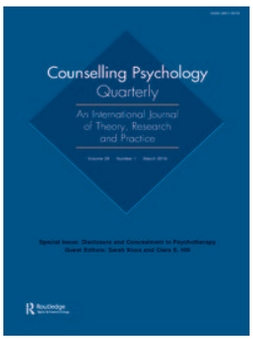

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Counselling Psychology Quarterly

ISSN: 0951-5070 (Print) 1469-3674 (Online) Journal homepage: http://www.tandfonline.com/loi/ccpq20

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To cite this article: Matt Blanchard & Barry A. Farber (2016) Lying in psychotherapy: Why and what clients don't tell their therapist about therapy and their relationship, Counselling Psychology Quarterly, 29:1, 90-112, DOI: 10.1080/09515070.2015.1085365

To link to this article: http://dx.doi.org/10.1080/09515070.2015.1085365

Counselling Psychology Quarterly, 2016
Vol. 29, No. 1, 90–112, http://dx.doi.org/10.1080/09515070.2015.1085365

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Lying in psychotherapy: Why and what clients don't tell their therapist about therapy and their relationship

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(*Received 2 May 2015; accepted 18 August 2015*)

Objectives: The primary aim of this study was to investigate one facet of a survey of client lying in psychotherapy, that which focused on the nature, motivation, and extent of client dishonesty related to psychotherapy and the therapeutic relationship. *Method*: A total of 547 adult psychotherapy patients reported via an online survey, incorporating both quantitative and qualitative methodologies, what topics they were dishonest about in therapy, and the extent of and reasons for their dishonesty. *Results*: Ninety-three percent of respondents reported having lied to their therapist, and 72.6% reported lying about at least one therapy-related topic. Common therapy-related lies included clients' pretending to like their therapist's comments, dissembling about why they were late or missed sessions, and pretending to find therapy effective. Most extreme in their extent of dishonesty were lies regarding romantic or sexual feelings about one's therapist, and not admitting to wanting to end therapy. Typical motives for therapy-related lies included, "I wanted to be polite," "I wanted to avoid upsetting my therapist," and "this topic was uncomfortable for me." *Conclusions*: Clients reported concealing and lying about therapy-relevant material at higher rates than previous research has indicated. These results suggest the need for greater therapist attention to issues of client trust and safety.

Keywords: self-disclosure; psychotherapy process; psychotherapy relationship; client variables; therapist training; lying

> Seldom, very seldom, does complete truth belong to any human disclosure; seldom can it happen that something is not a little disguised or a little mistaken. (*Emma*, Jane Austen)

Client honesty has been central to psychotherapy since Freud set out his "fundamental rule" – that the client should reveal everything that came to mind, as it came to mind, as honestly as possible. More generally, clients' disclosure of thoughts and feelings constitute the primary source material with which therapists work (Stiles, 1995). Nevertheless, as Freud and many other subsequent theorists and researchers found, clients are not always honest. They keep secrets (Kelly, 1998), hide their negative reactions to clinical interventions (Hill, Thompson, Cogar, & Denman, 1993), minimize discussion

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Portions of this paper are based on a presentation at the Annual Meeting of the American Psychological Association, Washington, DC August, 2014.

of personally salient topics (Farber & Sohn, 2007), and sometimes spin elaborate outright lies (Gediman & Lieberman, 1996). Researchers have tried to quantify the prevalence of dishonesty in psychotherapy, arriving at estimates between 20 and 46% of clients admitting to "secret-keeping" in therapy (Hill et al., 1993; Kelly, 1998; Pope & Tabachnick, 1994). A broader definition of dishonesty that includes twisting the facts, minimizing or exaggerating, omitting, or pretending to agree with the therapist would probably find that client dishonesty is almost universal. Defined in this manner, dishonesty is likely to be present to some extent in virtually all human interaction (DePaulo & Kashy, 1998; DePaulo, Kashy, Kirkendol, Wyer, & Epstein, 1996; Jellison, 1977). For purpose of this study, and reflective of the ways in which clients themselves view their lying in therapy (Blanchard & Farber, 2015), our focus is not just on overt distortions of facts but includes as well instances of concealment.

The question for clinicians, then, may not be "who lies in therapy?," but rather "what do clients lie about, and why?" The study of client dishonesty can highlight problem areas in psychotherapeutic treatment, alerting therapists to topics about which they may not have sufficient accurate information to know how to proceed clinically. Although clients lie about a great many matters, including the extent to which they experience distressing and even suicidal thoughts (Blanchard & Farber, 2015), in this paper, we focus on one specific category of client lie, one with significant implications for the therapeutic process: client dishonesty about therapy itself or their feelings about their therapist.

Most every contemporary psychotherapy, even those seen as primarily manual-driven and symptom oriented, endorses the central importance of the therapeutic relationship. It is widely considered a common element across therapeutic approaches (e.g. Norcross, 2011). Some orientations (e.g. Person Centered) hold the relationship as primary, as the essential healing force underlying therapeutic progress; others (e.g. CBT) view it as the foundation for effective interventions, and still others (e.g. relationally oriented psychodynamic psychotherapy) see the therapeutic relationship as both healing in its own right as well as the basis for understanding other prior and current interpersonal relationships. Extensive research on the significant positive relationship between treatment outcome and an effective therapeutic alliance (e.g. Horvath, Del Re, Fluckiger, & Symonds, 2011) as well as effective resolution of alliance ruptures (e.g. Safran, Muran, & Eubanks-Carter, 2011) provide further evidence of the importance of a good – and presumably trusting and honest – therapist–client relationship. Some theorists (e.g. Cabaniss, 2011) have even suggested that *trust* is at the heart of the therapeutic relationship. Thus, client concealment of salient information and/or outright lies may be seen as threats to the integrity and mutative potential of the client–therapist relationship. This is especially the case, given the evidence that therapists are typically unable to detect hidden client reactions and things left unsaid during sessions (Hill et al., 1993).

As noted above, we define client lying and dishonesty broadly – as any decision by the client to not be honest with their therapist about relevant information. This definition assumes both the intent to conceal or deceive, and a conscious awareness of the falsity. In keeping with previous work in this area, the definition excludes delusions, rationalization, repression, denial, or other forms of unconscious self-deception. While some authors have focused on specific types of dishonesty (e.g. secrets, etc.), we believe client dishonesty is best assessed as an all-encompassing phenomenon. Investigating any one portion of the dishonesty spectrum, such as secret keeping or

extent of self-disclosure, is likely to offer only a partial view of the underlying clinical situation, and may fail at Plato's classic injunction to "carve nature at its joints." When clients decide not to be honest with their therapist, they can choose from a range of strategies, from subtle avoidance and evasion to wild fabrications. The choice of strategy, while clinically interesting and perhaps diagnostic, is arguably less important than the underlying decision to be dishonest, which typically has significant implications for the therapeutic process.

The clinical and research scholarship on client dishonesty, though modest, addresses three major areas: (a) the types of and motives for dishonesty, (b) topics about which clients are dishonest, and (c) the consequences of dishonesty for therapy. We review these studies with a particular focus on the extent to which they have shed light on client dishonesty about therapy per se or the therapeutic relationship.

Types and motives

Several authors have sought to delineate *types* of dishonesty encountered in therapy, and in most cases, the notion of "type" encompasses both the strategy used and the client's motive for lying or concealing information. This approach has produced several taxonomies of clinical lying, with Gediman and Lieberman (1996), Ford (1996), and Grohol (2008), each proposing lists with more than a dozen separate types of client dishonesty. Gediman and Leiberman's taxonomy is the most comprehensive, consisting of 13 categories, including white lies (told for reasons of politeness), gratuitous lies (told to establish psychological distance), omissions, secrets (a subtype of omissions that is conscious), outright lies (told deliberately to mislead), and *pseudologia fantastica* (pathological lying) and delusions. Their list is meant to capture "all varieties of deception in the analytic dyad" (p. 15), with each associated with a motive. Thus, the white lie is thought to be motivated by politeness, whereas true delusions are considered the product of psychotic retreat from reality. By contrast, Newman and Strauss (2003) argue that non-delusional clinical lies fall into just two important categories: lies wherein the motive is fear and shame (i.e. the client is ashamed or afraid of the truth), and calculated lies where the motive is to achieve some conscious purpose (e.g. the client wants to escape responsibilities, get a prescription, or win a legal case).

Hill et al. (1993) distinguished between three types of "covert processes" engaged in by clients: hidden "reactions" to therapist interventions; "things left unsaid" in regard to their thoughts and feelings; and "secrets" about major facts or feelings outside therapy. Several studies by Hill and colleagues (Hill, Thompson, & Corbett, 1992; Hill et al., 1993; Thompson & Hill, 1991) found that clients hide negative reactions to therapist interactions far more often than they hide positive reactions, in both short and long-term therapy. Hill et al. (1993) suggested that, "when clients feel scared, stuck, lacking in direction, confused or misunderstood, they do not want their therapists to know" (p. 285). Hill et al. (1993) also reported that about half the instances of secret keeping were motivated by shame and embarrassment, and that the most common motive for leaving things unsaid was the client's desire to avoid an overwhelming emotion. Respondents reported a belief that the therapist "couldn't handle" or "wouldn't understand" the truth. Similarly, a study of secret keeping (Kelly, 1998) found the most common motive was the client's fear of expressing feelings, followed by shame/embarrassment, and fear of showing how little progress had been made in therapy.

In a related vein, Rennie (1994) documented a strong tendency of clients to be deferential. Participants in his qualitative studies reported a reluctance to express negative feelings, with many believing it was not their place to challenge their therapist's opinions, that criticizing their therapist might imperil the relationship, or that it was simply unfair to express discontent when therapy was, all-in-all, helping them feel better.

Topics lied about in therapy

A second line of inquiry has focused on *topics*, the subjects about which clients are likely to be dishonest in therapy. Again, our focus here is quite broad; that is, we are including in this section studies not only of overt lies, but of secrets and other forms as concealment as well. Hill et al. (1993) tallied the kinds of secrets kept by 26 clients in individual therapy, finding that sex was the dominant topic (27% of all secrets), followed by feelings of failure (7%), and mental health (7%). Pope and Tabachnick (1994) asked respondents (476 clients who were therapists themselves) if "there was something important they had kept secret and refused to disclose to any therapist" (p. 251). The highest percentage of reported secrets included sexual issues (51%), feelings about the therapist (10%), personal history of abuse (8%), and substance abuse (6%). Martin's (2006) survey of 109 psychology graduate students who had been in therapy indicated that the most prevalent lies were about relationships (13% of the total lies reported), substance use (11%), symptom severity (9%), and sexual behavior (7%); feelings or thoughts about the therapist constituted 4% of the lies reported in this study.

Farber and Hall's (2002) study of topics "least discussed in therapy" provides a somewhat different perspective on this general subject. According to their respondents (not restricted to mental health professionals), the least discussed topics in therapy include "My sexual feelings toward or sexual fantasies about my therapist," and "My interest in pornographic books, magazines, movies, videos, etc." A related study (Farber & Sohn, 2007) identified topics for which there were significant discrepancies between clients' self-perceived extent of disclosure and their ratings of the topic's importance to them. The greatest discrepancies were found for topics related to sex ("concerns about my sexual performance"; "the nature of my sexual experiences"), inadequacy ("my feelings of inadequacy or failure"), and abuse ("my experiences of being sexually abused as a child").

Consequences of dishonesty

Despite the widespread assumption that client honesty and forthright self-disclosure are essential to positive therapy outcomes – an assumption implicitly supported by studies of the therapeutic alliance – the empirical research is inconclusive. There is substantial evidence that disclosure through writing is helpful in dealing with trauma (e.g. Pennebaker, 1997). However, the link between extent of client disclosure and outcome in the context of face-to-face psychotherapy is more tenuous, at least in part because of the likelihood that more disturbed and harder-to-treat individuals (e.g. those with a history of trauma) disclose significant clinical material more intensely and repeatedly (Stiles, 1987). Kelly's (1998) study found that the tendency to keep relevant secrets from one's therapist was a significant predictor of having *fewer* symptoms of

psychological distress. This finding led to Kelly's (2000) "self-presentational view" of psychotherapy, suggesting that the choice to not disclose negative personal information allows clients to construct and strengthen positive identities. Kelly's view is, however, controversial (Hill, Gelso, & Mohr, 2000) and runs counter to other studies indicating significant positive associations between client disclosure and therapeutic outcome (e.g. Farber, 2006; Farber & Sohn, 2007; Sloan & Kahn, 2005).

Clients themselves tend to be primarily positive about the immediate consequences of their disclosures; they also tend to believe that withholding clinical material negatively affects the process of therapy (Farber, Berano, & Capobianco, 2004). In fact, the post-disclosure emotions rated most highly by interviewed clients included "relieved," "authentic," and "safe", at the same time, "vulnerable" was also a highly rated emotion.

Existing research paints an intriguing but contradictory picture of client dishonesty about therapy itself, and the motives behind it. Detailed, small-sample studies (e.g. Hill et al., 1992, 1993; Rennie, 1994) suggest client deference toward the therapist plays a role, and that much of what is hidden by clients does indeed involve the experience of therapy. Yet large-sample surveys suggest that dishonesty about therapy is rare, reported by only 1% of the sample in Pope and Tabachnick (1994) and 4% in Martin (2006). Lack of a common definition of lying and/or concealment, use of overlapping terms (including "lying," "secret keeping," "non-disclosure," and "hidden reactions"), and the adoption of highly divergent methodologies, all contribute to the apparent inconsistencies. For example, the seemingly low rates of dishonesty about therapy reported by Pope and Tabachnick and Martin may reflect a specific feature of their methodology. That is, both surveys asked an initial question to the effect of, "Have you ever lied to your therapist?" Answering such a question accurately would require a mental review of months or even years of therapy, a cognitive burden likely beyond the commitment level of most survey participants. Most respondents are likely to require more prompting to recall such instances. By contrast, the results of smaller sample qualitative studies are often confounded by the limitation of allowing therapists to recruit clients used in the study, a problem which Rennie (1994) has noted "may result in the recruitment of a group of clients characterized by relatively good working alliances" (p. 434). This may result in the unintended exclusion of clients with greater therapy-related dissatisfactions to conceal. Arguably, both large-scale quantitative approaches and smaller scale qualitative approaches have produced underestimates of the general rate of dishonesty in psychotherapy, including rates of dishonesty specifically related to therapy or the therapeutic relationship.

The present study

In keeping with our definition of client dishonesty, this study queried psychotherapy clients about the entire spectrum of conscious dishonesty, including times when they may have lied to their therapist, minimized, exaggerated, made up facts, concealed, or found it hard to tell the whole truth. No specific hypotheses were formulated. However, this study did have several specific aims. The first was to gage the prevalence of client dishonesty (broadly defined) in a large sample of psychotherapy clients. Our second aim was to determine the general prevalence of dishonesty about therapy-related topics. Our third, related, aim was to gage the relative frequency of specific types of therapy-related dishonesty. Our fourth aim was to assess clients' self-perceived motivations for

their dishonesty about therapy-related topics. Our final aim was to provide personal accounts of client dishonesty that could add narrative richness to the numbers.

Method

Participants

The study included 547 respondents (111 men, 427 women, 9 "other"; age range 18–80 years, $M = 34.8$, SD = 13.4) who are currently or were previously in psychotherapy. Marital status was reported as single or never married by 336 respondents (61.5%). Participants self-identified as Caucasian (80%), African-American (3.1%), Asian and Asian-American (4.6%), Latino (2.4%), and Native American (.7%); the sample also included 50 respondents who reported being biracial or "other" (9.2%). This was a well-educated sample with 59% reporting a bachelors or higher degree; 22.5% of the sample reporting being in or training for a mental health profession.

These demographics can be compared to the therapy-using population reported by the National Survey on Drug Use and Health (2012). While the current sample is somewhat younger and contains a greater proportion of college graduates, the two samples are similar in terms of gender and ethnicity. Thus, although the present study used a convenience sampling method, the demographics bear a good overall resemblance to a national therapy-using population.

The median number of therapy sessions for clients in the present sample was 51 over the lifespan, and 20 with their current or most recent therapist; 71% of participants were currently (or most recently) working with female therapists, and 29% with male therapists. The theoretical orientation of these therapists, as reported by respondents, included cognitive-behavioral (35.4%), psychodynamic (18%), addiction counseling (4%), as well as a range of eclectic, gestalt, humanistic, and other therapies (8.3%). Nearly a third of the sample did not know their therapist's orientation. The most commonly reported reasons for these clients entering therapy included depression (64%), anxiety (49%), stress (40%), personal growth (31%), relationship problems (30%), and traumatic experiences (25%).

Measures

The Columbia survey on disclosure and lying in psychotherapy

This is an online, self-report instrument, designed with the Qualtrics survey software, incorporating both quantitative and qualitative methodologies. The entire survey takes respondents an average of 20 min to complete. In order to help respondents access memories of dishonesty, the survey part of this instrument provides a list of 58 topics about which they may have been dishonest. The topic list was adapted from the Disclosure to Therapist Inventory IV (DTI-IV; Pattee & Farber, 2008), with items modified or discarded in keeping with the previous literature on lying and concealment. Two rounds of pilot studies were conducted to ensure no major topic areas were missed (i.e. no new topics were suggested by participants). The final version included a wide range of possible topics for dishonesty, such as "my use of drugs or alcohol," "my desire for revenge," and "pretending to like my therapist's comments or suggestions." The list

was designed to include situations previously described as "secrets" as well as "hidden reactions" and "things left unsaid" (Hill et al., 1993).

Respondents could browse the list and select topics on which they recalled being dishonest. Further, they had the option to indicate that they had *never* been dishonest with their therapist, or to volunteer an additional topic not covered in the list. Respondents who selected one or more topics were then presented with the list of topics they had chosen and asked to rate the extent to which they were dishonest about each one on a 5-point Likert scale (1 = "a tiny bit", 5 = "totally or extremely").

A second section of the survey asked respondents to choose one lie about which they would be willing to answer a series of additional questions about the circumstances and perceived consequences of their dishonesty. This section included a set of open-ended questions (e.g. "Why did you lie to your therapist about this topic?" "Can you tell us more about it?") in response to which respondents could type in narrative answers of any length. This section also included a 28-item inventory of possible motives, allowing participants to click multiple options that they felt described their reasons for being dishonest about a specific topic. A preliminary list of such motives was compiled based on previous research suggesting that clients may be dishonest for reasons of impression management (Goffman, 1959), in order to avoid offending the therapist (Rennie, 1994), to control the conversation (Regan & Hill, 1992), to avoid shame (Hill et al., 1993), and to meet the psychological needs of self and other (DePaulo et al., 1996), as well as for purely practical reasons, such as avoiding legal consequences (Newman & Strauss, 2003). Six graduate research assistants were then asked to record motives for lies they told in therapy over a three-week period, and later, a pilot study collected more motives for dishonesty from a sample of 25 respondents. Following a review by the research team (the two authors and six assistants) of the research literature and the new accumulated data, the final list of 28 possible motives were selected to be used in the survey instrument (e.g. "This topic was uncomfortable to me"; "I wanted to avoid shame"; "|I wasn't ready to discuss the topic"; "I wanted to avoid my therapist's disapproval"; "I wanted to make a good impression"; "I was concerned with legal consequences"). Respondents could also type in additional motivations if they did not see theirs on the list.

Self-concealment scale (Larson & Chastain, 1990)

The self-concealment scale (SCS) is a 10-item measure of a subject's tendency to actively conceal personal information from others that one perceives as distressing or negative. It uses a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). Internal consistency (Cronbach's alpha) for the SCS was .83 in Cramer and Barry (1999), and .89 in the present study. The SCS was administered as a validity check; it was expected that respondents who reported lying about more topics would have, on average, higher self-concealment scores.

Procedure

Participants were recruited through postings to Craigslist sites serving 13 large metropolitan areas of the United States. The posting message invited them to participate in a "survey on psychotherapy," and contained a link to the survey. All respondents

were entered into a drawing to win one of six $50 Amazon gift cards. There were no significant demographic differences in comparing completers of the survey ($N = 547$) and drop-outs ($N = 150$), with the exception of gender: the completer group had a higher proportion of women (78.1% female) than did the dropout group (69% female), $\chi^2 = 5.7$, $p < .05$. Dropouts were defined as those completing less than 80% of the survey questions.

Results

Overall client dishonesty

A very high percentage (93%) of the sample reported lying to their therapists, with a total of 4616 lies reported by the 547 participants. The mean number of topics respondents reported lying about was 8.4 (SD = 6.6), with no significant differences as a function of client gender, client income or education levels, therapist gender, and therapist–client gender match. There was a significant correlation between number of topics lied about and respondent age ($r = -.16$, $p < .001$), with younger clients likely to report a greater number of topics lied about. A one-way ANOVA also indicated that therapist age group significantly affected the number of lies reported, $F(5, 456) = 3.57$, $p = .04$: post hoc *t*-tests indicated that clients with therapists between the (estimated) ages of 60–69 reported fewer lies than clients with therapists in younger age brackets (22–29; 30–39; 40–49; 50–59) as well as the older age bracket (70 and above). In addition, an independent samples *t*-test showed that clients who are a different race from their therapist reported an average of 1.7 more topics lied about ($M = 9.66$) than clients who are the same race as their therapist ($M = 7.96$), $t\ (460) = 2.49$, $p = .013$.

A significant correlation was obtained between the number of topics lied about and the SCS, $r = .45$, $p < .001$, indicating, as expected, that those who clicked a higher number of lies were also likely to report a stronger general tendency to conceal negative personal information.

Only 37 respondents (6.8%) reported having told zero lies in therapy. This group was on average 6.2 years older than the rest of the sample, $t\ (545) = 2.6$, $p < .05$, and contained a larger proportion of women than the rest of the sample (86% vs. 71%, $\chi^2 = 4.1$, $p < .05$). The remaining 510 respondents (93.2%) reported dishonesty on one or more topics (see Table 1), with some topics endorsed by as much as 54% of the sample (i.e. "How bad I really feel – I minimized") and several other topics endorsed by more than 25% of the sample, including "My thoughts about suicide," "My insecurities about myself," and "My use of drugs or alcohol." The majority of topics were selected by between 5 and 25% of respondents, including lies about eating habits, self-harm, infidelity, violent fantasies, experiences of physical or sexual abuse, and religious beliefs.

A principal components analysis (PCA), with direct oblimin rotation was run on data generated from all 58 topics included in the full survey. A seven-factor solution was obtained that explained 42% of the total variance. One of these factors pertained to therapy-related topics; a therapy factor that explained 5% of the total variance and was comprised of five items: pretending to like my therapist's comments or suggestions; my real opinion of therapist; not saying I want to end therapy; that my therapist makes me feel weird or uncomfortable; and pretending to find therapy more effective than I really

Table 1. Topics of lies reported by therapy clients.

Topic		*N*	Percent reporting dishonesty (%)
1.	How bad I really feel – I minimized	295	54
2.	The severity of my symptoms – I minimized	212	39
3.	My thoughts about suicide	172	31
4.	My insecurities and doubts about myself	167	31
5.	Pretending to like my therapist's comments or suggestions	161	29
6.	My use of drugs or alcohol	159	29
7.	Why I missed appointments or was late	157	29
8.	Pretending to find therapy more effective than I do	156	29
9.	Pretending to be more hopeful than I really am	145	27
10.	Things I have done that I regret	141	26
11.	Pretending I did homework or took other actions suggested by my therapist	140	26
12.	My sexual history	119	22
13.	My eating habits	113	21
14.	My real opinion of my therapist	100	18
15.	My feelings about my body	99	18
16.	My sexual fantasies or desires	93	17
17.	Not saying that I want to end therapy	86	16
18.	Self-harm I have done (cutting, etc.)	85	16
19.	What I really want for myself	83	15
20.	Things I have done that were illegal	81	15
21.	Things my parents did that affected me	81	15
22.	Secrets in my family	75	14
23.	How I really act outside of therapy	73	13
24.	The state of my sex life these days	72	13
25.	Basic facts about my life	71	13
26.	My real feelings about my parents	71	13
27.	My masturbation habits	69	13
28.	That my therapist makes me feel weird or uncomfortable	67	12
29.	How I really act in relationships	62	11
30.	The way I give in to others' demands	61	11
31.	Experiences of sexual abuse or trauma	56	10
32.	My attempts to commit suicide	55	10
33.	My real feelings about my friends	55	10
34.	My desire for revenge	54	10
35.	How I am mistreated by others	54	10
36.	A sexual problem I have had	53	10
37.	My real feelings about my spouse or partner	53	10
38.	Times I cheated on my spouse or partner	52	10
39.	Violent fantasies I have had	51	9
40.	My use of pornography	50	9
41.	How I really act with my friends	45	8
42.	What I can afford to pay for therapy	45	8
43.	Placing blame on others when much of it lies with me	44	8
44.	My accomplishments (academic, professional, etc.)	39	7
45.	Unusual experiences (ex: seeing things, hearing voices)	39	7
46.	Experiences of physical abuse or trauma	35	6
47.	How bad I really feel – I exaggerated	34	6
48.	Religious or mystical beliefs that I hold	33	6

(*Continued*)

Table 1. (*Continued*).

Topic	*N*	Percent reporting dishonesty (%)
49. The severity of my symptoms – I exaggerated	33	6
50. My romantic or sexual feelings about my therapist	27	5
51. Lies to get a certain prescription	26	5
52. Cruel things I have done to people or animals	25	5
53. Racist feelings I have had	25	5
54. Not saying that I am seeing another therapist	16	3
55. Political beliefs that I hold	15	3
56. Lies to get a certain diagnosis	15	3
57. The way I treat my children sometimes	12	2
58. My real feelings about my children	9	2

Note: $N = 547$.

do. However, because factor analysis, including PCA, is a somewhat problematic and controversial procedure when used with binary data (Collins, Dasgupta, & Schapire, 2001), and because we view this study as primarily exploratory, we will present results (including narrative accounts) for each of the 10 therapy-related topics.

Prevalence of dishonesty about therapy and the therapeutic relationship

The survey included 10 possible lies about therapy and the therapist (see Table 2) mixed in with the other 48 possible lies about all other topics. Taken together, 72.6% of clients reported lying about at least one of these therapy-related topics. By comparison, only 46.8% of respondents reported one of seven sex-related lies included in the survey. Four of the 10 therapy-related topics were each reported by more than a quarter of the sample, making them among the most widely endorsed items on the survey. These included "Pretending to like my therapist's comments or suggestions" (29%), "Why I missed therapy appointments or was late" (29%), "Pretending to find therapy more effective than I do" (28%), and "Pretending I did homework or took other actions suggested by my therapist" (26%). By comparison, the most commonly reported sex-related lie, "My sexual history," was reported by only 23% of respondents.

Another three of the therapy-related topics were moderately common, including "My real opinion of my therapist" (19%), "Not saying I want to end therapy" (16%), and "That my therapist makes me feel weird or uncomfortable" (13%). The remaining three topics were comparatively rare in this sample, including "What I can afford to pay for therapy" (8%), "My romantic or sexual feelings about my therapist" (5%), and "Not saying I am seeing another therapist" (3%).

No significant differences were observed between men and women in likelihood of reporting at least one therapy-related lie ($\chi^2 = 1.1$, *ns*). Similarly, no differences were observed across age differences between client and therapist ($\chi^2 = 1.4$, *ns*), racial or ethnic differences ($\chi^2 = 2.4$, *ns*), or gender differences ($\chi^2 = 2.7$, *ns*). Furthermore, number of therapy sessions attended was not significantly correlated with the number of therapy-related topics lied about ($r = .02$, $p = .63$). Those reporting at least one therapy-related lie were on average 4.7 years younger than those who did not ($M = 33.4$ years

Table 2. Therapy-related topics that are most frequently lied about in psychotherapy.

Topic	*N*	Percent reporting dishonesty	Extent of dishonesty	
			M	(SD)
1. Pretending to like my therapist's comments or suggestions	161	29	3.1	(1.1)
2. Why I missed therapy appointments or was late	157	29	2.8	(1.2)
3. Pretending to find therapy more effective than I do	156	29	3.5	(1.1)
4. Pretending to do homework or take other actions suggested by my therapist	140	26	3.0	(1.1)
5. My real opinion of my therapist	100	18	3.6	(1.1)
6. Not saying I want to end therapy	86	16	3.7	(1.3)
7. That my therapist makes me feel uncomfortable	67	12	3.3	(1.4)
8. What I can afford to pay for therapy	45	8	2.8	(1.4)
9. My romantic or sexual feelings about my therapist	27	5	3.7	(1.6)
10. Not saying I am seeing another therapist	16	3	2.9	(1.6)

Notes: Extent of dishonesty was rated on a 5-point scale where 1 = very little, 3 = a moderate amount, 5 = totally or extremely; these means are based only on the scores of those individuals who reported they were dishonest about this topic. $N = 547$.

Table 3. Common motives for therapy-related vs. all other lies.

Reported motive	*N*	Percent reporting
For therapy-related lies ($n = 106$)[a]		
I wanted to be polite	57	54
I wanted to avoid upsetting my therapist	44	42
This topic was uncomfortable for me	36	34
I wanted to avoid my therapist's disapproval	35	33
For all other lies ($n = 325$)[b]		
This topic was uncomfortable for me	162	50
I didn't want to look bad	148	46
I wanted to avoid shame	143	44
I wasn't ready to discuss the topic	122	38

[a]Represents 106 respondents (out of the total 547) who provided motives for any of the 10 therapy-related topics.
[b]Represents 325 respondents (out of the total 547) who provided motives for any of the 48 topics which were not directly related to therapy.

vs. $M = 38.1$, $t = 3.5$, $p < .01$), and a significant negative correlation was observed between client age and the number of therapy-related lies reported ($r = -.18$, $p < .01$).

Extent of dishonesty about therapy and the therapeutic relationship

In addition to prevalence, the *extent* of dishonesty was measured for each topic on a five-point Likert scale. As Table 2 indicates, among the ten therapy-related topics, seven had mean scores of 3.0 or higher. Topics with the highest mean score on this scale were "My romantic or sexual feelings about my therapist," "Not saying I want to end therapy," and "My real opinion of my therapist." Notably, the mean extent of reported dishonesty for these three items was higher than those calculated for extent of dishonesty with regard to sexual abuse, physical abuse, and suicide attempts. Furthermore, across all 58 topics on the survey, these three topics were most likely to occasion the most extreme degree of dishonesty (i.e. generated the highest proportion of clients who rated the extent of their lies on these topics as "5", corresponding to "totally or extremely"). Lies about therapy, then, were not only among the most commonly reported lies – even more common as a category than lies about sex – but they also comprised a disproportionate percentage of those lies that were extreme in their degree of perceived dishonesty.

Motivations for therapy-related dishonesty

As noted earlier, motivations for dishonesty were assessed with a "clickable" checklist of 28 possible motives. As shown in Table 3, the most common motives selected for all instances of therapy-related dishonesty were, "I wanted to be polite," "I wanted to avoid upsetting my therapist," "This topic was uncomfortable for me," and "I wanted to avoid my therapist's disapproval." These four motives can also be compared to the most common motives reported for all other, non-therapy lies. As Table 3 indicates, "this topic is uncomfortable to me" is on both lists, but the remaining motives (for non therapy-related lies) are different, including: "I didn't want to look bad," and "I wanted to avoid shame."

Specific lies about therapy and the therapeutic relationship: primary motivations and narrative accounts

The following section provides more information about nine of the ten therapy-related lies, including (a) the primary motives (selected from a checklist) associated with each lie; and (b) clinical examples of each lie, drawn from the set of open-ended text-entry questions to which respondents could provide short narratives explaining their dishonesty in their own words. For purposes of clarity, we report the checklist data as "motives" and refer to the open-text data as "narratives." The one exception here is about the tenth topic, "Not saying I'm seeing another therapist," a lie about which no respondent provided a clinical example.

Pretending to like my therapist's comments or suggestions

As Table 2 indicates, this was one of the three most common therapy-related lies, reported by 29% of our sample. The extent of lying on this topic was generally moderate, as the overall mean was in the mid-range of the scale; moreover, only 8% of those who reported this lie indicated total dishonesty (i.e. chose "5" on the 5-point Likert scale).

As for motives, 10 out of the 14 respondents who elected to provide further details about this lie selected "I wanted to be polite" from the 28-item checklist. This politeness motive could also be gleaned from respondents' narrative accounts. As one client explained:

> I just wanted to make sure the therapist felt like she was helping me, even when her comments did not help, or maybe made things worse. I was already feeling so bad about myself, that I didn't want the guilt of making someone feel bad at their job.

This lie appeared to carry serious consequences for therapy, as 6 of the 14 narratives contained direct references to termination or a failure to progress in therapy, such as "It had the effect of totally neutralizing my progress" and "I was always unhappy when I left her office." The client quoted above, who wanted to make her therapist feel helpful, remarked:

> I ended up leaving therapy … It was a waste of time and money to continue to see her as I pretended to respond positively to her suggestions and observations.

Why I missed therapy appointments or was late

This lie was also among the three most common, admitted to by 29% of our sample. The extent of lying reported on this topic was modest, with an overall mean slightly below the mid-point on the 5-point scale; only 11% of those reporting this lie indicated total dishonesty (i.e. selected "5" on the 5-point scale), motives for this lie were diverse. Six the 14 respondents who provided more details about this indicated a desire to avoid embarrassment ("I didn't want to look bad"), with smaller numbers reporting a desire to "avoid my therapist's disapproval" or "simplify the conversation".

The 14 respondents who elected to provide narrative details about this lie tended to ascribe their dishonesty to a variety of seemingly mundane circumstances. Some

overslept. Others forgot. Others contended they could not pay for the session. The most common explanation for this lie revolved around clients' sense that they were in no condition to undertake therapy that day, often due to the very symptoms that brought them to therapy. As one patient explained: "There are times where I don't leave my apartment for days. I would lie and tell my therapist that I was physically ill (flu, etc.), though in reality, I was avoiding interacting with anyone, especially my therapist." Most said this lie had little effect on their therapy, although two respondents noted that it seemed to feed a tendency to lie about other topics.

Pretending to find therapy effective

Closely related to "pretending to like my therapist's comments or suggestions" is the dishonesty related to "pretending to find therapy more effective than I do" – also endorsed by 29% of the sample. The average extent of dishonesty about this topic ($M = 3.5$) was above the mid-point of the scale; 21% of those who reported this lie indicated total dishonesty about it. The motives for those respondents who provided further information on this topic ($n = 20$) included a desire to be polite (16 respondents) and a wish to avoid upsetting their therapist (12 respondents).

Consistent with these data, the narrative accounts of respondents indicated a strong desire not to make the clinician feel bad. An example:

> I told my therapist that it was very helpful for me because she seemed to think it was helpful. I would have felt bad if I told her it really hadn't helped me. It affected therapy because if I had said this method wasn't working, I could have been helped more. I felt like I was getting worse but didn't say anything.

A second client acknowledged that this lie led to significant implications for her:

> When I was in short-term intensive dynamic psychotherapy, I was not happy with the outcomes. It was making me more anxious about seeing my family, and my mental state was increasingly worse. My therapist kept saying how much this therapy helps and can cure people, but I wasn't believing him. After I stopped seeing him, I became suicidal. Since I did not believe in the therapy when I said I did, I lied to him and myself. Thus, it made my mental state much worse.

Clients described the consequences of pretending to find therapy effective in two main ways: whereas three respondents reported no impact, ten directly referenced significant impacts, such as "It made it useless" and "I never dealt with my core issues."

Pretending to do homework or take other actions suggested by my therapist

More than a quarter (26%) of the total sample's respondents admitted pretending they had done homework or carried out other promised therapy-related actions when they had not; 62.5% of those who reported this lie indicated they were in treatment with a CBT therapist. The average extent of dishonesty about this topic was exactly at the mid-point of the scale, with only 9% of those reporting this lie indicating total dishonesty about it.

Respondents who answered follow-up questions ($n = 15$) were most commonly motivated by a desire to "make a good impression" and "avoid my therapist's disapproval." In their personal narratives, they described pretending to keep a journal, pretending to have practiced meditation, and pretending to have studied a book on anxiety management. Some also reported being in "secret revolt" against their therapist, as one male CBT client explained:

> I want advice from a therapist, not a complete takeover of my life. She is asking me to let go of all my life issues…and just fill out a stupid form whenever I have a feeling, or when I eat, drink, pee, or even 'pleasure myself'. I pretend to fill those sheets she gave me, to make it seem that I am improving.

Asked how this form of dishonesty affected their therapy, several respondents noted feelings of guilt, a failure to make progress, or a sense of disconnection from their therapist.

My real opinion of my therapist

A total of 18% of the sample acknowledged this form of therapy-related dishonesty. As Table 1 indicates, ratings of the extent of dishonesty on this topic exceeded the midpoint of the scale; moreover, as noted above, this was among the topics with the highest proportion of "total or extreme" dishonesty (27%). Respondents who offered more details about this lie ($n = 15$) described therapists who talk too much, seem too culturally different, are intimidating, give "ridiculous" advice, fall asleep, seem too supportive, or seem not supportive enough. As for motives: Thirteen of the 15 attributed their dishonesty to politeness.

Their narratives suggested that many were eager to protect their therapist's feelings, As one respondent explained:

> She asked me if there was some feeling that this wasn't working, and I lied and said that it wasn't about her. I didn't want to have deal with her feelings or my own about what it means for me to not particularly like her style.

Another client described the trap he'd fallen into as he desperately tried to conceal his real feelings about his therapist:

> I don't like the guy … The sessions are horribly awkward and I don't feel like I'm representing myself accurately and I know he doesn't have a clear picture of what I'm really like. I can't think straight when I'm there so I over- and under-exaggerate all the time.

While three respondents reported little or no impact on therapy of this lie, nine explicitly referenced negative outcomes, such as termination or lack of progress.

Not saying I want to end therapy

A (non-communicated) desire to terminate was another common focus of client dishonesty, reported by 16% of the sample. The mean extent of dishonesty on this topic

(3.7) was among the two highest of all therapy-related topics, with 37% of respondents who acknowledged this form of dishonesty reporting total dishonesty.

Six out of the eight respondents who reported motives said they "wanted to be polite," four wished to "avoid upsetting my therapist," and three reported a fear that they would "look bad" if they were honest about wanting to end therapy. As one respondent explained in her narrative account, "I couldn't bring myself to tell my therapist I no longer wanted to continue sessions because I was afraid she would disagree or take it personally." The reported consequences of not being honest involved wasted money, early termination, and a lack of progress. In the words of one young client, the dishonesty "prevented me from getting closure and figuring out what it was about therapy that did or didn't help me in my life."

My therapist makes me uncomfortable

Although a relatively uncommon lie (12% of sample), about a quarter of respondents who selected this topic rated the extent of their dishonesty to be total or extreme. Respondents who elected to provide details of this lie ($n = 6$) indicated that their choice to dissemble or remain silent was motivated, not only by a desire to avoid upsetting their therapist (5 respondents) and to be polite (4 respondents), but also by their own discomfort (5 respondents). One female respondent explained:

> I brought up some sex-related anxieties and he asked LOTS of detailed questions and I got uncomfortable so I gave really vague answers and haven't brought up sex in sessions with him since. I don't know if I'm being overly paranoid or if he was actually being creepy.

Another woman wrote about being disturbed by her therapist's response to a social encounter *before* treatment began:

> I allowed my therapist to save face by not fully exploring an experience in which he admitted that he felt personally rejected by me when, prior to our therapeutic relationship beginning, we had met briefly in a social situation … Though we acted as if it was water under the bridge, I believe it created the undercurrent that ultimately contributed to the relationship's demise.

Respondents were evenly split on the impact of this lie, with three reporting negative outcomes (e.g. "It makes me not want to go to therapy") and three reporting minimal impact.

What I can afford to pay for therapy

Payment issues are a common point of dispute and negotiation in therapy (Schonbar, 1967), and in some (primarily psychodynamic) modalities may be used to facilitate discussions of the client's interpersonal dynamics. Dishonesty about "what I can afford to pay for therapy" was uncommon in the survey (8% of the sample), and the mean extent of dishonesty was among the lowest of the therapy-related lies; 13% of those reporting this lie rated their dishonesty as total or extreme.

Only three respondents elected to tell us more about this particular topic, and none ever admitted it to their therapist. An example: a man in his mid-30s started lying about

his ability to pay only after more than a year of therapy – and only after he had spent most of his life savings:

> In the last two years I have lost my job due to my mental health issue. At the time I started seeing my therapist I did not have insurance and had to pay out of pocket. In the past two years I have spent over $17,000 (almost all of my life savings). I don't think the therapy has helped but I'm very attached to my therapist. A few months ago I told my therapist I could no longer afford to see her because of the cost. My therapist agreed to reduce her fee. The truth is my parents help me with my bills, so I can afford to continue seeing her, I just don't think the therapy is worth what she is charging, because I haven't made any progress.

My romantic or sexual feelings about my therapist

While only 5% of the sample reported lying about romantic or sexual feelings about their therapist, this topic, along with "Not saying I want to end therapy," elicited the highest mean extent of lying score. Moreover, among all the therapy-related lies, it elicited the highest proportion of respondents indicating that this lie was total or extreme (46%). The most common motives were "I wanted to avoid shame" and "The topic was uncomfortable for me." Looking to the narrative accounts provided by six respondents, there was an evident concern that acknowledging the truth would change the therapeutic relationship or possibly end it. As one woman explained:

> I never told him how obsessed I became the first few years of therapy. I think he knew but we never talked about it. It was painful and I missed him between sessions and thought about him constantly. Even found out where he lived and drove past his house sometimes, hoping to see him … I was afraid he would stop seeing me.

Of the 26 respondents who lied about this topic, 11 acknowledged concealing attraction to a therapist of the same sex (9 woman-to-woman, 2 man-to-man). Notably, one young woman described her romantic feelings for a female therapist as ultimately quite helpful and something she hid for practical reasons:

> Being able to see her while I'm attracted to her is beneficial to me, since it makes me want to always be on time for all my sessions and try very hard to not slip-up or relapse in order to impress her. If the lie got out, I would likely be transferred or treated differently, so there is a bit of stress and anxiety about not revealing it.

Discussion

Overall, this study was an attempt to map the terrain of client dishonesty by surveying a large number of psychotherapy clients about a wide spectrum of possible topics about which they were dishonest with their therapist, through the use of any strategy from subtle omissions to outright fabrications. We found that a high percentage of clients (93%) reported lying, in one fashion or another, to their therapist, and that, for the most part, this occurs across all types of clients across all types of psychotherapies.

The percentage of reported lying in the current study is substantially higher than previous estimates of between 20 and 53% of clients admitting to "secret-keeping" in therapy (Baumann & Hill, 2015; Farber, 2006; Hill et al., 1993; Kelly, 1998; Pope & Tabachnick, 1994), and 37% reporting having "lied" to their therapist (Martin, 2006).

We attribute most of this difference to our approach, which relied on cued memory (selecting from a list), rather than free recall (open-ended question). Our figure is closer to some estimates of lying in everyday social life, which suggest a prevalence rate near 95% over the course of a single week, at an average rate of 1–2 lies per day (DePaulo et al., 1996; DePaulo & Kashy, 1998).

Younger clients were more likely to report that they had lied about more topics. In addition, clients whose therapists were of a different ethnicity than themselves reported more topics lied about. These findings underscore the need for open discussion of such differences and their implications for the clinical process, a point of increasing emphasis for many professional training programs in psychology (e.g. Sue & Sue, 2012). Still, the prevalence of lying across our sample, as well as the lack of significant differences observed across many other demographic variables (e.g. gender) defining the client, the therapist, or the dyad, suggests that lying in therapy is nearly universal and that its occurrence needs to be understood not in terms of individual ethics or pathology, but rather in terms of the structure and demands of the psychotherapeutic situation.

That is, the expectation of revealing one's most profound thoughts and feelings in time-limited segments to a typically high-status, non-reciprocally disclosing other, even in a context where confidentiality is almost unconditional and one's therapist is likely to be accepting and empathic, may inexorably lead to moments or instances of concealment and dishonesty. It is at times, all too much; self-judgment and/or assumed external judgment leads most all therapy clients to less-than-honest expressions of the truth about many topics, including their experiences of therapy itself and/or the therapeutic relationship.

Our focus on therapy-related lies produced several notable findings. First, we found the proportion of clients who report lying about therapy-related topics – lies about the therapist or therapy per se – to be over 70%, making this domain of dishonesty far more prevalent in this study than even lies about sex, the topic which has often been found in previous studies of therapy clients to be the most commonly concealed type of material. The prevalence of therapy-related dishonesty appears to have been overlooked by many previous studies, partly because secrets have been defined as events occurring outside therapy (Baumann & Hill, 2015) or because these topics have been omitted or minimized in survey research (e.g. Farber & Hall, 2002). Our operationalization of therapy-related lies is closer to Hill et al.'s (1993) notion of "things left unsaid," a study in which the prevalence of this type of secret or lie was a roughly similar 65%.

Second, we found that some therapy-related topics occasion more extreme degrees of dishonesty than almost any other subject. Three topics – romantic feelings about the therapist, the desire to end therapy, and the client's "real opinion" of their therapist – elicited "total or extreme" dishonesty at a higher rate than any of the other 55 topics on the survey. Discussing here-and-now feelings, especially feelings that may be considered off-limits or impolite, demands more intimacy and courage than many therapy clients can muster. We suspect that difficulties in discussing this cluster and other related items are a major factor underlying the tendency of great numbers of clients to terminate therapy without involving the therapist in the decision.

Third, we found that clients' motivations for therapy-related dishonesty are different from motives associated with other subjects of dishonesty. Whereas shame and embarrassment may motivate secret keeping on many topics brought into therapy, therapy-related dishonesty is more often motivated by "other-oriented" psychological

concerns (DePaulo, 1996), such as a desire to be polite, to avoid upsetting the therapist, and to minimize the possibility of provoking the therapist's disapproval. This finding could be seen as lending more empirical support to Rennie's (1994) argument that clients' fears of criticizing their therapist, their eagerness to meet their therapist's expectations, and their attempts to avoid threatening their therapist's self-esteem are part of an overall pattern of deference to the clinician.

While some lies are clearly motivated by the tendency for clients to be deferential, other lies seem triggered primarily by a poor therapeutic relationship – that is, by clients' dislike and/or distrust of their therapist, leading to their sense that honesty would be pointless. Although it may be difficult on a priori basis to determine the elements of an effective therapeutic "match," the data documenting the importance of a positive therapeutic alliance by the third session (e.g. Horvath et al., 2011) point to the fact that some therapeutic dyads simply do not work well from the very beginning, providing a too-easy context for dishonesty.

Limitations

Our efforts to take a different methodological tack based on cuing the respondent's memory introduced two important limitations. First, the survey title included the words "lying in psychotherapy." Individuals agreeing to complete such a survey were arguably more likely to remember having lied to their therapist, undermining the generalizability of the high proportion of therapy "liars" in this study. In a related vein, the focus of this survey on lying (to the exclusion of instances of truth-telling) may have led to an overestimation on the part of respondents of the extent and salience of instances of their dishonesty. Second, this study provided a list of 58 possible topics from which respondents could choose. While this list served to trigger memories that might otherwise have been forgotten, this set of topics cannot presume to capture all experiences of dishonesty in psychotherapy. In this regard, a notable absence was possible dishonesty regarding one's sexual orientation, although space was provided for users to write in new topics, topics not on the list may have been under-reported.

Another notable limitation was the absence of data on when participants who were no longer in therapy had terminated treatment. The passage of time may have an impact on what is remembered, in terms of the valued aspects of the treatment as well as those less positive, more problematic aspects.

Clinical and research implications

That so many clients seem to struggle with being honest with their therapists about their therapeutic experiences, including their relationship, is perhaps both inevitable and troubling. It is inevitable, in the sense that people are rarely fully honest or fully disclosing in any interpersonal situation. As Goffman (1959) noted so aptly, we are constantly doing the work of impression management, of attempting to find a balance between wanting to be genuine in our expression of self and wanting to "sell" some not quite accurate sense of who we are in an effort to fit others' expectations and judgments. Furthermore, per Goffman, people conceal aspects of themselves in order to mitigate inner feelings of fear, guilt, or shame. The results of the present study, consistent with the work of others who have studied similar processes, attest to the applicability of

Goffman's observations even in the "sanctity" and presumed safety of a therapist's office. As noted above, we are perhaps never entirely free of the fear that others – especially highly esteemed others – will judge us harshly, or even think less well of us. And so, clients dissemble – to protect themselves from their therapists' judgments and presumed subsequent reactions, and to guard and preserve their own often idealized and sometimes fragile sense of whom they should be and how they should act.

But this is a troubling state of affairs as well. In some sense, these findings suggest that, as a profession, we are failing to provide a sufficiently safe place for our client to disclose some quite significant clinical information. While therapy is a *somewhat* safe place, a place where most clients do reveal a good deal of their innermost thoughts and feelings (Farber, 2006), it appears as if there are true limitations. In fact, despite the trend toward relationally oriented practices across multiple theoretical orientations (e.g. Norcross, 2011), many clients are still struggling mightily to discuss honestly the very nature of their thoughts about the therapeutic relationship and therapeutic process. Not doing so – not discussing the ways in which therapy is helping or the ways in which it is disappointing – surely has consequences for the client (including his or her commitment to therapy and self-image), the therapist (including his or her morale and feelings of self-efficacy), the therapeutic alliance, the likelihood of premature termination, and of course, the probability of positive therapeutic outcomes.

We believe, however, that there are ways in which clinicians can increase the likelihood that clients will disclose significant material, including that related to the process of psychotherapy and the nature of the therapeutic relationship. While client honesty will never be totally unbounded, clinicians who address issues of emotional safety, trust, confidentiality, and disclosure in the earliest stages of therapy and who revisit these issues periodically throughout treatment, are likely to encounter more open and engaged clients (e.g. McWilliams, 2004). In a related vein, while most clinicians are aware of the importance of such relational elements as empathy and positive regard, some would undoubtedly profit from more focused attention on the dynamics of the relationship per se. We would also argue for the need for increased therapist training in identifying and resolving therapeutic ruptures as a means to attenuate client inclinations toward dishonesty in the room. Lastly, we believe that renewed attention to the possibilities and benefits of pre-therapy client "role induction" (e.g. (Patterson, Anderson, & Wei, 2014) could sensitize clients to expectations regarding therapeutic tasks, including disclosure about the relationship itself. As Yalom (2002) writes, "the therapist should carefully prepare new patients by informing them about psychotherapy – its basic assumptions, rationale, and what each client can do to maximize his or her own progress" (p. 86).

Future research on client dishonesty is needed, especially in the possibly related areas of client minimization of emotional distress and client avoidance of discussions of the current state of the therapeutic relationship. The groundbreaking work of Hill et al. (1993) on "things left unsaid" and by Safran and Muran (2000) on the identification and repair of therapeutic ruptures are excellent examples of research that has begun to move the field to a greater awareness of the clinical implications of client dishonesty or reluctance to disclose significant clinical material. Still, more is needed to further identify those specific therapeutic practices that increase or decrease the probability of client dishonesty. As we understand more about the processes that inhibit or facilitate client disclosure, we are likely to be in a better position to help our clients heal.

Acknowledgments

We gratefully acknowledge the contributions of excellent research assistants – Melanie Love. Laura Curren, Lauren Grabowski, Mona Khaled, Lama Khouri, Veronica Ozog, and Katelyn Zmigrodski.

Disclosure statement

No potential conflict of interest was reported by the authors.

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