-Cola blind taste tests, Social Anxiety (expectancies about what other people are thinking).

**The Placebo Effect**

It is well established that a patient’s expectations surrounding a treatment can influence the effectiveness of that treatment. This phenomenon, known as the placebo effect, can either mimic (Marlatt & Rohsenow, 1980; Hull & Bond, 1986), or augment/attenuate (Penick & Hinckle, 1964; Penick & Fisher, 1965) the effects of the active treatment itself, depending on whether the anticipated effects are positive or negative. For years the placebo effect has been considered a nuisance, a thing to be ‘controlled out’ in order to gauge the precise effects of the treatment alone. However new advances in placebo research suggest that patients’ expectations of treatment effects, far from being a nuisance, can in fact be harnessed in order to enhance treatment outcomes.

Placebo effects have been observed for a wide range of phenomena, including analgesia (Amanzio & Benedetti, 1999), improved motor function (Pollo et al. 2002), reduced insomnia (Suetsugi, Muzuki, Yamamoto, Uchida, & Watanabe, 2007), bronchioconstriction (Butler & Steptoe, 1986) and immunosuppression (Ader, Cohen, & Bovbjerg, 1982). Placebo effects can be positive or negative, depending on what the patient is expecting from the treatment. Side-effects of a drug for example are sensitive to conditioning and expectancy manipulations in much the same way as the desired effects (Shapiro, Chassan, Morris, & Frick, 1974). Possibly the most salient example of an aversive expectancy-induced effect (or nocebo effect) is the anticipatory nausea experienced by patients undergoing chemotherapy (Montgomery & Bovbjerg, 2001; Roscoe, Hickock and Morrow, 2000).

**Placebo Effects: Expectancy or Conditioning?**

The placebo effect is traditionally explained as a learning phenomena, specifically an example of classical conditioning. Wickramasekera (1980) used a Pavlovian, stimulus-substitution model of conditioning to explain placebo effects. According to this model the treatment itself is the US, the contextual cues surrounding the treatment’s administration the CS, and the acute effects of the treatment on the central nervous system the UR. Repeated contiguous pairings of the US and the CS eventually lead to a conditioned response, similar to the UR, which can be elicited following the presentation of the CS alone. This conception views placebo effects, and in fact classical conditioning generally, as being mediated mostly by unconscious associative processes.

However findings such as the fact that the CS + US pairings do not always lead to conditioning (if, for example, prior to the CS + US pairing, the CS occurred many times in the absence of the US) have largely caused the stimulus substitution model of classical conditioning to be rejected in favour of an expectancy model (Rescorla, 1988). According to this model, conditioning is dependent not on contiguity but on expectancies, which are based on the perceived likelihood of one set of stimulus (the CS) being followed or accompanied by another (US). The extent to which a CS is able to produce a conditioned response depends on the information the CS provides about the US. For a stimulus to function as a US it has to be perceived. In the case of the placebo effect, the active nature of the drug can only be perceived via its effects. Thus the effects of the drug are the US, not the UR, as is held by the stimulus substitution model (Montgomery & Kirsch, 1997). The conditioned response—in our case the placebo response—then can be seen as an anticipatory response that prepares the organism for the occurrence of the anticipated US (Siegel, 1983).

The principle difference between the stimulus substitution and expectancy accounts is whether the placebo effect is mediated by mostly conscious or unconscious learning. Benedetti et al. (1998) were able to induce a placebo respiratory depression response that, though objectively measurable, was unnoticed by participants and which had not been mentioned as a consequence of the administration of the drug. The control group, who had not received any prior pairings of the active drug with the placebo pill, showed no such respiratory depression. Since conditioning was achieved without perception this result would seem to indicate a completely unconscious placebo response that contradicts the expectancy account. Need more examples!!!!!!.

Butler and Steptoe (1986) on the other hand found that the same placebo inhaler could either induce or prevent bronchioconstriction in asthmatics, depending on which outcome researchers lead participants to expect via verbal instruction. Flaten (1988) similarly found that the same inert substance (lactose) led to either sedation or arousal depending on the instructions given to participants, and that patients who were given a muscle relaxant but who were told it was a stimulant reported greater muscle tension than those who were truthfully told it was a muscle relaxant (Flaten, 1999). One multi-centre placebo-controlled trial testing the effects of aspirin on unstable angina listed “gastrointestinal irritation” as a possible side-effect in the information statements supplied by 2 of the 3 centres but not in the third. Patients at the former centres reported significantly higher rates of gastrointestinal problems than those at the latter, and were 6 times more likely to drop out of the study due to gastrointestinal distress (Myers, Cairns, & Singer, 1987). Fillmore and Vogel-Sprott (1992) found that participants who were informed that caffeine improved motor performance demonstrated a greater improvement in performance following administration of a caffeine placebo than participants who were told caffeine would impair performance. The examples above suggest that some placebo and nocebo responses to drugs appear to be entirely mediated by conscious verbal expectancies, occurring in the absence of any prior pairings of the drug with its effects. Furthermore when subjects are told that there is a possibility that they will receive a placebo the placebo response is lessened (Kirsch & Weixel, 1988). These results appear to show that a verbal manipulation, even without prior pairings of a vehicle to a treatment/drug, can lead to a placebo response. How does this happen? The generalising of salient stimulus-response-outcome contingency features of the old situations to a new situation with similar percieved stimulus features. This produces the strange situation whereby we *can get a conditioned response to a completely new stimulus,* based on expected similarity of the new stimulus to old.

While there has been much heated debate about whether learning generally and placebo effects specifically are due to conscious or unconsciously mediated processes (Mitchell, Houwer, & Lovibond, 2009), Stewart-Williams and Podd (2004) point out that there is no reason why these two explanations of the placebo effect need be mutually exclusive. They point out that classical conditioning can lead to learning which is entirely unconscious *or* to learning which contains elements of both consciously and unconsciously mediated processes, whereas verbal information must always result in conscious learning. Thus it is likely both unconscious conditioning and conscious expectancy mediate placebo effects to varying degrees.

That unconsciously conditioned responses to drugs can co-occur in conjunction with, but separate to, conscious expectancies is most obvious when conditioned responses and expectancies contradict one another. For example smelling a plastic rose or being shown a sealed jar filled with dust can induce asthma attacks in asthmatics (Luparello, Lyons, Bleeker, & McFadden, 1968; Dekker & Groen, 1956). A similar phenomenon is when long-abstinent heroin addicts suffer physical tolerance/withdrawal symptoms such as runny nose, goose-bumps and lachrymation upon merely witnessing the tools of heroin administration or another addict shooting up (Valliant, 1988). In both examples the sufferers are aware that they have not ingested the agent in question and thus do not have a conscious expectancy of a response, but nevertheless suffer a physiological reaction to the visual stimulus that they have come to associate with that agent.

**Sources of Expectancies**

The expectancies of drug or treatment effects that are tested in the lab can be grouped broadly into three categories. These mode of acquisition of the expectancies can effect which sub-systems of the brain are responsible for the resulting placebo effects. For example expectation triggers endogenous opioids whereas conditioning activates specific subsystems (Amanzio & Benedetti, 1999)

***Verbally-Induced Expectancies***

Firstly there are those expectancies concerning the effects of a drug or treatment which participants do not hold prior to the experiment and which are induced verbally by the experimenter. As mentioned earlier expectancies are derived from the information an organism receives about the contingency between events. Many animals possess the ability to generalise the information gained from one set of CS-US associations to a new set. This allows them to generate expectancies about the imminent arrival of a familiar US, based on the perceived similarity of certain features of a novel CS to a familiar CS that had reliably signalled the US in the past. Humans however are unique in that we are able to generate these expectancies not based solely on the physical and/or environmental features of the new CS, but on verbal information alone.Humans are unusual in that we have the ability, mainly through language, to abstract information (i.e. isolate salient features of particular instances from their specific context in order to form generalisations). Thus expectancies can be induced verbally in the absence of direct experience with a contingency between events (unlike in non-literate animals for whom contingencies can only be obtained through direct observation of events). Humans are unusual in that we have the ability, mainly through language, to abstract information (i.e. isolate salient features of particular instances from their specific context in order to form generalisations)

This abstract information can serve as a cue, an abstract cue, which can elicit placebo responses not possible in creatures who do not have language.

Thus merely by providing credible information about the likely effects of a drug to participants it is possible to have:

1. a conditioned response being elicited by a novel stimulus

e.g. analgesia can be caused by a placebo masquerading as a new treatment

b) a novel response (though the response itself can never be novel) being elicited by a familiar stimulus. For example omitting gastrointentinal irritation as a side effect on boxes containing aspirin in one group of participants led to significantly decreased reports of gastrointestinal complaints compared to a who received identical aspirin except packaged in boxes where the side effect was listed (Myers, Cairns and Singer, 1987).

c) The same inert substance leading to opposing effects. For example inert lactose pill causes sedation or arousal depending on what participants are told it was (Flaten, 1998).

Because we are able to abstract information from language we are able to produce conditioned responses in the absence of direct observation of a contingency between events. In other words, by **decontextualising** a previously acquired contingency between a drug and its unconditioned response and then **superimposing** that contingency onto a new drug we are able to produce what amounts to a conditioned response to a novel stimulus.

For verbal information alone to be able to induce conditioned responses participants must: a) be previously unaware that the effects in question are associated with the drug or treatment they think they are about to receive[[1]](#footnote-1); b) believe that the experimenter is a credible source of information about the likely effects of the drug and that the vehicle they are given actually contains an active agent.

For example participants with food allergies who were told that a saline injection was an allergen developed allergic symptoms (Jewett, Fein, & Greenberg, 1990). Luparello, Lyons, Bleecker and McFadden (1969) gave asthmatic patients nebulised saline to inhale and told them it was an allergen. Approximately half of all participants developed dyspnea, decreased vital capacity, and increased airway resistance.

Arguably these purely verbally induced expectancies still rely, for their ability to induce placebo effects, on some familiarity with the physical or psychological symptoms that experimenters suggest will follow administration of that drug. Thus even verbally induced expectancies may be mediated to some extent by prior conditioning. ???????? reference

***Expectancies Acquired from Personal Experience***

Secondly there are those expectancies about a drug or treatment which have been derived prior to the experiment, either from participants’ first-hand personal experience of the association between the drug and its effects or from observation of others reactions to the drug (i.e. social learning; Bandura, 1977). As with purely verbally induced expectancies harnessing long-held expectancies in the lab also requires credulity on the part of participants that any vehicle they are given by experimenters does actually contain an active agent.

Here you need to give evidence of expectancy and suggestion vs evidence of conditioned negative placebo responses (see Barsky et al for a review, look in Side effects file in Lit Review Section). Paragraph below is the start of expectancy & Suggestion bit.

***Experimentally-Conditioned Expectancies***

Lastly there are expectancies which are acquired by direct experience but where this experience is acquired during the conditioning phase of laboratory trials. These can be induced without any prior awareness or ignorance of likely outcomes of administration of the drug or treatment, nor need there be any belief in the experimenters trustworthiness, for the unconditioned effects of the drug are paired with the conditioned stimulus over repeated trials/administrations during the experiment. Expectancies conditioned in the lab are typically stronger than those acquired by simple verbal suggestion (Pollo, Carlino, & Benedetti, 2008), and those which have been acquired by first hand experience over a lifetime in naturalistic settings and, of course, stronger than either.

**What is the Placebo Effect?**

Four possible explanations for placebo effects.

a) bona fide psychophysiological mimicry of an unconditioned response by a conditioned response (e.g analgesia, immunosuppression, bronchioconstriction)

b) smudging/ignoring of bodily cues which contradict our expectancies

c) Somatic focus/interpretive frame causes ambiguous and incidental symptoms (e.g. headache, fatigue etc.), which overlap with symptom profile of drug, to be interpreted as instances of drug effects

d) Anticipatory anxiety/worry over onset of negative symptoms of drug either:

i) carry over post drug-administration and resemble the unconditioned symptoms so that they are once again misinterpreted as instances of drug effects.

ii) and/or triggers bona fide symptoms which resemble drug effects.

**Chains of Expectancies**

Fillmore and Vogel-Sprott (1992) have identified four types of events that are relevant to expectancies: the stimulus accompanying the administration of a drug (S); the stimulus effect of the drug (Sd); the particular effect of the drug on a response (Rd); and the environmental outcome of this effect (S\*). These four events can lead to three sets of expectancies. The first is when the stimulus of administration lead to the expectancy of the drug’s effect (S–S­d). This expectancy is assumed to produce the effects observed in double-blind and balanced placebo studies, where the learned association between, for example, a bottle labeled with a familiar brand of alcoholic beverage, a taste that resembles this beverage, and (therefore) the belief that it *is* this alcoholic beverage lead to an expectancy that the beverage will cause bodily sensations which have been caused by this type of liquor in the past. The second set of expectancies occurs in relation to the connection between the effects of the drug and the responses to those effects (Sd–Rd). Expectancies of this sort are evoked by the past associations of the drug stimuli—the bodily sensations of alcohol in our example—with the behaviour that these sensations have produced (disinhibition, aggression, or sexual arousal in the case of alcohol). Lastly there is the set of expectancies known as response expectancies, between the response to the drug and the environmental outcomes of the behavioural effect of the drug (Rd–S\*). This expectancy is important because if the environmental outcome is desirable (because it leads to some form of catharsis in the case of aggression leading to a fight or sexual arousal leading to coupling) it may increase the incentive to display Rd (Sdao-Jarvie & Vogel-Sprott, 1991). Placebo responses rely on all three of these expectancies occurring in sequence.

**Drugs of Abuse**

Drugs of abuse also show expectancy effects. For example, expectations of receiving alcohol (Fillmore, Carscadden, & Vogel-Sprott, 1998), THC (Kirk, Doty, & deWit, 1998), Caffeine (Lotshaw, Bradley, & Brooks, 1996), and d-Amphetamine (Mitchell, Laurent, & de Wit, 1996) have all been shown to mimic effects of the drugs themselves.

It has been suggested that many of the effects of the long-term abuse of drugs such as tolerance (Siegel, 2000) and sensitivity (Schenk & Partridge, 1997), may in part be learned responses due to repeated pairings of environmental and/or endogenous affective stimuli with the acute effects of the drugs themselves. Tolerance and withdrawals are hallmark symptoms of drug dependence according to the Diagnostic and Statistical Manual of Mental Disorders (5th Ed.; DSM-V, American Psychiatric Association, 2013) description of substance abuse disorders. Tolerance is a neuroadaptive homeostatic response of the organism to repeated exposures to a substance, whereby the required dose to achieve the same psychophysiological effects increases over time. Tolerance has been shown to be comprised of a significant learned component, shown by the fact that it can be reduced in novel locations and that treatments that retard learning ­- such as Actinomycin D, electroconvulsive shock therapy, and frontal cortical stimulation - also inhibit the development of tolerance (see Siegel, Baptista, Kim, McDonald, & Weise-Kelly, 2000, for a review). Given that many of the effects of drugs of abuse, including tolerance, have been shown to be sensitive to expectancy manipulations, there is no *a priori* reason why withdrawals should not also have a significant placebo component.

**Drug Withdrawals**

Withdrawals are a suite of mostly aversive psychophysiological phenomena that occur upon discontinuation or reduction of dose of a substance that has come to be relied upon for maintaining affective, cognitive and physiological equilibrium. Withdrawal symptoms can be divided into two categories: physical and psychological. Physical withdrawal symptoms are more likely to be specific to particular drugs, begin rapidly upon cessation of drug-taking, generally peak within the first 1-3 days of abstinence, and dissipate within 7-21 days (Hughes, Higgins, & Bickel, 1994). Psychological symptoms on the other hand tend to be common among all drugs of abuse (West & Gossop), and persist considerably longer (Hughes et al. 1994; Martin et al. 1963; Maurer & Vogel, 1967; Goldberg & Schuster, 1969; Gawin & Kleber, 1986; O’Brien et al. 1992). In fact addicts report these withdrawal symptoms as more distressing than physical withdrawal symptoms (Cohen, Klett, & Ling, 1983). These symptoms, such as anxiety, depression, insomnia, irritability, lack of energy, restlessness, decreased appetite, and craving for drugs do not tend to be as salient as physical symptoms during the acute stage of withdrawal (though addicts still rate the level of distress caused by them more highly than clinicians) but are usually much longer lasting. This is born out by the fact that: a) patients on methadone maintenance programs report psychological symptoms as relatively more distressing than physical symptoms (Cohen et al, 1983) and b) most relapses occur well after the physical symptoms have dissipated. Withdrawal symptoms are certainly not the only factor determining duration of abstinence and relapse. Long-term motivational factors, such as commitment to treatment outcome (Miller, 1985), abstinence goal (Elal-Lawrence, Slade, & Dewey, 1987), desire to abstain (Best, 1975), expectation of success (Mothersill, McDowell, & Rosser, 1988), expected difficulty of quitting (Rosen & Shipley, 1983), perceived self-efficacy (Annis & Davis, 1988), and perceived costs and benefits of change (Hall, Rugg, Tunstall, & Jones, 1984) also have been shown to predict successful attempted abstinence. In all likelihood there is an interaction between withdrawal symptoms and motivational goals, particularly during times of significant stress (Benfari & Eaker, 1984; Cronkite & Moos, 1980; Krueger, 1981; Rosenberg, 1983).

**Expectancy and Withdrawals**

If expectancies of changes in psychophysiological state, caused by the repeated pairings of environmental stimuli surrounding the administration of a drug with the drug’s pharmacological effects, are enough to cause placebo effects that mimic or augment the active effects of the drug, it also follows that repeated pairings of the stimulus surrounding discontinuation or reduction of a drug with the concomitant withdrawal symptoms could also produce expectancies of withdrawal that lead to placebo withdrawal responses.

The symptoms that follow abstinence are very similar across many different types of drugs: headache, irritability, fatigue, depression, difficulty concentrating. These symptoms are also present in non-medicated, non-addicted persons in everyday life (Reidenberg & Lowenthal, 1968; Khosla, Bajaj, Sharma, & Mishra. 1992). The overlap in symptom profile between abstinent addicts experiencing withdrawal, and normal non-addicted, non-medicated individuals suggests that at least a portion of the withdrawal symptoms reported by abstinent addicts may be the result of the misattribution in the mind of the addict of the vague, incidental physical or psychological symptoms which occur commonly simply as a part of everyday life to withdrawal symptoms. It is expectancy of experiencing these withdrawal symptoms which cause this misattribution.

Solomon and Corbit (1974), in their opponent-process theory of motivation, suggest that drug withdrawals, initially, are a slave process, which can only be evoked indirectly via the absence of the primary process, which is the drug. In time however this slave process, the opponent process, ‘can, under proper conditions, be activated by events in memory, as a consequence of Pavlovian conditioning procedures.’ According to the theory the opponent process—withdrawals in this case—acquire more power if frequently elicited. Applying this idea to withdrawal expectancy we could make predictions such as that addicted individuals who have been addicted longer and who have thus had more experience with withdrawals will have a greater expectancy-induced withdrawal response.

Kleber 1981 (as cited in Phillips, Gossop, & Bradley) cumulative effect of expectancies on withdrawal as pronounced as any pharmacological factors.

Need to go over F& V-S’s model of expectancies in more detail.

If the environmental and verbal/cognitive stimuli surrounding the administration of a drug can be considered S1, which then evokes a chain of expectancies concerning the physiological, behavioural and environmental effects of the drug, then the presence of stimuli signaling the absence or reduction of maintenance dose of the drug can be thought of as S­­2 , a stimulus which signals a different chain of expectancies[[2]](#footnote-2). Thus applying Fillmore and Vogel-Sprott’s (1992) schema above to withdrawals: the absence of the drug (S2) elicits a physical withdrawal response (S2d) which in turn evokes a behavioural response (R2d) and an environmental consequence (S2\*). In case of drug addiction, the behavioural response to the physical discomfort, boredom, depression etc. of withdrawals is to obtain the drug, the environmental consequence of which is relief from withdrawals. The more the process is repeated the stronger, more automatic, less goal-directed and more habitual become the links between these steps, and the more difficult it becomes to break the drug-seeking behaviour. With enough reiterations of this chain of stimulus-response contingencies, the same three sets of expectancies that occur with respect to the presence of the drug (S–Sd: Sd–Rd: Rd–S\*) come to form around its absence. It is the anticipation that the absence of the drug (S2) will lead to withdrawals (S2d)followed by obtaining the drug (R2d)to seek relief that causes the habitual use of drugs that are otherwise detrimental to the wellbeing of the addicted individual. If it is this chain of stimulus and their expected consequences that sustains drug-seeking behaviour then it is possible that altering either the valence of steps (eg. if the environmental consequence of obtaining drugs became considerably more negative to the point where it outweighed the relief caused by eliminating withdrawals) or the degree of automaticity/contingency between the steps (eg. if an alternative method of coping with withdrawals, other than obtaining the drug, became available) could conceivably lead to a change in the behaviour.

The expectancy that one set of stimulus will reliably lead to another is thought to be the cause of placebo responses to drug treatment (Kirsch, 1997). Placebo responses rely on all three of the above expectancy sets occurring in sequence. However it is likely that knowledge of the contingency between S and Sd is not the only association made. It seems probable that when the individual senses the initial stimulus relating to drug administration (S), this causes them not only to anticipate the physical effects of the drug (Sd), but also the behavioural (Rd) and environmental consequences (S\*). This is also most likely true of the absence of the drug. Thus what begins as a slave process, withdrawals, which can only be initiated indirectly by the presence of the primary process, drug use, eventually becomes a conditioned response, able to be elicited in the absence of the drug, by environmental cues or expectancy alone.

Schema theory (see pdf ‘Expectancy and side effects in cancer patients’ in ‘Nocebo\_Side Effects’ folder)

**Evidence for Placebo Withdrawals: Tolerance vs Withdrawal**

The notion of conditioned withdrawals is not a new one There is ample evidence of withdrawal-like conditioned responses, both physiological and psychological, to stimuli that have been paired with drug use in the past. For example men on research wards who have been abstinent for months can experience acute craving and signs of withdrawal, such as goose-flesh, lacrimation, runny nose etc. upon merely seeing another man receive an injection of morphine (Valliant, 1988). (also see Childress, McLellan and O’Brien, 1986 for conditioned withdrawal evidence). In addition, addicts maintained on such high doses of methadone they did not feel the effects of heroin, still reported symptoms of withdrawal when they experienced psychological stress (Dole and Nyswander, 1965). Both these examples show that visual and/or affective triggers can induce cravings and physical withdrawal symptoms in individuals who should not have any physiological reason for feeling them — in Valiant (1988) because they had been abstinent for months and were no longer experiencing physical withdrawals, and in Dole and Nyswander (1965) because they were on a very high dose of methadone.

Not only can withdrawal symptoms be induced by expectancy alone, they can be reduced by the expectancy of receiving the drug needed to relieve them, even if that drug is actually a placebo. Thompson & Schuster (1964) for example, found that withdrawal symptoms of monkeys could be effectively relieved by injections of saline administered in settings where morphine was given in the past. Findings such as the above led Valliant (1988) to suggest that ‘even withdrawal symptoms themselves are not simple physiological responses to the withdrawal of a biologically active substance.’

However a distinction needs to be made between conditioned tolerance and conditioned withdrawal. Conditioned tolerance is a homeostatic/allostatic response that occurs in response to stimuli surrounding the impending *presence* of a drug. It can occur even in the absence of expectancy (in much the same way as the jar of dust in asthmatics) of receiving the drug (e.g. addicts in Childress et al. and Valliant.). There is ample evidence, both in humans and animals, of conditioned tolerance (see Siegel). While O’Brien etc. have written many papers based on what they call conditioned withdrawal in humans what they are likely observing is conditioned tolerance. However perhaps this internally-generated tolerance response itself becomes conditioned to presence of drug-related stimuli, so that over time what initially was a conditioned tolerance response (an unconscious physiological response preparing the body for the impending ingestion of the drug) becomes a expectancy-induced withdrawal response (i.e. over repeated exposures to drug-related stimuli *without a corresponding ingestion of the drug* the conditioned negative withdrawal-like tolerance response becomes an expectancy-induced bona fide expectancy-induced withdrawal response to the presence of drug-stimuli *combined* with the and expectancy of actually recieiving no drug.

Experimental studies dealing with conditioned withdrawal proper (as opposed to conditioned tolerance) have dealt mostly with pharmacologically-induced withdrawal pairing antagonist drugs such as naloxone with compound stimuli (Kenny et al.) Well-run studies in animals have shown good evidence for conditioned withdrawal. Evidence in humans using similar designs has however been hampered by small sample sizes, an understandable problem given the complexities of accessing a sample size of sufficient statistical power in a population of addicted individuals (O’brien et al). Both these studies (O’Brien and Kenny) show that bona fide withdrawal responses can be conditioned to occur in the absence of a pharmacological agent in response to environmental stimuli that had been paired with withdrawals in the past and in organisms who had sufficient drug levels in their system for there to be no physiological reason for withdrawals.

The designs mentioned above tested a conditioned withdrawal response to the presence of a signaling stimuli. If there is such a thing as *in vivo* conditioned withdrawal however, it would have to occur in response to stimuli that signal the impending *absence* of a drug. To prove this would require conditions where participants have a pre-existing expectancy that discontinuation or reduction of dose of a drug will lead to adverse symptoms. The challenge to experimenters who wish to test this notion is that separating the conditioned or expectancy-induced component of withdrawals from the physiological component would require surreptitious reduction or interruption of the dose of a drug in one group of participants, in other words, convincing participants that they are still taking their expected dose of a drug when in fact it has been reduced.

The reason that conditioned tolerance and conditioned withdrawal are confused is that the physiological symptoms of acute withdrawal (e.g. in opiate addiction: lachrymation, rhinorrhea, myoclonus, piloerection, dilation of pupils, craving etc.) strongly resemble conditioned tolerance responses. Tolerance responses however are relatively ephemeral whereas chronic withdrawal can last 6 months or more and is characterized by symptoms that are more psychological in nature: insomnia, depression, anxiety, dysphoria, boredom, irritability. I would argue that real-world expectancy-induced withdrawal responses, if they exist, can only occur in response to cues which signal the *absence* of a drug. (i.e. removing an aversive stimulus – withdrawals - by administering a placebo (i.e. signalling *presence* of a drug) is different to removing aversive withdrawal symptoms by omitting absence of a drug.)

Expectancy

Expectancy

Expectancy

Expectancy

S­–\*

Environmental consequence of drug-seeking: eg. relief from withdrawal but also social/financial problems

S1\*

Environmental consequence of behaviour: eg. violence, sex, criminality, socializing etc.

***Figure 1.* Chain of Expectancies involved in Repeated Drug Taking (adapted from Fillmore and Vogel-Sprott, 1992)**

Expectancy

Expectancy

Expectancy

Expectancy

Expectancy

Expectancy

S1d­

Bodily and Cognitive/Affective effects of drug e.g. euphoria,

R–d

Behavioural response to withdrawals: eg. drug-seeking

R1d

Behavioural response to drug: eg. arousal, disinhibition etc.

S–d

Bodily effects of absence of drug. i.e. withdrawals

Presence of Drug

Absence of Drug

S–

Cues surrounding absence of drug

S1

Cues surrounding administration of drug

Perhaps the ‘placebo’ euphoria etc, observed when people believe they have received a drug (the left arm of the above diagram) is *not* after all a conditioned behavioural response to a conditioned *physiological* reaction (i.e. the chain S+:S+d:R+d) but a conditioned behavioural response to a stimulus (which would be represented by the chain S+:R+d) where the physiological S+d is ‘manufactured’ ad hoc via an over-willingness to be in a ‘high’ state, and therefore an intentional misperception or ‘smudging’ of bodily cues.

Following on from this: perhaps the efficacy of a placebo is enhanced with drugs or dosing regimens whose physical effects are very mild and/or whose target symptomatology is mostly psychological. For example ‘cravings’, though they may have a physiological cause, that is the absence of active drug in the system, do not *manifest* in the perception of the addict as a physical symptom but rather as a ‘strong desire’. Though this desire can be very intense it is easy to imagine how this response, since it has a purely psychological manifestation could be mediated (i.e. either induced or reduced) entirely by expectancy in some cases, whereas more physiological withdrawal symptoms (lachrymation, piloerection, diarrhea) may be much harder to induce by expectancy alone.

Is it possible to condition ‘positive’ physical symptoms of drugs (eg. dilation of eyeballs) in a convincing manner? i.e. behaviourial symptoms may not be convincing evidence for a placebo effect. Surely conditioned ‘positive’ drug effects are ephemeral.

***Open/Hidden Designs***

There have been several studies that have looked at the effect that removal of information about timing of dose and magnitude of change of dose have on subjective effects of treatment. This paradigm, known as the open/hidden paradigm can estimate the extent to which expectations of treatment efficacy influence perceived treatment effects over and above direct effects by comparing the DV of interest – in this case withdrawals but it really could be any expected consequence, positive or negative, of treatment – in a group who knows they are receiving a treatment (or treatment change) with a group who do not.

This design can be contrasted with the placebo-controlled trial, which attempts to isolate the effects expectancy have on treatment outcome by comparing a group who receive active treatment with a group who think they are receiving an active treatment but who are actually receiving an inert substance. Placebo-controlled trials measure psychological effects in the absence of the active treatment whereas open/hidden paradigms measure treatment effects in the absence of psychological effects (see Figure 1). Furthermore most placebo-controlled trials do not measure expectancy effects accurately because they do not contain a no-treatment group, which allows for the effects of natural history upon treatment outcome to be compared against placebo effects (Hróbjartsson & Gøtzsche, 2001).

|  |  |  |  |
| --- | --- | --- | --- |
|  | In Clinical and Commercial Setting | Placebo Arm of Placebo-Controlled Trial | Hidden Arm of open-hidden Design |
| Expectation About Drug | ✓ | ✓ |  |
| Active Effects of Drug | ✓ |  | ✓ |

***Figure 2. Combination of Expectancy and Active Effects of Drug in Different Settings***

***(based on Benedetti, Carlino, & Pollo, 2011)***

Benedetti et al., (2003) showed that perceived postoperative pain increased less following interruption of morphine delivery in patients who were not informed about the interruption compared with those who were informed. The same result was shown for perceived anxiety in patients who were informed their diazepam was interrupted vs those who were not.

  
 ***Figure 2. Open vs Hidden Interruption of Morphine and Diazepam (from Benedetti et al., 2003)***

**Treatment of Addiction with Drug Replacement Regimens**

There are many ways of treating addiction to drugs of abuse: counseling or psychotherapy; non-profit fellowship societies such as Narcotics Anonymous or Alcoholics Anonymous; total ‘cold turkey’ abstinence, either unsupervised or in an inpatient rehabilitation facility; or pharmacological drug replacement/maintenance therapies. Drug replacement therapies involve controlled administration of either an agonist or the drug itself but in a different form. For example heroin addicts are given methadone or buprenorphine orally instead of injecting and nicotine addicts are given nicotine gum, patches or nasal spray instead of smoking. Drug maintenance/replacement therapies allow the patient to focus on coping with the sudden discontinuation of the habitual behaviours, emotions, and cognitions surrounding their drug dependence without having to deal with the physical withdrawal symptoms. When a stable maintenance dose has been achieved the patient can either discontinue use of the replacement therapy completely, which once again is likely to induce a withdrawal response, or a reduction regimen can begin. Reduction regimens involve the replacement dose being reduced in discrete stages down to a zero dose.

If the increase in pain following interruption of morphine can be seen as a related phenomenon to the onset of withdrawal symptoms following the discontinuation or reduction of the normal dose of a drug in an addicted individual, then, based on Benedetti et al. (2003), there does seem to be some grounds for expecting that removal of information concerning the timing and magnitude of dose reduction may serve to ameliorate subjective withdrawal symptoms in addicted individuals on a drug-reduction regimen.

If withdrawal symptoms, whether physical or psychological, relate directly to likelihood of relapse, and if placebo withdrawal symptoms contribute to total perceived withdrawal symptoms over and above actual withdrawals, then any intervention that can minimise placebo withdrawal symptoms in patients on a drug reduction regimen may help to reduce subjective distress and the likelihood of relapse.

In long-term, dependent drug users a discontinuation or reduction of dose will have been paired many times in the past with aversive physical and psychological withdrawal symptoms. Thus any cues that suggest such a discontinuation or reduction should produce an expectancy of aversive withdrawal symptoms and a concomitant placebo withdrawal response. Removing all cues that may allow the generation of such an expectancy should therefore also remove the placebo withdrawal response that follows. These cues can be perceptual (such as the size/shape/volume/colour/taste of the vehicle), environmental (the location where the drug is administered/purchased, the identity of the administrator/vendor of the drug) or verbal. Arguably the most important of these in drug reduction/maintenance regimens is the verbal information concerning the dose, supplied by the doctor, pharmacist or on the packaging (if it is a commercially available, over-the-counter replacement therapy).

**Hypotheses**

Hypothesis one is that by removing information concerning the schedule and magnitude of dose titrations, and by masking any changes in the physical attributes of the vehicle following dose reduction, it should be possible to eliminate the placebo component of subjective withdrawal symptoms in drug reduction regimens, thereby reducing total withdrawal symptoms and potentially preventing relapse.

Hypothesis two is that if it is conditioning that leads to a placebo response then the placebo withdrawal response should be more pronounced in individuals who have been drug dependent for longer and/or who have attempted to quit on more occasions prior to the trial.

**Proposed Drug Reduction Intervention**

The experimental design by which we propose to test hypothesis one and two will be a one way, between-subjects design with an open/hidden manipulation. There will be four levels of the independent variable Reduction Condition. The dependent variables will be subjective ratings of both physical and psychological withdrawal symptoms, number of cigarettes smoked, and duration of abstinence both during and subsequent to the reduction intervention comprised by the study. In order to assess hypothesis two, a classification variable will be included: Number of Previous Quit Attempts. The vehicle will be the same in all physical/perceptual characteristics regardless of dose.

***Conditions/Instruction/Consent***

For the conditions where dose is being reduced there will be a fixed titration period. Withdrawal symptom inventories will be completed at the beginning and halfway through each titration period for all conditions. Ss in the no reduction conditions will go from full dose (same throughout the study) to no dose/no vehicle on the day after the last day of the test period. Prior to random allocation Ss will be informed that they are taking part in a study designed to assess the effects of knowledge and dosing schedule on withdrawal symptoms. They will be asked to give consent to having information about their dosing schedule withheld if need be.

*Blind Reduction*: Ss actual dose will be reduced at the beginning of each titration but they will not be given any information about the timing or magnitude of dose reduction. Ss in the Blind Reduction condition will be told that their dose will be reduced but that they will not know when. This is important since this condition represents the particular expectancy conditions that would be present were this regimen to be made available to addicted individuals in a real-world setting, i.e. the participant wishes to enroll in a drug replacement-therapy reduction regimen and thus wishes to reduce their dose gradually, but gives their consent to have the information about when or by how much their dose will be reduced withheld in order to minimise withdrawal symptoms.

*Informed Reduction/Reduction*: Ss dose will be reduced at the beginning of each titration period and Ss will be informed when and by how much.

*Informed Reduction/No Reduction:* Ss will be informed that their doses are being reduced but their actual dose will not be reduced.

*Informed No Reduction/No Reduction:* Ss will be informed that their dose is being maintained at the same level across the entire study and their actual dose will not be reduced.

A balanced placebo version of this design would consist of, instead of a Blind Reduction condition, actually generating an expectancy of no dose-reduction, while surreptitiously titrating dose. However theoretically interesting this situation is it has little external validity. The goal of this experiment is to model a possible real-world intervention that could minimise withdrawals in a drug-replacement therapy dose-reduction regimen. There is no real-world situation that can be envisaged visage where a person would enroll in a drug-replacement dose-reduction regimen with a view to eventual discontinuation while not expecting that their dose is actually being reduced. Therefore, rather than generating an expectancy of no dose-reduction-related withdrawals, participants in the Bind Reduction condition will have a *general* expectation of dose-reduction but will receive no information concerning the timing or magnitude of withdrawals.

**Experiment 1: Brief Proof of Concept Study Using Nicotine Patches**

The above design, which could in theory apply to any drug of abuse, will be tested first on smokers who wish to quit smoking using nicotine patches as nicotine replacement therapy.

Transdermal nicotine patches have been shown to be effective at aiding smoking cessation (Stapleton et al., 1995; Shiffman, Ferguson, Gwaltney, Balabanis, & Shadel, 2006).

Withdrawal symptoms are a significant predictor of relapse to smoking (West, Hajek, & Belcher, 1989; Piasecki et al., 2000; Shiffman et al., 1997a, Killen & Fortmann 1997; Patten & Martin, 1996). Physical withdrawal symptoms include decreased adrenaline, cortisol, heart rate, orthostasis, thyroid function and tremor and increased taste for sweets, metabolic rate, weight and slowing of the EEG. Psychological symptoms include anxiety, craving for cigarettes, depression, irritability, restlessness, difficulty concentrating, hunger and nocturnal awakenings. These symptoms are highly reproducible, observable by others, and can be clinically significant (Hughes, 1992a; Hughes & Hatsukami, 1987). Cravings for cigarettes are generally held to be the most salient of the nicotine withdrawal symptoms and the most significant predictors of relapse (West & Schneider, 1987; Russell, 1988) and can continue up to 6 months after the acute physical symptoms have disappeared (Hughes et al., 1994), however their subjective nature has led to confusion about whether they can be considered a physical or a psychological symptom of abstinence.

However in order to prove that removal of the opportunity to anticipate the precise timing or magnitude of a withdrawal response can ameliorate subjective withdrawal symptoms, and that this concept can apply to smoking and transdermal nicotine patches, it is first necessary to prove that expectancies regarding timing of onset of nicotine replacement alone are enough to affect withdrawal symptoms in a group of medium to heavy smokers given placebo drug replacement therapy compared to a no-treatment group. Several studies have shown that expectancies about nicotine can influence therapeutic outcome.

Juliano and Brandon (2002) used a balanced placebo design to assess the effects of nicotine and instructional set on anxiety reduction in smokers given either nicotine or de-nicotinised cigarettes. They found that being instructed that the cigarette had nicotine in it produced a pronounced anxiolytic effect in those who believed that nicotine reduced anxiety and not in those who didn’t. In addition they found that urge to smoke/cravings were significantly lower in the group who were told they had smoked a nicotinised cigarette, regardless of whether they had actually smoked on or not. Balanced placebo designs are more powerful than placebo-controlled designs as they allow the separation of expectancy effects from effects due to active treatment effects. Dar, Stronguin and Etter (2005) also used a balanced placebo design, measuring reduction in cigarette consumption in smokers on either nicotine gum, patches or inhaler, and found that subjects who believed they had received active treatment had larger reductions in cigarette consumption than those who believed they had received placebo regardless of whether they had received active treatment or not. Bailey, Fong, Bryson, Fortmann, and Killen (2010) compared the assignment beliefs of those participants in a nicotine patch dose-reduction regimen with a group receiving equivalent placebo patches and found that those who believed they had received active avoided relapse for longer than those who believed they had received placebo, regardless of actual assignment condition (see Figure 3). This was not true of abstinence status at 12 months, where assignment beliefs predicted abstinence in only the active patch group. Lastly Gottlieb, Killen, Marlatt & Taylor, 1987, found, using a balanced placebo design, that expectation of receiving nicotine gum predicted significant decreases in physical symptoms and less smoking in the first week after quitting, and that, compared with the effects of expectancy, the *actual* gum that subjects received, either nicotine or placebo, seemed to have no effect on either withdrawal symptoms or smoking behavior. Thus there seems to be grounds for the hypothesis that the expectancy that a nicotine replacement therapy will ameliorate nicotine withdrawal symptoms is enough to produce a reduction in these withdrawal symptoms even in the absence of actual nicotine.



***Figure 3. Time to Relapse Based on Belief of Treatment Assignment and Actual Assignment (from Bailey et al., 2010)***

**Design**

This will be a one-way, between-subjects design designed to test whether instructions regarding the timing of onset of active nicotine dose in a transdermal nicotine patch are enough on their own to affect both level and timing of withdrawal symptoms in a sample of heavy smokers. There will be three levels of the independent variable Dose: Fast-Dose (told is fast acting), Low-Dose (told is slow acting) and No-Dose (given no patch). Dependent variable will be withdrawal symptoms, measured using the Withdrawal Rating Form (Shiffman & Jarvik, 1976). This is a 25-item self-report measure of smoking withdrawal symptomatology with five subscales: Craving, Psychological Discomfort, Stimulation/Sedation, Physical Symptoms and Appetite. In addition subjects will be asked to rate how long after the administration of the patch their withdrawal symptoms began to reduce. In order to assess whether subjects’ beliefs mediated the effect of the patches on perceived withdrawal symptoms, subjects will be asked, upon completion of the 24-hour abstinence period, whether they believed a) they were assigned a placebo or an active patch, b) whether they were assigned a fast-or slow-acting patch. In addition to the experimental manipulation, a classification variable will be included: number of previous attempts to quit.

**Hypotheses**

If expectancy alone can generate a placebo withdrawal-reduction effect then we would anticipate that an expectation of a fast-acting withdrawal-reduction effect will lead to faster onset of withdrawal reduction than expectation of a slow-acting withdrawal effect. Thus the hypothesis of this study is that subjective cravings and withdrawals will begin to reduce faster in the fast-dose group, followed by the slow-dose and no-treatment group.

It is also hypothesised that number of previous attempts to quit will positively correlate with placebo reduction of withdrawal symptoms.

**Consent**

Since it is an expectancy manipulation, in an effort to simulate real-world conditions (where individuals on patches do not doubt that they have bought a genuine product with active pharmacological ingredients) subjects in the two patch conditions will not be told that there is a chance that they will been given placebo patches without their knowledge. Given that the trial is only 24-hours and that the sample will be heavy smokers rather than abstinent ex-smokers (and thus that there is no chance of causing relapse) we would expect minimal harm resulting from this deception.

**Subjects**

Subjects will be recruited from the undergraduate pool and from ads taken out in newspapers and local suburban street press. In order that a marked withdrawal response can be induced upon commencement of abstinence, only heavy, dependent smokers (i.e. those who smoke within 30 min of waking and > 10 medium-to-high dose cigarettes per day) will be admitted to the study. Subjects will be reimbursed for travel expenses and will be provided with patches free of charge. Subjects will be excluded if they: 1) are experiencing severe cardiovascular disease, hypertension, or diabetes; 2) are currently on psychotropic medication; 3) are pregnant or breastfeeding; 4) are suffering from chronic dermatological disorders; 5) have a history of moderate to severe allergies; 6) have been on nicotine replacement therapy of any kind in the 3 months prior to commencement of the study; 7) are regular users of marijuana or other illegal drugs; 8) are currently prescribed or are taking anti-depressants. Carbon Monoxide Meters will be used to verify both extent of dependence (i.e. level of daily use prior to testing) and whether abstinence during test phase has been maintained.

**Procedure**

Once admitted to the study subjects will be asked how many times previous to admission to the study they had attempted to quit smoking. Subjects will be told that the study is a placebo-controlled trial intended to test the precise time of onset of a new fast-acting transdermal nicotine patch. They will be told that they may be allocated to the new fast-acting patch or to a normal slower-acting patch or to no-treatment. If asked about expected time on onset subjects will be told the new patch begins to work within 3-4 hours and the old patch within 6-12 hours of administration. Subjects will then be randomly allocated one of the three conditions and will be supervised administering the patches to the lower back. Upon administration of the patches will be asked to abstain from smoking for 24 hours and will be allowed to leave. Subjects will return the next day and complete the Smoking Withdrawal Questionnaire (Shiffmann & Jarvik, 1976) to assess their symptoms over the previous 24 hours. Subjects will also be asked to rate how long after applying the patch their withdrawal symptoms began to abate.

**Statistical Analyses**

A two-way ANOVA will be performed on the data from the self-report measures of withdrawal symptoms. Treatment Group will be the first independent variable, with three conditions: Fast-Dose, Slow-Dose and No-Dose. Number of previous attempts to come off methadone will be the second independent variable, a two-level classification variable where subjects are classified into two groups: those who are attempting to quit for the first time (the first-attempt group) and those who have attempted to quit one or more times in the past (the one or more attempt group).

Planned Contrasts will be performed on the self-report data both for the main effects of each independent variable and for interactions between independent variables.

**Experiment 2 : Patch-based Nicotine Replacement Reduction Regimen**

The design for Experiment 2 will be as outlined under the heading ‘Proposed Drug Reduction Intervention’ above.As with Experiment 1, the drug will be nicotine and the method of dose reduction will be via transdermal nicotine patches. Exclusion and inclusion criteria, recruitment method, dependent variables and statistical analyses will be the same as in Experiment 1.

**Procedure**

Once allocated to condition subjects will be instructed that they are taking part in a 31-day trial testing the efficacy of different dosing schedules in minimising withdrawal symptoms on a transdermal nicotine-patch replacement therapy intervention. Before giving consent subjects will be told that they may have information about the dosage of their patch withheld during this trial, but that over the course of the trial period they will go from a high-dose patch at the beginning to no patch when the study is completed. They will be asked to return to the university to collect their nicotine patches twice each week where they will also be asked to complete a Withdrawal Rating Form (Shiffman & Jarvik, 1976).

Patches of different strength, including 0-mg placebo patches, will be the same size, shape and colour, i.e. with no inherent indication that the dose has changed. For each condition, save for the blind reduction and delayed reduction condition, patches will be labeled with the actual mg dose. The delayed reduction condition will have half their patches labeled correctly and half incorrectly for each 7-day titration period (see Table 1). Any subjects not randomly assigned to the Blind Reduction Condition will be given the option to complete this reduction regimen free of charge upon completion of the trial. At the end of 28 days, the blind reduction condition will be informed that they have actually been on 0-mg dose patch for a week. The reduction as usual condition will already be aware of this. The no treatment condition will simply discontinue patches. The delayed reduction condition’s patch will say 0-mg accurately for the last 3 days of the study. The reduction as usual and blind reduction conditions will be encouraged to wear the 0-mg labeled patches for the final week for the validity of the study.

For reduction conditions there will be a fixed 7-day titration period. Withdrawal symptom inventories will be completed at the beginning and halfway through each titration period for all conditions.

*Blind Reduction*: Ss actual dose will be reduced at the beginning of each 7-day titration but they will not be given any information about the timing or magnitude of dose reduction. Ss in the Blind Reduction condition will be told that their dose will be reduced but that they will not know when. This is important since this condition represents the particular expectancy conditions that would be present were this regimen to be made available to addicted individuals in a real-world setting, i.e. the participant wishes to enroll in a drug replacement-therapy reduction regimen and thus wishes to reduce their dose gradually, but gives their consent to have the information about when or by how much their dose will be reduced withheld in order to minimise withdrawal symptoms.

*Informed Reduction/Reduction*: Ss dose will be reduced at the beginning of each titration period and Ss will be informed when and by how much.

*Informed Reduction/No Reduction:* Ss will be informed that their doses are being reduced but their actual dose will not be reduced.

*Informed No Reduction/No Reduction:* Ss will be informed that their dose is being maintained at the same level across the entire study and their actual dose will not be reduced.

**Table 1. Reduction Schedule by Condition for Nicotine Patch Reduction Intervention**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Dose | | | |
|  | Blind/No Reduction | False Informed | Informed Reduction | Blind Reduction |
| Day 1 | 21 | 21(21) | 21 | 21 |
| Day 8 | 21 | 21(14) | 14 | 14 |
| Day 15 | 21 | 21(7) | 7 | 7 |
| Day 22 | 21 | 21(0) | 0 | 0 |
| Day 28 | End | End | End | End |

*Note: Numbers refer to mgs of nicotine in each 16-h patch. Numbers in brackets refer to mg indicated on the patch itself.*

**Randomised Dosing**

So that there is no opportunity in the delayed and blind reduction conditions to ascertain, and hence anticipate, withdrawals, actual dose reduction will occur on one day randomly during a ‘window’, on or around the middle of each titration period. Thus, despite each individual titration period being marginally longer or shorter depending on which day within the window the actual dose reduction occurs, duration of titration periods in the delayed and blind reduction conditions will be the same on average across the study as the reduction as usual and no treatment conditions.

**Follow-up**

Follow-up interviews will be sought, at 3, 6 and 12 months from the trial, to determine whether group had any effect on the duration of abstinence.

**Final Paragraph: Demystification of the Substance**

If the main variables that sustain addiction and prompt relapse are psychological rather than physiological, it is possible then that the mechanism by which drug replacement therapies work is by providing the individual with the knowledge that they have ingested the substance they are addicted to. The fact that cravings and psychological withdrawal symptoms persist even on a drug replacement therapy is testament to this. It is likely that addicts engage in a type of mystification or overestimation of the role the substance plays in their addiction, and an underestimation of the psychological factors (learning, motivation, identity).

The subjects in the Hidden/Reduction condition will be told on day 29, the no-patch day, that they have actually been on a placebo patch for 7 days. If it appears on follow-up that this condition abstains from smoking reliably longer, then we would suggest that perhaps, by learning that they have been on 0 mg dose for 7 days, and thus that the relative absence of withdrawals they experienced during this week were not due to the active pharmacodynamic effects of the drug but rather to the expectancy of the absence of withdrawals, they learned that their withdrawals were to a large extent ‘in their head’. It could be that in some sense the knowledge that long-term withdrawal symptoms are mostly ‘in the head’ may be personally empowering, because not only do they realise that the *substance* is not as responsible for their withdrawals as they thought, but that their withdrawals are due mostly to the discontinuation of a habitual routine that is or was cherished and ego syntonic. By showing patients that their addiction is more psychological than physical it may help them to understand that overcoming their addiction is dependent more on establishing new routines, forming new goals, and learning how to find pleasure in other areas, than in their body slowly being weaned off a particular type of molecule.

Stimulus generation and chaining. Tolerance feels similar to withdrawal. Therefore conditioned tolerance response is interpreted as withdrawal, causes anxiety, which is itself a withdrawal symptom, which causes further anxiety (feedback loop), which chains to an avoidance/relapse response. Associative sydtem is agnostic to cause of negative affect, therefore even after chronic withdrawal has passed, a sufficient ‘threshold charge’ of non-drug-related negative affect serves as an interoceptive cue which chains to an avoidance response (i.e. relapse) via hot processing etc.

Stimulus generalization accounts for relapse in tapered dose reduction. 1) causally-ambiguous physical symptoms interpreted/generalized as withdrawals which then chain to response expectancies (culminating in avoidance/relapse response). 2) causally ambiguous affective symptoms also interpreted/generalized as withdrawals which also chain to response expectancies (note: these ambiguous affective symptoms can be the anxiety caused by the expectancy of withdrawals caused by the physical symptoms in 1) or merely just the knowledge that dose of drug has not been ingested and therefore that withdrawals are impending (i.e. this can happen even before any directly withdrawal related negative affect has occurred).

Placebo repsonses come about by two means a) stimulus generalization (i.e. unconsciously and/or consciously conditioned response brought about by stimulus that is similar enough to familiar stimulus to cause a conscious or unconscious expectancy of that familiar response; b) Humans’ ability to decontextualize abstract associations between stimulus and expected response and superimpose these onto novel or ambiguous stimuli (i.e. is unfamiliar but that we nevertheless have sufficient reason to believe will cause a similar response to familiar stimuli) is responsible for placebo effects.

Expectancies sustain drug addiction in that anticipated negative affect and anticipated inability to cope with it, prevent learning that withdrawal a) is not as bad as anticipated b) can be endured and c) will reduce in intensity over time. Panic disorder is a model of how avoidance and expectancy exacerbate and intensify the symptom being avoided.

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1. For example it is traditionally very difficult to implant expectancies concerning effects of alcohol consumption which run contrary to established effects since most participants are very familiar with the effects of alcohol consumption (reference, Rohsenow???) [↑](#footnote-ref-1)
2. Absence and presence of drug should be thought of as S1 and S2 rather than S+ and S–. S+ is a symbol for presence of a particular stimulus. S– is a symbol for absence of S+ as well as *any other* stimuli (Konorsky????) [↑](#footnote-ref-2)