## Mind-set Matters: Exercise and the Placebo Effect

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Mind-Set Matters
Exercise and the Placebo Effect
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ABSTRACT—In a study testing whether the relationship between exercise and health is moderated by one's mind-set, 84 female room attendants working in seven different hotels were measured on physiological health variables affected by exercise. Those in the informed condition were told that the work they do (cleaning hotel rooms) is good exercise and satisfies the Surgeon General's recommendations for an active lifestyle. Examples of how their work was exercise were provided. Subjects in the control group were not given this information. Although actual behavior did not change, 4 weeks after the intervention, the informed group perceived themselves to be getting significantly more exercise than before. As a result, compared with the control group, they showed a decrease in weight, blood pressure, body fat, waist-to-hip ratio, and body mass index. These results support the hypothesis that exercise affects health in part or in whole via the placebo effect.

The placebo effect is any effect that is not attributed to an actual pharmaceutical drug or remedy, but rather is attributed to the individual's mind-set (mindless beliefs and expectations). The therapeutic benefit of the placebo effect is so widely accepted that accounting for it has become a standard in clinical drug trials to distinguish pharmaceutical effects from the placebo effect and the placebo effect from other possible confounding factors, including spontaneous remission and the natural history of the condition (Benson & McCallie, 1979; Brody, 1980; Nesbitt Shanor, 1999; Spiro, 1986). Kirsh and Sapirstein (1998), in a meta-analysis of 2,318 clinical drug trials for antidepressant medication, found that a quarter (25.16%) of the patients' responses were due to the actual drug effect, another quarter (23.87%) were due to the natural history of depression, and half (50.97%) were due to the placebo effect.

EXERCISE AND THE PLACEBO EFFECT

As the most common health threats are now infectious rather than chronic, remedies have also changed. Doctors now prescribe behavioral changes such as exercise for chronic diseases like diabetes, heart disease, and even cancer. We wondered whether the well-known benefits of exercise are in whole or in part the result of the placebo effect. A positive finding would speak to the potentially powerful psychological control people have over their health.

There is evidence supporting the idea that the placebo effect plays a role in occasioning the psychological benefits associated with exercise (Desharnais, John, Cote, Levesque, & Godin,

The placebo effect extends much further than medications or therapy: Subjects exposed to fake poison ivy developed real rashes1 (Blakeslee, 1998), people imbibing placebo caffeine experienced increased motor performance and heart rate (and other effects congruent with the subjects' beliefs and not with the pharmacological effects of caffeine; Kirsch & Sapirstein, 1998), and patients given anesthesia and a fake knee operation experienced reduced pain and swelling in their “healed” tendons and ligaments (Blakeslee, 1998). More generally, studies suggest that 60 to 90% of drugs and other therapies prescribed by physicians depend on the placebo effect for their effectiveness (Benson & Freedman, 1996; Nesbitt Shanor, 1999).

The placebo effect does not have to involve inert pills or sham procedures. Symbols, beliefs, and expectations can elicit powerful physiological occurrences, both positive and negative (Hahn & Kleinman, 1983; Roberts, Kewman, & Mercie, 1993). For example, the mere presence of a doctor increases patients' blood pressure (the “white coat effect”), reinterpreting pain in nonthreatening ways (e.g., as sensations) prompts patients to take fewer sedatives and leave the hospital sooner; and the health decline of cancer patients often has less to do with the actual course of the illness and more to do with their negative expectations regarding the disease (Langer, 1989).

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1When negative expectations are met with negative results, the placebo effect is often called the nocebo effect (Hahn, 1997).
Exercise and the Placebo Effect

METHOD

Logic

The Surgeon General has stated that all adults should accumulate at least 30 min of physical exercise per day for a healthy lifestyle (Centers for Disease Control and Prevention, CDC, 1996). Everyday moderate physical activity can be achieved by taking a brisk walk, climbing the stairs, or performing active housework (CDC, 1996). Although many people today have sedentary jobs, there are some jobs that are intrinsically physical. Hotel room attendants, for example, clean on average 15 rooms a day (each room taking between 20 and 30 min to complete), and engage in exerting activities that require walking, bending, pushing, lifting, and carrying, clearly meeting and exceeding the Surgeon General’s requirements. Room attendants may not perceive their work as exercise. If they do not, and if the relationship between exercise and health is moderated by mind-set as we hypothesize, then these workers may not be receiving the full health benefits of their exercise. Similarly, if their mind-sets are shifted so that they become aware of the exercise they are getting, then health improvements would be expected to follow.

Design

Each of seven hotels was randomly assigned to one of two conditions: informed or control.

Subjects in the informed condition received a write-up discussing the benefits of exercise and were informed that their daily housekeeping work satisfied the CDC’s recommendations for an active lifestyle. Specifically, they were told that exercise does not need to be hard or painful to be good for one’s health, but that it is simply a matter of moving one’s muscles and burning calories (accumulating approximately 200 calories per day to meet the recommendations). They were given specific details of the average calorie expenditure for various activities (changing linens for 15 min burns 40 calories, vacuuming for 15 min burns 50 calories, and cleaning bathrooms for 15 min burns 60 calories), and they were told that although these figures were based on results for a 140-pound woman and each of them would burn calories at a different rate, it was clear that they were easily meeting and even exceeding the Surgeon General’s recommendations.2 This sheet, written in both English and Spanish, was read and explained to the subjects and then posted on the bulletin board in their lounge.3

The subjects were told we were interested in getting information on their health so that we could study ways to improve it, and in return for helping, they would receive information about research on health and happiness.

Subjects in the control group were given all the same information as those in the informed group except they did not receive information about how their work is good exercise until after the second set of measures was taken (see Procedure).

Subjects

Subjects were recruited through hotels. To prevent information contamination, we assigned all room attendants within a hotel to the same condition. Four hotels were assigned to the informed

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1 This information is based on extensively researched recommendations for exercise and calorie expenditure made by the CDC, American College of Sports Medicine, and Surgeon General (Pate, Pratt, Blair, et al., 1995, as cited in CDC, 1996).

2 All of the written information was translated into Spanish, and each hotel had a designated and qualified supervisor to translate the verbal information and instruction to the subjects.
exercise outside of work (i.e., whether or not subjects named activities such as swimming, running, doing sit ups, or other non-work-related activities). Additional questions asked how often subjects attended a gym and whether or not they walked to work each day.

It was assumed, and later confirmed by the hotel housekeeping managers, that the workload of the room attendants remained constant in the 30 days prior to and the 30 days during the study. Therefore, if there was no increase in reported exercise outside of work, any increase in perceived regular exercise, perceived amount of exercise, or perceived work as exercise would be assumed to reflect a change in mind-set initiated by the intervention and not due to an increase in actual exercise.

Dependent Variables: Physiological Measures

Weight and percentage of body fat were measured using the Tanita Body Fat Monitor/Scale (Model UM-026, Tanita Manufacturing Co., Tokyo, Japan). In addition to giving a normal weight reading (to the closest 1/10 pound), this model measures body fat using a simplified version of bioelectrical impedance analysis that uses leg-to-leg bioimpedance analysis. After weight and impedance are measured, computer software (a microprocessor) embedded in the product uses the measured impedance, the subject's weight, and the subject's gender, height, and age (which are entered in) to determine the percentage of body fat and body water, according to equation formulas. Tanita’s standard formulas have been derived by multiple regression analysis, using the institutional standard, dual-energy x-ray absorptiometry (DEXA), as a reference. 5

Body mass index (BMI) was calculated after the fact using the following equation: [(weight in pounds)/(height in inches \( \times \) height in inches) \( \times \) 703. BMI expresses weight as adjusted for height.

Waist-to-hip ratio (WHR) was measured by a tape measure and calculated as the waist circumference divided by the hip circumference. Waist measurements were taken at the midpoint between the upper iliac crest and lower costal margin in the midaxillary line (the narrowest point of the waist). Hip circumference was measured at the largest point around the buttocks or gluteofemoral fold.

Blood pressure (BP) was measured using the HEM-711AC OMRON Automatic Blood Pressure Monitor with IntelliSense (Omron Co., Tokyo, Japan). The OMRON monitor uses the oscillometric method of BP measurement, detecting blood’s movement through the brachial artery and converting it to a digital reading of systolic and diastolic blood pressure.

4Subjects in the informed group (mean age = 34.12, \( SD = 9.23 \)) were significantly younger than subjects in the control group (mean age = 42.40, \( SD = 12.54 \)), \( F(1, 81) = 11.86, \ p_{\text{rep}} = .006 \).

5Initial and final measurements were taken at the same time of day (morning). (Body-fat readings are normally highest in the morning; therefore, because measures were taken in the morning, these readings may be higher than normal.) In addition, measures were taken 4 weeks apart to eliminate the hydration fluctuation involved in a woman's menstruation cycle. Clothing weight was accounted for by virtue of the fact that the women wore the same uniforms at the two sessions.
**Dependent Variables: Behavioral Measures**

In addition to assessing changes in exercise outside of work (including gym attendance, walking to work, or other non-work-related physical activities), we assessed substance abuse and diet through questions asking subjects to reflect on their habits over the past 30 days, including how much they ate relative to their normal intake, how many cigarettes they smoked, how many servings of vegetables and sugary foods they ate, and how many glasses of caffeinated beverages, alcoholic beverages, and water they drank.

**RESULTS**

**Change in Self-Reported Exercise**

Subjects’ self-reported exercise was examined using 2 (time: Time 1, Time 2; within subjects) × 2 (condition: control, informed; between subjects) repeated measures analyses of variance (ANOVAs). These analyses yielded no significant effects for exercise outside of work. Perceived amount of exercise, however, showed main effects of time, F(1, 65) = 6.80, p = .009, and condition, F(1, 65) = 4.79, p = .03, which were qualified by a significant interaction, F(1, 65) = 6.34, p = .009, and 

**Perceived regular exercise**

Informed 3.76 (3.41) 5.74 (3.48)**

Control 3.17 (3.42) 3.21 (2.67)

**Perceived work as exercise**

Informed 0.42 (0.5) 0.68 (0.5)**

Control 0.39 (0.5) 0.36 (0.5)

**Change in Dependent Variables: Physiological Measures**

Repeated measures 2 (time: Time 1, Time 2; within subjects) × 2 (condition: control, informed; between subjects) ANOVAs yielded a significant interaction effect for weight, F(1, 71) = 10.39, p = .001; percentage of body fat, F(1, 49) = 7.31, p = .01; BMI, F(1, 67) = 7.34, p = .01; WHR, F(1, 67) = 7.46, p = .01; systolic BP, F(1, 67) = 7.34, p = .01; and diastolic BP, F(1, 67) = 7.34, p = .01. No significant differences were found in diastolic BP.

**DISCUSSION**

**Mind-Set Matters**

This study did not test the placebo effect in the traditional manner, in which expectations are aroused through inert pills or sham procedures. Rather, subjects were actually engaging in a behavior that is clinically proven to have positive effects on the physiological variables measured (e.g., CDC, 1996; Hubert, Feinleib, McNamara, & Castelli, 1983; Lee, Manson, Hennekens, & Paffenbarger, 1993; Press, Freestone, & George, 2003; Raglan & Morgan, 1987; Schnohr, Scharling, & Jensen, 2003; Tipton, 1984). To determine if the placebo effect plays a role in the benefits of exercise, this study investigated whether subjects’ mind-set (in this case, their perceived levels of exercise) could inhibit or enhance the health benefits of exercise independently of actual exercise.

Although it is clear that the room attendants studied met or exceeded the Surgeon General’s recommendations for physical activity.
activity, initial measures suggest that the subjects were not aware that their work is good exercise. At the onset of the experiment, 66.6% of subjects reported not exercising regularly, and 36.8% reported not getting any exercise. Interestingly, the health of the room attendants reflected their perceived levels of exercise rather than their actual levels: According to their initial physiological measures, the subjects were at risk with respect to BP, BMI, percentage of body fat, and WHR—all important indicators of health. These results suggest the possibility that at the onset of the study, the room attendants were not receiving the

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**Fig. 1.** Changes in self-reported exercise as a function of time and group. Bars denote standard errors of the means.

**Fig. 2.** Changes in physiological dependent variables as a function of time and group. Bars denote standard errors of the means. BMI = body mass index.
full benefits of their exercise because they were not aware that they were getting exercise at work. Of course, there may have been many confounding reasons (e.g., genetics or diet) why these women were unhealthy despite their intense activity levels.

Over the course of the study, the percentage of informed subjects who reported exercising regularly (perceived regular exercise) doubled (39.4% to 79.4%), and the average amount of exercise that subjects in the informed group believed themselves to be getting (perceived amount of exercise) increased by more than 20%. It is important to note that although the informed room attendants did report higher levels of exercise at the end of the study, they did not report getting any additional exercise outside of work. In addition, although the subjects in the informed group showed a significant increase in recognizing their work as a form of exercise, their actual workload did not change. Thus, the changes in reported physical activity appear to be attributable not to actual increases in physical activity, but to a shift in mind-set initiated by the information given to them in the intervention.

This shift in mind-set in the informed group was accompanied by remarkable improvement in physiological measures associated with exercise. After only 4 weeks of knowing that their work is good exercise, the subjects in the informed group lost an average of 2 pounds, lowered their systolic BP by 10 points, and were significantly healthier as measured by body-fat percentage, BMI, and WHR. These were small but meaningful changes given the state of health the subjects were in, especially considering that the change occurred in just 4 weeks. All of these changes were significantly greater than the changes in the control group. These results support our hypothesis that increasing perceived exercise independently of actual exercise results in subsequent physiological improvements.

But How?
How exactly did the change in mind-set bring about such significant physiological changes? Conventional science assumes that in order for weight to be lost and body fat to be reduced, certain biological and physiological events must also take place. In the case of BP, it is assumed that it is lowered during exercise because the peripheral blood vessels are dilated, and that, over time, the attenuating effect of exercise on the sympathetic nervous system’s activity helps to reduce rennin-angiotensin system activity, reset baroreceptors, and promote arterial vasodilation (which helps to control BP; CDC, 1996). In the case of weight, it is assumed that exercise helps to reduce body fat by increasing energy expenditure: To the extent that energy expenditure exceeds caloric intake, the result is weight loss (theoretically, about 1 pound of fat energy is lost for each additional 3,500 kilocalories burned; CDC, 1996).

Given this knowledge, one interpretation of our results regarding the relationship between increased perceived exercise and improved health would be that they were mediated by a change in behavior. The data collected in this study, however, do not support this conclusion. As mentioned, the room attendants did not report any increase in exercise outside of work, nor did they experience any increase in workload over the course of the study. In addition, the subjects reported their habits had not changed over the past 30 days with respect to how much they ate (including servings of sugary foods and vegetables) and how much they drank (caffeine, alcohol, and water). Thus, neither increased exercise nor decreased caloric intake was reported by the subjects.

Of course, it is possible that the room attendants actually did change their behavior—actually did cut back on calories, improve the quality of the food they ate, or work harder or more energetically—but did not report such changes. However, previous research has found it very difficult to change behavior of this sort (Deutschman, 2005). Thus, even if these behavioral changes did occur as a result of the intervention, that too would make these results interesting.

In summary, the data collected in this study, coupled with previous research indicating the difficulty of changing behavior, make it unlikely that the relationship between mind-set and improvements in health was mediated by a change in behavior. In either case, whether the change in physiological health was brought about directly or indirectly, it is clear that health is significantly affected by mind-set.

IMPLICATIONS AND FUTURE RESEARCH

The results of this study provide another example of the power of the placebo effect. The moderating role of mind-set and its ability to enhance health should be identified further, substantiated, and utilized. The present results may have particular relevance for treating diseases associated with a sedentary lifestyle.

There is still no generally accepted, scientifically grounded model substantiating the relationship between mind-set and health, although several models have been proposed (see Lavo allo, 2005). The present findings warrant investigation in this area.

Future research might benefit from using measures (e.g., pedometers, food journals, or other people’s assessment of diet and activity levels) to enhance control for these variables.
People have mindlessly overlooked what it means that placebos are inert. Ultimately, each individual is responsible for their effects. Recognizing this suggests that it is time for us all to explore more direct means of controlling our health, such as pursuing mindfulness (see Langer, 1989) as a tool to actively and deliberately change our mind-sets.

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REFERENCES


