LYING IN PSYCHOTHERAPY: RESULTS OF AN EXPLORATORY STUDY

Except where reference is made to the work of others, the work described in this dissertation is my own or was done in collaboration with my advisory committee. This dissertation does not include proprietary or classified information.

_____

Leslie Erin Martin

Certificate of Approval:

_____	_____
Jamie S. Carney Professor Counselor Education, Counseling Psychology and School Psychology	Randolph B. Pipes, Chair Professor Counselor Education, Counseling Psychology and School Psychology
_____	_____
Marie F. Kraska M.C. Fraley Distinguished Professor Educational Foundations, Leadership and Technology	Joe F. Pittman Interim Dean Graduate School

LYING IN PSYCHOTHERAPY: RESULTS OF AN EXPLORATORY STUDY

Leslie Erin Martin

A Dissertation

Submitted to

the Graduate Faculty of

Auburn University

in Partial Fulfillment of the

Requirements for the

Degree of

Doctor of Philosophy

Auburn, Alabama
December 15, 2006

LYING IN PSYCHOTHERAPY: RESULTS OF AN EXPLORATORY STUDY

Leslie Erin Martin

_____
Signature of Author

_____
Date of Graduation

DISSERTATION ABSTRACT

LYING IN PSYCHOTHERAPY: RESULTS OF AN EXPLORATORY STUDY

Leslie Erin Martin

Doctor of Philosophy, December 15, 2006
(B.A. Purdue University, 1999)

227 Typed Pages

Directed by Randolph B. Pipes

Although the topic of lying in psychotherapy has been addressed in philosophical and theoretical discussion, it has received scant attention in research endeavors. In order to gather data on lying in psychotherapy, the Lying in Psychotherapy Survey was developed. A link to this survey and three additional surveys (designed to measure the quality of the therapeutic relationship, clients' satisfaction with their therapists, and social desirability) was sent to graduate students in psychology and related programs via the American Psychological Association of Graduate Students listserv. Participants were graduate students in psychology and related fields who reported that they currently were or previously had been clients in psychotherapy. It was hypothesized that individuals having less positive perceptions of their therapeutic alliances would be more likely to report that they had previously lied to their therapists than individuals having more positive perceptions of their therapeutic alliances. It was also expected that

individuals who lied to their therapists would report being less satisfied with treatment outcome than individuals who did not lie.

Data were collected for a total of 109 participants: 40 who indicated that they had previously lied to a therapist and 69 who indicated that they had never lied to a therapist. Results of a logistic regression analysis revealed support for the hypothesis that lower scores on the therapeutic relationship could predict lying in psychotherapy: individuals with lower scores on this instrument were more likely to report that they had lied to a therapist than individuals with higher scores on this instrument. Results of a *t* test revealed support for Hypothesis Two, which predicted that individuals who lied to their therapists would report being less satisfied with treatment outcome than individuals who did not lie to their therapists. It was concluded that lying in psychotherapy is a common phenomenon that may be influenced by clients' perceptions of their therapists and the therapeutic alliance. Implications for psychotherapists, explanations for the obtained results, limitations, and recommendations for future studies are discussed.

ACKNOWLEDGEMENTS

The author would like to thank Dr. Randolph Pipes for all of the time and energy he put into consulting, collaborating, and providing feedback during the writing of this manuscript. The author is also grateful to Drs. Jamie Carney, Marie Kraska, Becky Liddle, and Phil Lewis for their feedback and guidance. Finally, thanks are due to my parents, Bobbie and Tom Peck, my husband, Bryan Martin, my little sister Snuff and her family, and all of my friends for their support and encouragement.

Style manual or journal used *Publication Manual of the American Psychological Association, 5th Edn.*

Computer software used Microsoft Word, Statistical Package for the Social Sciences (SPSS) 11.0

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

The pervasive nature of lying in society and everyday life has been commented upon by numerous scholars (see, for example, Ford, 1996; Gediman & Lieberman, 1996; Serban, 2001; Vrij, 2000). In fact, the ubiquity of lying has been described across cultures (Friedl, 1962; Gilsenan, 1976), across species (Patterson & Linden, 1981), across types of relationships (DePaulo, Kashy, Kirkendol, Wyer, & Epstein, 1996), and throughout time (Barnes, 1994). Perhaps because of its ubiquity, the topic of lying has been addressed by scholars of many disciplines, including communications (Lippard, 1988; Miller, 1983), sociology (Barnes, 1994; Goffman, 1959), philosophy (Adler, 1997; Bok, 1979; Nyberg, 1993), business (Grover, 1993), medicine (Bilney & D'Ardenne 2001; Burgoon, Callister, & Hunsaker, 1994), anthropology (Friedl, 1962; Gilsenan, 1976), and psychology (Gediman & Lieberman, 1996; Newman & Strauss, 2003).

It has been noted that, while lying is quite prevalent in society, it is considered a vice, while truth is considered a virtue (Solomon, 1993 p. 31). Saxe summed up this observation nicely, stating that "Lies are considered bad, immoral, and reprehensible" yet "there is considerable evidence that prevarication is a ubiquitous feature of social interaction" (1991, p. 409). Barnes agreed with assumptions that lying is ubiquitous, and

introduced his book on lying with the quote "lies are everywhere" (1994, p. 1) and ended with the statement "we all tell lies" (p. 168).

Rationale for the Study

To date, much of the empirical work on lying has explored the detection of lies (see, for example**,** Ekman, 1992; Miller, Mongeau, & Sleight, 1986; Vrij, 2000). Scholars such as DePaulo and her colleagues (DePaulo et al.., 1996; DePaulo & Kashy, 1998) and Vrij and his colleagues (Vrij, Floyd, & Ennis, 2003) have made significant contributions to our current understanding of lying in everyday social interactions, including the types of lies people tell and their motivations for doing so. These and other authors (Camden, Motley, & Wilson, 1984; Hample, 1980) have helped underscore the commonality of lying in daily interactions. However, there is much about this topic that remains to be explored, including lies that occur in different social relationships, such as the therapeutic encounter.

Some research exploring lying in the context of specific social relationships, such as the doctor-patient (Bilney & D'Ardenne, 2001; Burgoon et al., 1994) and supervisor-supervisee (Hantoot, 2000) relationship has been examined by researchers of different disciplines. In the psychological literature, however, the topic of lying in the therapeutic relationship has received relatively little attention. Related concepts such as secret-keeping and withholding information in psychotherapy have been empirically examined by authors such as Kelly (1998; 2000) and Regan and Hill (1992). Several scholars (Gediman & Lieberman, 1996; Marcos, 1972) have suggested that lying frequently occurs in the therapeutic encounter, and have discussed the topic from various

philosophical and theoretical positions in psychology (most notably psychodynamic theory). Empirical information on lying in psychotherapy, however, is lacking.

Purpose and Nature of the Present Study

As a result of the gap in empirical literature aimed at examining lying in psychotherapy, a study was designed to explore this phenomenon. The present study was exploratory in nature, and was designed to gather information on lying in psychotherapy, including information on prevalence, factors that influence lying, and consequences of lying in therapy. A survey developed for this study (the Lying in Psychotherapy Survey, or LPS, as described in Chapter III) was used to gather data from current and/or former clients of psychotherapy (the American Psychological Association Graduate Students (APAGS) listserv members who reported that they had been in therapy before or currently were undergoing therapy). Information was gathered from individuals who reported that they *had lied* to a therapist, *had not lied but had been tempted to lie*, and individuals who *had never lied and were never tempted*.

In addition to the Lying in Psychotherapy survey, participants responded to three other instruments: the Therapist Satisfaction Scale (Conte, Buckley, Picard, & Karasu, 1994), the Agnew Relationship Measure (Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998), and the Social Desirability Scale-17 (Stöber, 2001). The TSS and ARM were included in order to examine relationships among lying/not lying to therapists and participants perceptions' of their therapists and the quality of their therapeutic relationships. As will be described in Chapter II, several authors have implicated

therapist characteristics and the therapeutic relationship in clients' decisions to lie in therapy. The TSS and ARM were intended to help test the assertions of such authors.

Because several scholars (e.g., Bilney and D'Ardenne, 2001; Brody, 1995; Zagon & Jackson, 1994) have described a relationship between lying and social desirability, a social desirability scale was included in the present study. The inclusion of this instrument was intended to aid in exploring the possibility that social desirability might serve as a confounding variable in the relationship between lying in psychotherapy and the quality of the therapeutic relationship.

The following chapter critically reviews the existing literature on lying. Specific attention will be given to studies that examine lying in everyday life, including the prevalence of lying, motivations for lying, and types of lies told. Philosophical and theoretical speculations on lying in psychotherapy will be briefly discussed. Because research examining lying in psychotherapy is scarce, the empirical literature on related phenomena, such as secret keeping and withholding information in psychotherapy, will also be described. Studies concerning the detection of lying, while numerous in the literature on this subject, were excluded from the literature review, as they are not central to the topic under investigation in the present study.

CHAPTER II

REVIEW OF THE LITERATURE

Definitions of Lying

Scholars who have discussed the phenomenon of lying have used many different definitions to describe the term *lie*. Definitions vary in numerous ways, most notably in terms of whether or not they include intent and/or consequences in their description of the elements of a lie.

In her philosophical examination of lying, Bok described the lie as "any intentionally deceptive message which is *stated*" (1978, p. 13). Barnes (1994) built on Bok's definition and added that lies may also include statements that are *thought* (as part of an inner dialogue) but not spoken or written. This definition permits the description of "lie" to encompass self-deceit and does not require the involvement of more than one actor.

Wile defined lies as "consciously false statements uttered or written to achieve definite results through the deception of others (1942, p. 295)." Three elements are involved in this definition: the awareness of falsity, intentional deception, and a distinct, preconceived purpose. Miller (1992) described the "conscious awareness of falsity" as the critical factor in the definition of a lie, one which distinguishes the lie from

misinformation (in which the actor does not realize the information is untrue) or a delusion (in which the actor believes false information to be true).

DePaulo and colleagues defined lying as "intentionally try[ing] to mislead someone" (1996, p. 980). These and many other authors, such as Bok (1978) and Wile (1972) involve the *intent* to mislead in their definitions of a lie. Other definitions of the term "lie" omit the focus on intent and concentrate on the inaccuracy of the content of the statement. For example, one of the definitions of *lie* offered by the Random House Dictionary (1987) is "an inaccurate or false statement."

In the present discussion, the term *lie* will not presuppose intent and will refer to *statements, which are known not to be true, told by an actor to a target*. Several factors involved in this definition merit attention. First, like Miller (1992), this definition focuses on "the conscious awareness of falsity" on the part of the individual telling the lie. The present definition includes the involvement of the person making the false statement and at least one additional actor—the target of the lie. Statements involving lies may be verbal or written. Lies may or may not involve the *intent* to deceive, but certainly involve deception as a possible *consequence*. Note also that this definition excludes acts of self-deception, and does not consider the success or failure of the lie. Finally, the above definition of a lie does not include related behaviors that may result in deception, such as withholding information, keeping secrets, or misleading through nonverbal behavior.

Intent is left out of the current definition because it is assumed that lies may occasionally be told for reasons other than to deceive. For example, a client may lie to a therapist not to deceive him or her, but rather to "test" the therapist. To illustrate, this

author was informed by a former client that she (the client) had lied to a previous therapist in order to examine if her therapist was capable of being duped. She reported that she had hoped her therapist would not be mislead by the lie, and in fact wanted the therapist to recognize that a lie was being told. The lie told by the client in this case was not motivated by an intent to deceive, but rather as a way to test the therapist's abilities to accurately perceive the client.

In present-day vernacular, numerous terms have been used interchangeably with the word *lie*. For example, *dishonesty*, *fallacy*, *lie*, and *duplicity* are often used synonymously with the noun *lie*, while *prevaricate*, *fabricate*, *slander*, and *malinger* are just a few of the numerous terms that may be used synonymously with the verb *to lie* (Ford, 1996). Although these words are used interchangeably by many people, the technical definitions of these terms may not fully encompass the definition of a lie described earlier in this paper. Therefore, for purposes of clarity, the terms *lie* and *lying* will be used throughout this paper.

Taxonomies of Lying

Just as there is some disagreement between the exact definition of a lie and the components that make up a lie, there has been dissension in the classification of lies. Some individuals (see, for example, Karpman, 1953) have classified lies based on the motivation of the individual telling the lie, while others have classified lies based on the malignancy or consequences of the lie (Bok, 1978) or the psychopathology of the liar (Davidoff, 1942). Complicating a discussion of the taxonomy of lies is the use by various authors of the same term to describe different types of lies (see below, for

example, where the terms *altruistic lies* and *social lies* are used differently by various authors), or the use of different terms to describe the same types of lies. Because a comprehensive discussion of all proposed taxonomies of lying is beyond the scope of the present study, only more commonly described types of lies will be described here.

Taxonomies Based on Lie Malignancy/Severity

On one end of the severity-of-lies spectrum falls what several authors (Wile, 1942; Ford, 1996) described as *aggressive lies*, which are those told in order to hurt someone else, advance the self, or gain advantage for oneself. Other scholars have used different labels to describe similar types of lies, such as *black lies* (Gediman & Lieberman, 1996) and *serious lies* (Anderson, Ansfield, & DePaulo, 1999). For example, Barnes (1994) used the term *malicious lies* to refer to lies which benefit the liar at the expense of the individual being lied to. *Antisocial lies* are defined as those which are used to cover up misdeeds (Bussey, 1999). It is apparent from the terms selected to describe these types of lies that they often involve harmful or malignant intentions or consequences.

On the other end of the severity-of-lies spectrum fall *white lies*, described by Bok as being of "little moral import" (1978, p. 58), and which are not meant to cause harm to anyone. Most authors espousing a classification of lies describe a similar type of lie, though many use different names to describe these lies. For example, Barnes (1994, p. 14) referred to such lies as *simple benevolent lies*, and also noted the benign nature (e.g., not involving the intention to injure any third parties) of these lies. Bussey (1999) added that white lies are often told in order to preserve interpersonal relationships. In a similar manner, Karpman (1953), in his classification of lies based on motive, described *benign*

and *salutary lies* as those told to effect social conventions. Examples of such lies include thanking a host for a delightful party (when in actuality one found it quite dull) or complementing a friend's new haircut when it is truly unflattering. Although some authors use the terms *white lies* and *altruistic lies* interchangeably, Ford (1996) distinguishes between the two: white lies are told to "lubricate" social relationships, while altruistic lies are told for the more express purpose of benefiting another person.

The various lies reviewed in the preceding paragraph have been described as benign and/or essentially harmless. Several authors have described more important types of lies that are told by individuals in order to protect themselves, others, or society in general. For example, Barnes (1994) and Wile (1942) labeled those lies told to preserve social harmony *social lies*, and Bussey (1999) described *altruistic lies*: those more extreme forms of social lies that are told to protect individuals from danger. Bok (1978) also described what she termed *paternalistic lies* (those told to allegedly benefit the target of the lie), *noble lies* (those told to advance the public good), and *lies to the sick and dying* (told with the intent of avoiding upsetting or destroying the hope of ill patients). Finally, the term *defensive lies* (Ford, 1996; Karpman, 1953) has been used to broadly describe any lies that protect individuals (the liar or another person) from being punished, physically harmed, or having self-esteem damaged (Ford, 1996).

Lies that may be classified as neither aggressive nor white lies include *trick lies*, which are told for fun and do not involve the intent to harm another or gain benefits. For example, a child who tells her father that a leaf which has just fallen on his back is actually a spider is telling a trick lie (Bussey, 1999). *Humorous lies* are related to trick lies and involve attempts to amuse the target (Ford, 1996).

Taxonomies Based on Pathology

Individuals who have classified lying based on pathology have typically endorsed a psychodynamic framework. For example, *pathological* (or *compulsive*) *lies* are told in the absence of any apparent gain to the individual telling the lie (Ford, 1996). Deutsch (1923/1982) and Fenichel (1954) discussed *pseudologia fantastica,* a specific form of pathological lying that involves the telling of elaborate stories about past and present life stories. After repeated telling and elaboration, patients come to believe these evolved stories. It is perhaps appropriate to note here that lying is a typical symptom of many mental disorders, including the DSM-IV-TR Cluster B personality disorders (borderline, histrionic, narcissistic, and antisocial), obsessive-compulsive personality disorder, and Munchausen syndrome (American Psychiatric Association, 2000; Ford, King, & Hollender, 1988; Ford, 1996).

Classification Based on Multiple Components

Some authors have classified lies using multiple components. For example, DePaulo and colleagues (1996) classified the lies told by participants in their study on several different dimensions: content of the lies, reasons for the lies, types of lies, and referents of the lies.

The content of lies described by DePaulo and colleagues included lying about feelings, actions, plans, whereabouts, achievements, and knowledge. Reasons for lying were broken down into *self-centered* lies (told to benefit the individual telling the lie) and *other-oriented* lies (told to benefit others). Types of lies included outright lies, exaggerations, and subtle lies, while referents of the lies (the objects of the lies) included

the liar, the target (the person to whom the lie is being told), outside individuals, and objects or events (DePaulo et al., 1996).

Motivations for Lying in Everyday Life

Motivations for lying in everyday life have been described by numerous authors. The results of multiple studies have supported the notion that "people lie in a purposeful and motivated way" (Lippard, 1988; p. 92). Because many of the motivations were described above in the section on classifications, they will only briefly be reiterated here. The following section reviews motivations for lying in everyday life; specific motivations for lying in psychotherapy are described later in this chapter, under the section "Lying in Psychotherapy."

Lies Told to Benefit the Self

Many lies are told in order to benefit the individual telling the lie (Bok, 1978; Camden et al., 1984; DePaulo et al., 1996; Hample, 1980; Lippard, 1988). DePaulo and colleagues (1996) classified lies told to benefit the self (or *self-oriented lies*) into two separate categories: lies told for *psychological reasons* and lies told for reasons of *personal advantage.* Self-oriented lies told for psychological reasons include those intended to protect the liar from embarrassment, having his or her feelings hurt, or looking bad. People may also lie to avoid experiencing unpleasant emotions such as conflict or worry, or to make their lives appear better than they actually are. Lies intended to aid in emotion regulation also fall in the category of self-oriented lies, as do lies to protect confidentiality and privacy (Anderson et al., 1999; Bok, 1978; DePaulo et al., 1996; DePaulo, Wetzel, Sternglanz, & Wilson, 2003). Self-centered lies told for

personal advantage included those intended to help people get their way or gain benefits, protect them from physical punishment, protect their property, prevent them from loss of status, and to prevent them from having to do things they did not want to do (DePaulo et al., 1996) .

DePaulo and colleagues (1996) found that the majority of lies told by participants in their study were self-centered lies. Participants reported that most of these lies were told for psychological reasons, such as the protection of self-esteem and emotional concerns, as opposed to the pursuit of personal gain or convenience. In a similar manner, Turner, Edgely, and Olmstead (1975) found that more than one half of the participants in their study lied in order to "save face." Hample (1980) reported that two-thirds of his participants admitted that they had lied for their own benefit, but did not elaborate on the nature of these self-centered lies.

Self-Oriented Lies and Impression Management

Many of the lies told to benefit the self can be viewed as motivated by a desire for *impression management*, or the "conscious or unconscious attempt to control images that are projected in real or imagined social interactions" (Schlenker, 1980, p. 6). In other words, lies can be used to influence how other individuals perceive various characteristics of the individual telling the lie. In the present discussion, only those active and conscious (rather than unconscious) attempts to control images in real (as opposed to imagined) social interactions are of interest.

Goffman (1959) initially suggested that lying is used by actors in daily social interactions to manage the impressions others have of them. He noted that social interactions provide a stage where people often engage in *performances*, which are the

activities of a "given participant on a given occasion which serves to influence in any way any of the other participants" (p. 15). In a similar manner, Millar and Tesser (1988) examined influences on lying and found that people often lie when they feel they have violated the expectations of the individual to whom they are lying. For example, a college student who tells his mother that he did not drink at a party when, in reality, he became intoxicated at the party, may be telling the lie in order to preserve his mother's image of him as a "clean-cut" and dutiful son. Essentially, Millar and Tesser found support for Goffman's contention that lies aid in impression management, as the participants in their study reported increased instances of lying when their behaviors violated the expectations of the individuals to whom they lied. Anderson and colleagues (1999) also described lies motivated by a desire to convey "desired impressions of ourselves" (p. 381), and Kashy and DePaulo (1996) noted that lies are used to manage the impressions others have of us.

It should be noted that impression management is one of the two components of the construct of *social desirability* (Paulhus, 1984). Self-deception, the other component of social desirability, indicates a denial of psychologically harmful cognitions and serves as a source of protection from painful self-information (Sabourin, Bourgeois, Gendreau, & Morval, 1989). Social desirability refers to the tendency to respond in ways that are perceived as socially acceptable and appropriate. Some researchers (e.g., Bilney & D'Ardenne, 2001; Brody, 1994; Zagon & Jackson, 1995) have commented on the relationship between lying and social desirability, noting that the two concepts appear to be positively related.

Additional Self-Oriented Lies

In addition to the aforementioned lies motivated by self-interest, several additional self-serving lies have been described. For example, Ford (1996) suggested that people may be motivated to lie in order to create a sense of identity, to preserve a sense of autonomy, and to obtain a sense of power. Although lies told to preserve a sense of autonomy are presumed by some authors to be unconsciously motivated (see "Unconscious Motivations," below), other scholars have presumed that sometimes people consciously lie to others in order to maintain a sense of independence (Winnicott, 1964).

Several authors have implicated motives of gaining power in lying. Bok (1978) noted that individuals often feel a sense of power after they lie to others. Tedeschi, Schlenker, and Bonoma (1973) suggested that individuals who occupy low-power positions often resort to lying because they have few alternative methods of influencing people in more powerful positions. Turner and colleagues (1975) also described exploitive or power motives in their description of lying in social relationships. Hample (1980) suggested that lying is used by individuals to balance power and can be a "means of social or economic defense in a disadvantaged situation" (p. 45). Lies told as acts of aggression (e.g., in order to "get back at" someone with whom one is angry) and lies told to obtain a sense of power were also described by Ford (1996).

A final self-oriented lie that merits discussion here was described by Grover (1993). This author described situations in which an individual's various roles and values may come into conflict (e.g., an individual's job responsibilities versus their personal value system) and suggested that people may lie in order to resolve such

conflicts between roles. To illustrate his role conflict theory of lying, Grover gave an example of a salesman working for an auto dealership that endorses the use of high-pressure sales tactics to persuade customers to buy cars. If the salesman believes that customers should be permitted to take time and be told the full truth about the value of the car, he may lie to his employer (stating that he pressured the customer to buy the car) in order to relieve the distress caused by the conflict between his personal values and those of the organization for which he works.

Lies Told to Benefit Others

Although some scholars (e.g., DePaulo et al., 1996; Hample, 1980) have suggested that the majority of lies people tell are told in order to benefit the person telling the lie, these scholars have also suggested that many lies are told in order to benefit others. For example, in their diary studies, Bella DePaulo and her colleagues (1996) found that approximately 25% of the lies reported by the college students and community members in their sample fell into their classification of "other-oriented." Motivations to lie in order to benefit others for *psychological reasons* described by participants in this study included protecting others from embarrassment, unpleasantness, loss of face, or having their feelings hurt. Lies told for *another person's advantage* included helping others get their way, protecting others from harm, and protecting others from loss of status.

Consistent with the results of DePaulo and colleagues' (1996) study, Hample (1980) reported that a quarter of the lies reported by participants in his study were motivated by a desire to give an advantage to another person or an interpersonal relationship. Similarly, approximately one-fifth of the lies reported by participants in the

Camden's study (Camden et al., 1980) were told to benefit another person. Metts (1989), in her exploration of lying in close relationships, found that lying to avoid hurting an individual's partner was the most common motivation reported for lying to significant others in her study.

Lies Told to Affect Social Relationships

Many authors have noted the motivation to lie in order to facilitate or preserve social relationships. Because these lies often benefit both the self and others, they cannot easily be separated from self-serving and other-oriented lies, and are therefore described here in a separate category.

It has already been noted that Millar and Tesser (1988) described the ways in which lies may occur in relationships where one has violated the expectations of another and wishes to maintain the other's impression of him or her. These authors concluded that lies are often motivated by attempts to resolve perceived threats to relationships. Miller and colleagues (1986) also commented on the protective function of lies and described the motivation of lying to preserve social relationships. In her categorization of the major reasons for lying, Metts (1989) acknowledged the intent to protect relationships. Burgoon and colleagues (1994) described "interpersonal motives" as one of the three major classes of motives for lying, and described how lies can be used to initiate, maintain, or terminate interpersonal relationships.

Additional Motivations for Lying in Everyday Life

Of course, motivations for lying are numerous, and it would be impossible to describe every possible motivation underlying the telling of lies. There remain, however, significant motivations for lying that have not yet been described and which

warrant attention. Bok (1978), for example, described various other motivations for lying in addition to those described above, such as lying with the intent to maintain the appearance of fairness. For example, a doctor may "fudge" a low-income patient's diagnosis in order to assist that patient in obtaining the medical treatment he or she needs. Motives pertaining to protecting the truth, including lies told to "further some larger or more important truth," (p. 84) were also described by Bok. Finally, the author discussed the possible motivation of lying to protect the common good. She gave the example of government officials lying to the public about preparing for long-term challenges of war in order to protect the public from painful experiences associated with facing this truth, and termed this type of lie the *noble lie*. Although Bok described these motivations, it should be noted that she questioned whether or not they are benign in nature, despite the fact that people often cite altruistic purposes for telling such lies.

Ford (1996) outlined multiple common motivations for lying. Related to Bussey's (1999) description of the "trick lie," Ford (1996) described the motivation of lying for the enjoyment of fooling other people. Ekman (1992) used the term *duping delight* to refer to the pleasure individuals get from playing jokes on others.

Related Literature

Thus far, the focus of the discussion on lying has been limited to defining the term *lie*, classifying types of lies, and describing motives for lying in everyday life. The following discussion includes additional information gleaned from empirical studies on lying that occurs in daily social interactions and in special relationships. A look at

research on withholding information and secret keeping in psychotherapy will conclude this section.

Lying in Everyday Life

Frequency of Lying

Participants asked to record the frequency of white lies in a study by Camden and colleagues (1984) reported averaging 16 lies in a 14-day period. Participants who recorded all acts of deception that occurred over a three-week period (Lippard, 1988) reported telling an average of 10 lies during this time frame. Although participants in her study reported lower rates of lying than did participants in the Camden study (Camden et al., 1984), these and other studies (e.g., DePaulo et al., 1996; Hample, 1980) have made it clear that lying is indeed a normal part of everyday social interactions.

DePaulo and her colleagues (DePaulo, et al., 1996; DePaulo & Kashy, 1998; Kashy & DePaulo, 1996) conducted a pair of studies on lying in everyday life and reported their results in several different articles. They asked college students and other community members who participated in their study to keep journals documenting their social interactions (including incidence of lies told to others) over the course of a week. The participants in this study reported telling an average of one to two lies per day, lying in approximately 20% of their social interactions, and lying to nearly one-third of the people with whom they interacted (DePaulo & Kashy, 1998; DePaulo, Kashy, Kirkendol, Wyer, & Epstein, 1996; Kashy & DePaulo, 1996). These results are consistent with those of Camden and colleagues (1984).

Prompted and Unprompted Lying

Some studies have investigated whether lies tend to be prompted (e.g., told in response to the query of another individual) or unprompted (told spontaneously or in response to an anticipated query). Metts (1989) found that participants in her study reported that most of their lies were responses to comments or queries. She found that omitting information was a more common deceptive strategy in instances in which information was not prompted by others, and suggested that relationships with high levels of information seeking (prompting) may involve higher incidences of lying than relationships involving less information-seeking.

Both Hample (1980) and Lippard (1988) have also found that the majority of lies are told in response to the comments or queries of others. This finding led Lippard (1988) to title the article in which she summed up these results "Ask me no questions, I'll tell you no lies."

Impact of Relationship Quality and Duration of Relationship on Lying

Bell and DePaulo (1996) explored the relationship between "liking and lying." They found that participants commenting on paintings they disliked lied more frequently to artists they had just met and liked, while they lied less to artists whom they disliked. The lies told by participants in this study involved "kind lies" about participants' perceptions of the paintings they were evaluating. Bell and DePaulo concluded that telling "kind lies" early in relationships might facilitate the development of that relationship. Thus, the telling of certain kinds of lies may be impacted by both the way individuals feel about the person to whom they are lying and the stage of the relationship.

Just as people may be more likely to lie in the beginning of a relationship in order to expedite relationship development (Bell & DePaulo, 1996), duration of the relationship may impact lying in other ways. For example, people with more extensive relationship histories know each other's idiosyncrasies and personal histories. Access to that information may cause an individual to consider alternatives to lying, as they may be more likely to get caught when lying to someone who knows them well (Anderson et al., 1999). In addition, Anderson and colleagues suggested that lying to an individual with whom one is involved in a close relationship may threaten the relationship; therefore, people may be less likely to lie to people with whom they are closest.

DePaulo and Kashy (1998) examined the data from the diary studies conducted by DePaulo and colleagues (DePaulo et al., 1996; Kashy & DePaulo, 1996) in order to gather some data about lying in everyday life and test the hypothesis that relationship quality is related to frequency and types of lies told. They found that participants reported lying less to individuals with whom they felt emotionally closest and felt more uncomfortable lying to these individuals than to people with to whom they were less close. They also found that more altruistic lies were told to friends, while self-serving lies were more commonly told to acquaintances and strangers.

Based on the above results, DePaulo and Kashy (1998) concluded that the subjective report of emotional closeness was the best predictor of participants' rates of lying and discomfort with telling lies, and that frequency of interactions with others (for both college students and community members) and duration of relationship (for community members) also was inversely correlated with the number of lies told per social interaction. The authors also concluded that the results of their study supported

their notion that people will lie less to emotionally close partners because lying violates the openness and authenticity that people value in meaningful relationships. When individuals misrepresent themselves often, they suggested, it can destroy feelings of closeness in the relationship.

Although DePaulo and Kashy (1998) found that subjective closeness predicted lower rates of lying to others, they mentioned two notable exceptions to this finding. They found that participants reported higher rates of lying to their mothers and to romantic partners who were not spouses. The authors suggested that individuals may be more likely to lie to people who have different power and control of resources (like a mother for college students) in order to obtain desired resources and privileges. The power of the target of the lie influencing an individual's likelihood of lying has also been suggested by Hample (1980) and Lippard (1988). In addition, DePaulo and Kashy noted that caring about the opinions of others (such as mothers and romantic partners) and wanting to impress them may motivate individuals to lie for self-presentational/ impression management reasons.

As noted previously, Millar and Tesser (1988) found that participants in their study reported that lying occurred when their behaviors violated the expectations of the individuals to whom they lied. They concluded that lying is used to maintain social relationships, and the results supported Goffman's (1959) notion that lies are valuable components of impression management used in daily social relationships. The authors noted that an implication of their findings is that "the greater number of expectations our partner has for us…, the greater probability of a lie" (Miller & Tesser, p. 273).

Sex Differences in Lying

Several research endeavors have pointed to significant sex differences in frequency of lies and types of lies told. Shippee (1977) found a "marginally significant" effect of gender on rates of telling "serious lies." Men in his study reported telling more serious lies than did women. Women in Lippard's study (1988) were more likely than men to lie in order to protect the feelings of others. Bilney and D'Ardenne (2001, described below) found that only women in their study reported they had previously lied to their physicians. It should be noted that this finding has not been replicated and may have been a result of small sample size.

Bella DePaulo and her colleagues have published numerous articles describing some support for sex differences in lying. In general, they concluded that, although women and men appear to lie with equal frequency, it is the ways in which they lie that differ (DePaulo, Epstein, & Wyer, 1993). They noted that women lie "warmly and protectively" as compared to men (p. 143). In their diary study with college students, for example, DePaulo and colleagues (1996) found that men and women did not differ in the average number of lies they told. In a subsequent study, however, Bell and DePaulo (1996; as described above) found that women were more likely than men to exaggerate or lie to artists in order to avoid hurting their feelings regarding their liking for paintings. Women also reported putting more effort into planning the lies they told to close friends than did men. Women in Wyer's study (1989; as described by DePaulo et al., 1993) reported feeling more discomfort during the telling of lies than did men. DePaulo and colleagues (1996) noted that dyads involving women interacting with other women in their study were more likely to involve "kind lies" than were dyads involving men.

Lying and Individual Differences

Kashy and DePaulo (1996) examined the data from DePaulo et al.'s (1996) study to find out if six individual difference variables (manipulativeness, impression management, self-confidence, socialization/social desirability, sociability, and relationship quality) could be used to predict who lies and the type of lies individuals are more likely to tell. They found that, generally, the participants in their study who reported telling more lies were more manipulative, more concerned with managing the impressions of others, and more sociable. These individuals (along with people having lower-quality same-sex relationships) tended to tell more self-serving lies. Individuals who told fewer lies were more highly socialized and were involved in higher-quality same-sex relationships. The lies told by these individuals tended to be other-oriented lies.

Vrij and colleagues (2003) expanded on the work of DePaulo and her colleagues (DePaulo et al., 1996; DePaulo & Kashy, 1998; Kashy & DePaulo, 1996). Like the DePaulo studies, Vrij and colleagues analyzed the frequency of self-centered and other-oriented lies among participants in their study. To these types they added altruistic lies, which they described as those told to third parties in order to protect close friends or to make close friends look better. They also examined the relationship between the individual difference variable of attachment style (anxious/ambivalent, avoidant, or secure) and types of lies people reported telling. Results indicated that all participants reported telling more lies to strangers than close friends, and that they reported telling more altruistic than self-centered lies. There were no differences in telling other-oriented lies to strangers or close friends. These results are inconsistent with those of

DePaulo and Kashy (1998), who found that participants were more likely to tell other-oriented lies to strangers. Consistent with the results of previous studies (e.g., DePaulo & Kashy, 1998; Metts, 1989), however, participants reported telling more self-oriented lies to strangers than to close friends.

In regards to attachment style, Vrij and colleagues (2003) found that, as predicted, anxious/ambivalent and avoidant attachment styles were positively correlated with rates of lying and type of lies told. Secure attachment styles, in contrast, were negatively correlated with rates of lying and type of lies told. People who reported being more avoidant or anxious/ambivalent reported lying more to strangers and close friends, while people who reported having more secure in attachment styles indicated lower frequencies of lying to strangers and close friends. In addition, the authors found that specific types of lies told were correlated with attachment style. Secure participants reported telling fewer self-centered, other-oriented, and altruistic lies to both strangers and close friends. Anxious-ambivalent attachment styles were positively correlated with telling self-centered lies to strangers and close friends, and other-oriented lies to strangers. Finally, avoidant attachment styles were positively correlated with telling self-centered, other-oriented, and altruistic lies to strangers and close friends.

Lying in Special Relationships

The studies described above examined individuals lying in everyday social relationships. The following discussion will briefly report on literature that examines lying in relationships that more closely mimic the therapeutic relationship, including the doctor-patient relationship and the psychotherapy supervisor-supervisee relationship.

Lying to Medical Doctors

Bilney and D'Ardenne (2001) examined whether clients attending a genito-urinary medicine clinic in the UK reported withholding or falsifying sexual history information in their interactions with physicians. They found that a significant number of respondents reported they had lied, and identified social desirability, language, and concerns about confidentiality as factors that influenced clients' decisions to falsify information on their histories. Interestingly, these authors noted that only women reported they had lied or withheld information. Bilney and D'Ardenne also found that women were less likely to lie to women physicians.

Burgoon and colleagues (1994) have also explored the phenomenon of patients lying (and using other forms of deceit) to physicians. Approximately one-third of the 754 adults in his study reported lying to physicians on occasion. Reasons given for lying included a sense of need to protect privacy, to avoid getting bad news or social disapproval, and to create positive relationships with their physicians. They also found that patients reported lying to their physicians for reasons of personal benefit, including financial benefits, in order to get a particular type of treatment, or in order to justify a desired action. Based on this data, the authors concluded that patients are most likely to lie to physicians when they have something to gain, such as medication, insurance benefits, or excuses for actions.

Lying in Psychotherapy Supervision

Hantoot (2000) examined lying in psychotherapy supervision. He interviewed four psychiatry residents who described situations in which they had deliberately lied to their psychotherapy supervisors. He suggested that lying in psychotherapy supervision

may represent an outgrowth of the interaction between a vulnerable individual and a challenging situation (p. 183). Lying in psychotherapy supervision, according to the author, can help supervisees set limits in the supervisory relationship, which helps the supervisee avoid anxiety associated with expressing emotions or material that may have difficult symbolic meaning.

Hantoot (2000) suggested that lying in supervision ought to be understood as an interpersonal transaction that is subject to the same factors that influence other transactions. Lies may allow individuals to express impulses, defend against impulses, or represent a combination of an expression and a defense. Hantoot expressed his belief that lying in supervision represents the supervisee's failure to manage his or her impulses and emotions in more effective ways.

Lying and Related Concepts in Psychotherapy

Because most of the literature that addresses the topic of clients failing to provide full disclosures to therapists pertains to secret keeping and withholding information, this literature will be reviewed first in the following section. A review of the literature addressing lying in psychotherapy will follow.

Secret Keeping and Withholding Information in Psychotherapy

Although lying in psychotherapy has not yet received empirical attention, many authors have examined the related phenomena of secret keeping and withholding information in therapy. For example, Regan and Hill (1992) explored the nature of the material clients undergoing brief therapy in their study reported withholding (information regarding emotional content, behavioral/cognitive content, or clinical conjectures) and subsequent reports of satisfaction with therapy and change. Their

findings indicated that most of the material clients reported withholding concerned feelings, behaviors, and thoughts (mostly negative) that occurred during therapy sessions. In addition, Regan and Hill found that the more emotional material clients withheld, the more satisfied they reported being with treatment. However, the proportion of material with cognitive or behavioral content left unsaid was negatively related to clients' satisfaction with treatment and change. Based on these results, Regan and Hill (1992) reported that, overall, the amount of material clients left unsaid was unrelated to satisfaction with treatment outcome. However, the type of material that clients do not share with therapists may significantly affect treatment outcome.

In describing motives for withholding information from therapists, Rennie (1985, as cited in Regan & Hill, 1992) suggested that clients often withhold information because they are concerned that, by revealing certain information, they will offend the therapist. Regan and Hill (1992) suggested that clients might also withhold information because they do not believe the material is relevant and/or because they do not know how to articulate their feelings. They also proposed that clients may be motivated to withhold information in order to feel more control in the therapeutic relationship. Participants in Kelly's study (1998; as described below) reported keeping secrets from therapists for reasons similar to those proposed by Rennie (1985) and Regan and Hill (1992).

In a subsequent study by Hill, Thompson, Cogar, and Denman (1993) the authors explored the nature of the material that clients withheld from therapists. They considered three types of client "covert processes:" *reactions* (thoughts and feelings clients have regarding therapist interventions), *things left unsaid*, (thoughts and feelings

experienced in-session and not shared with the therapist), and *secrets* (significant experiences, facts, or feelings not shared with the therapist). They found that clients were more likely to hide negative reactions than positive reactions to therapist interventions. Sixty-five percent of participants reported leaving things unsaid during therapy. Reasons for leaving things unsaid included experiencing overwhelming emotions, wanting to avoid dealing with disclosure, fear that the therapist would not understand, perception that the therapist did not seem interested, being uncertain of their emotions, and thinking the therapist would ask if it were important.

Nearly one half of the participants in the study by Hill and her colleagues (1993) reported keeping a secret from their therapist. Reported reasons for secret-keeping differed from reasons for leaving things left unsaid and included feeling shame or embarrassment, feeling unable to deal with the disclosure, and concern that the therapist could not deal with the disclosure. The majority of secrets kept involved sexual content, while other major themes were failure and mental health. These results are consistent in some ways with those of other authors (e.g., Norton, Feldman, & Tafoya, 1974; Yalom, 1970), who have also found that secrets withheld from therapists and members of encounter groups often involve sexual content, content pertaining to failure, and content concerning mental health.

Kelly (1998; 2000) hypothesized that withholding information in therapy can actually be beneficial to clients. By presenting themselves in a favorable manner and avoiding being too open in therapy, clients can benefit from perceiving that their therapists have favorable opinions of them. This *self-presentational* theory of psychotherapy posits that individuals shift their self-beliefs in the direction of the

therapist′s feedback, change their self-concepts, and can have positive therapeutic outcomes when they present themselves favorably to therapists.

In research supporting her self-presentational theory of psychotherapy, Kelly (1998) found that keeping secrets in therapy was a significant predictor of having fewer symptoms. In her study, nearly 40% of participants revealed that they were keeping "relevant" secrets from their therapists. Clients' most common rationale for secret-keeping was fear of expressing feelings. Shame and embarrassment, fear of revealing lack of progress, not enough time, not wanting to tell anyone, lack of motivation to address the secret, and loyalty to others were also cited as reasons for withholding information. After adjusting for clients' dispositional tendencies to withhold information and attempts to present themselves in socially desirable manners, Kelly found that clients who reported they were keeping relevant secrets in therapy had symptomology scores that were significantly lower than clients who denied keeping relevant secrets from their therapists. It should be noted that, although Kelly addressed how withholding information can lead to more positive therapeutic outcomes, she did not discuss situations in which keeping secrets can be countertherapeutic for clients.

Results of the studies described above suggested that withholding information in therapy may be either unrelated to treatment outcome (Regan & Hill, 1992) or associated with more positive outcomes (Kelly, 1998). The findings of those studies are inconsistent in some ways with those of Wright, Ingraham, Chemtob, and Perez-Arce (1985), and Pope and Tabachnick (1994), who found that withholding information was negatively correlated with satisfaction with treatment outcome. Wright and colleagues (1985) examined the relationship between amount of material "held back" by clients in

small groups and their satisfaction with therapy. They found that group members' satisfaction with group therapy sessions was negatively correlated with the amount of material they left unsaid. These authors did suggest, however, that the type of information being withheld may differentially impact satisfaction with treatment; this hypothesis found support in the work of Regan and Hill (1992).

In their survey of therapists' experiences as clients, Pope and Tabachnick (1994) found that 20% of respondents indicated that they had previously withheld important information from a therapist when they were in therapy. They found that the nature of the information respondents withheld from their therapists fell into seven general categories: sexual issues, feelings about the therapist, personal history of abuse, engagement in substance abuse, an eating disorder, the identity of third parties who respondents mentioned in therapy, and miscellaneous. Information regarding sexual issues was the most common type of secrets clients kept from their therapists. The authors found that respondents who reported an absence of secret-keeping tended to report more successful therapeutic outcomes. Participants who reported perceiving higher rates of helpfulness from their therapists were least likely to withhold information from their therapists. As noted above, these findings contradict those of Kelly (1998) who suggested that withholding information and secret-keeping in therapy is associated with more positive therapeutic outcomes.

Lying in Psychotherapy

As described earlier in this paper, the literature examining lying in psychotherapy to date is speculative in nature. The majority of theoretical speculation on this topic has been discussed from psychodynamic theorists. Many authors assuming a

psychodynamic framework for analyzing lying in therapy highlight unconscious motives and operations that impact lying in psychotherapy. Although the present study seeks to explore conscious factors involved in clients' decisions to lie to their therapists, a brief description of the literature describing unconscious forces follows.

Unconscious motives for lying in psychotherapy. Many psychodynamic theorists (for example, see Deutsch, 1923/1982; Freud, 1913; Marcos, 1972; Weinshel, 1979) have described motivations for lying which are presumably out of the awareness of the person telling the lie. According to these authors, although people are aware that they are lying, their true motivation for doing so is out of their immediate understanding. Because the present study seeks to examine why individuals consciously choose to lie to their therapists, unconscious motives will only briefly be discussed here. For a more comprehensive discussion on psychodynamic and unconscious explanations of lying, see Gediman and Lieberman (1996).

Essentially, authors examining lying that is motivated by unconscious forces have suggested that such deception serves to protect individuals against unconscious wishes or emotions that might be painful or threatening if they are revealed consciously (Marcos, 1972). Although individuals may consciously recognize that they are telling a lie, they are unaware of their actual reasons for doing so. Freud (1913), for example, wrote about a patient who lied about her relationship with her father, and suggested that she did so in order to hide her hidden incestuous feelings for her father.

Weinshel (1979) perceived that lies told by neurotic patients to their therapists allowed them to re-enact aspects of their early childhood, recovering old memories and unconscious fantasies. Blum (1983) understood a lie that a client had told him about

missing therapy due to his mother's death (when in actuality she was still alive) to be a reflection of matricidal wishes. Finally, Davidoff (1942) and Deutsch (1923/1982) described how lies can aid in wish fulfillment and provide temporary gratification for individuals who are unable to create genuine accomplishments on their own. These and other authors described their beliefs that patients' lies aided in the repression of unconscious material and facilitated self-deception (Fenichel, 1954; Ford, 1996).

The cases described by the above authors all suggest that lying is motivated at an unconscious level to help clients maintain repressed wishes and fantasies. Other psychodynamic authors (O'Shaughnessy, 1990) posit that lying can help people to maintain autonomy and avoid attachment and rejection. Gediman and Lieberman (1996), for example, described two cases involving patients who lied to their psychoanalyst. After processing the lies with their patients, the authors concluded that the lies had helped the patients feel a sense of control and autonomy over situations (in their cases, the therapeutic relationship) that could be frustrating and beyond their control.

Conscious motives for lying in psychotherapy. The following discussion examines the literature on conscious motives for lying in psychotherapy from various theoretical perspectives. Information on this topic is scarce outside of psychodynamic theory, as the brevity of the discussion will suggest.

As noted previously, Gediman and Lieberman (1996) discussed lying in psychotherapy in one of the most detailed works to date on this topic. Although they examined lying in psychotherapy from a psychodynamic position, some of their assumptions on *conscious* factors merit attention here. These authors described a

potential motive-based classification of lies that clients tell therapists. They described white lies using Bok's (1978) definition, but elaborated that, in psychoanalytic therapy, these lies are typically used consciously by clients to spare the therapist some hurt for which the client unconsciously wishes. *Gratuitous lies*, on the other hand, are told to the therapist for no apparent conscious benefit to the client. Gratuitous lies typically concern trivial information and are told, in part, to establish some psychological distance from the therapist. *Outright lies*, in contrast, are told in order to deliberately mislead the therapist about material that is significant to the individual telling the lie (Gediman & Lieberman, 1996).

Miller (1992), like Gediman and Lieberman (1996), called attention to the fact that there has been little written on the topic of lying in psychotherapy in the counseling journals. In his (non-empirical) discussion of lying in therapy, he reported that client dishonesty occurs frequently enough to warrant research examining its effects on the counseling process. Miller described three theoretical positions on the reasons lying may occur in psychotherapy, using the work of the authors cited in the previous section to discuss the topic from a psychodynamic framework (see "Unconscious and self-deceptive motives for lying in psychotherapy" above). He speculated that, from a client-centered framework, clients' lying may be seen as an early form of denial or a way to temporarily avoid uncomfortable thoughts and emotions. From this perspective, once the facilitative conditions of congruence, genuineness, unconditional positive regard and empathy (Rogers, 1957) have been attained, the client will choose to be honest with the therapist. Finally, from a behavioral perspective, Miller concluded that clients may lie to therapists because they have learned that lying helps secure rewards from the

environment. This speculation was echoed by Glenn (1983), who suggested that lying is an avoidance behavior that therapists might reinforce by giving the client wanted sympathy, attention, or approval.

Newman and Strauss (2003) discussed lying in psychotherapy from a cognitive perspective. They indicated that clients sometimes "deliberately distort their self-presentation for unwarranted personal gain, avoidance of anticipated consequences, or some other patently inappropriate use of therapy" (p. 242). The authors additionally suggested that clients may lie as a result of feeling ashamed or scared to be honest in therapy, or because they have an ulterior motive, such as avoiding responsibilities or gaining rewards from an outside party.

Rankin (1990) suggested that individuals lie to their therapists when they have not yet come to trust and have confidence in the therapist. He described several motivations for lying in therapy, including fear of rebuke, an inability to deal with anger, a desire to please the therapist, and to avoid feeling shame. Rankin suggested that the therapeutic relationship is a "critical variable influencing the client's openness and honesty in therapy" (p. 108).

Marcos (1972) also examined the role of the therapist and therapeutic relationship in situations involving client lying. He assumed that lies grow out of fear, and, as a result, non-accepting and punitive therapists may "force" clients to lie in order to avoid humiliation.

Conclusions

After reviewing the literature on lying in everyday life, it is clear that lying is a ubiquitous occurrence in daily social interactions. Scholars such as Barnes (1994) have pointed out that very few (if any) individuals can truthfully report that they have never told a lie. Research that has examined the targets of lies has demonstrated that no one is outside of the realm of potential targets for being lied to. Authors such as Metts (1989), and Knox, Schacht, Holt, and Turner (1993) have demonstrated that we lie to the people we love and with whom we are involved in close and intimate relationships. Hample (1978) found that we lie to peers and social and economic superiors, while Grover (1993) discussed lying in professional relationships. DePaulo and colleagues (1996) found that, in addition to close friends and relatives, we lie to strangers and casual acquaintances. Finally, Bilney and D'Ardenne (2001) and Burgoon and colleagues (1994) found that patients in their hospital reported lying to medical doctors, while Hantoot (2000) described how psychotherapy supervisees lie to their supervisors. Based upon the evidence that many people lie and that lying occurs in all types of relationships, it seems reasonable to conclude that clients sometimes lie to therapists.

Many psychology scholars (Ford et al., 1988; Gediman & Lieberman, 1996; Newman & Strauss, 2003; Rankin, 1990; Wolf, 1988) have endorsed the idea that lying in psychotherapy is a common occurrence. For example, Wolf, in a response to Ford and colleagues' article on psychiatric aspects of lying, stated that "Patients inevitably deceive psychiatrists and clinicians, and it is not uncommon for them to lie consciously" (1988, p. 1611). It is interesting that, despite such assertions, lying in psychotherapy has not been explored empirically. Of particular note is the scarcity of research that

addresses: (1) prevalence and incidence of lying in psychotherapy (whether or not clients report they have lied to their therapists); (2) what clients lie about; (3) the reasons or motives underlying clients' decisions to lie to therapists; (4) what characteristics of the therapist (e.g., lack of warmth or appearing judgmental) or therapeutic relationship (e.g., the stage of the relationship or the level of disclosure in the relationship) might make it more likely for a client to lie; and (5) how lying may or may not affect treatment outcome.

Although lying in psychotherapy has been widely ignored in research, studies on topics related to lying in psychotherapy, such as secret keeping and withholding information in therapy (Kelly, 1998; 2000; Regan & Hill, 1992), have yielded interesting results. For example, Pope and Tabachnick (1994) and Wright and colleagues (1985) have demonstrated that secret keeping in therapy is associated with less positive treatment outcomes, while other studies (e.g., Kelly, 1998) have revealed that more positive outcomes are associated with withholding information. Although these results lack consensus, it appears that secret keeping and withholding information from therapists affects therapeutic outcome in some way. It seems reasonable to conclude from these results that lying may affect the therapeutic outcome in some way as well. Furthermore, if there are particular therapist characteristics that contribute to an individual's propensity to lie or be completely honest with their therapist (as suggested by Marcos, 1972), it seems that it would benefit our profession to learn more about such potential characteristics.

If therapists operate from a position of attempting to help clients make improvements in their lives, perhaps it is reasonable to hypothesize that the therapist's

having accurate information from the client will facilitate therapeutic progress. As Gediman and Lieberman noted, "[it] could seem paradoxical that patients lie to their analysts or omit telling them what might enable them to genuinely help them" (1996, p. 7). In a similar manner, Rankin (1990) reported that, because therapy is presumably conducted in order to assist the client, it would seem that clients have "some very direct vested interest in the veracity of their comments to the therapist" (p. 107). He went on to suggest that clients who lie to therapists can jeopardize their treatment, and that clients lie to therapists because they have not yet reached a level of trust in the therapeutic relationship. Rankin (1990) and Marcos (1972) implicated the therapy alliance and therapist characteristics, respectively, in their discussions of lying in psychotherapy.

Researchers such as Pennebaker and his colleagues have demonstrated that individuals can facilitate the coping process by translating stressful and upsetting experiences into language (Pennebaker, Colder, and Sharp, 1990; Pennebaker, Hughes, & O'Heeron, 1987). His inhibition-confrontation model of coping suggests that individuals' emotional and physical health can benefit by talking or writing about upsetting or stressful events. If we examine the inhibition-confrontation model in terms of psychotherapy, it is reasonable to assume that one reason therapy is helpful to clients is that it provides an opportunity for people to talk about stressful events in their lives. Indeed, this is the premise underlying "talk therapy" in general: that by discussing problems, clients can come to new insights, adopt new perspectives, make positive changes, and decrease distress levels associated with those problems. If we believe that discussing unpleasant events, thoughts, and emotions frequently accelerates coping, it

seems not reasonable to wonder about the effects of the client's not being forthcoming with truthful material.

As evidenced by a review of the literature, numerous authors believe that lying in psychotherapy is a common occurrence that has particular causes and potential consequences. Thus far, the primary sources of information concerning lying in psychotherapy are scholars and practitioners of psychology, psychiatry, and related fields. In order to examine whether or not the assumptions and theoretical speculation of these scholars have any merit, it is necessary to approach the individuals who have first-hand involvement in lying in psychotherapy: the therapy clients. While practitioners and theorists have written about this topic and made assumptions about the prevalence, causes, and consequences of lying in psychotherapy, perhaps we can best begin to understand the phenomenon by asking the clients who are directly involved. Such was the aim of the present study.

Hypotheses

Hypothesis One

After removing the effects of social desirability, individuals who rate their therapeutic relationships and therapist characteristics less positively will be more likely to report that they have lied to their therapists than individuals who rate their therapeutic relationships and therapist characteristics more positively. Participants' perceptions of therapist characteristics will be assessed using the Therapist Satisfaction Scale (TSS) (Conte et al., 1994), and the quality of the therapeutic relationship will be assessed using

the Agnew Relationship Measure (ARM) (Agnew-Davies et al., 1998). Participants' social desirability will be assessed with the SDS-17 (Stöber, 2001).

Hypothesis Two

Individuals who report that they have lied to a therapist will report being less satisfied with treatment outcome than individuals who report that they have never lied to a therapist. Satisfaction with treatment outcome will be assessed using a Likert-type item in the Lying in Psychotherapy Survey (LPS; see question 22 in Appendix C).

CHAPTER III

METHOD

Design

The present study utilized an ex-post facto research design to examine differences among individuals who reported that they had previously lied to a therapist and individuals who reported that they had never lied to their therapists. As described below, four surveys were used to gather data from participants: the Lying in Psychotherapy Survey (LPS), the Therapist Satisfaction Scale (TSS) (Conte, Buckley, Picard, & Karasu, 1994), the Agnew Relationship Measure (ARM) (Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998), and the Social Desirability Scale – 17 (SDS-17) (Stöber, 2001). All participants were asked to respond to all four surveys; the items to which participants responded on the LPS varied according to their responses to two different questions on the LPS survey, as described in The Lying and Psychotherapy Survey section of this chapter.

Procedure

The present study utilized on-line surveys to gather data. It was first necessary to develop an instrument that could be used to gather information on lying in psychotherapy, as no instrument existed to collect data on this phenomenon. The LPS

was therefore developed by the researcher in collaboration with the dissertation chair and committee members. Pilot testing was then conducted (n=6), and suggestions for improvement were incorporated into the LPS as a result of the pilot testing and suggestions from committee members. Instruments measuring client's satisfaction with their therapists, therapeutic relationship quality, and social desirability were reviewed and selected (see descriptions of these instruments in the Measures section). A research proposal was then submitted to the Auburn University Institutional Review Board (AU IRB).

Following approval by the AU IRB, a research proposal was sent to the American Psychological Association of Graduate Students (APAGS) program coordinator, requesting permission to collect data via the APAGS listserv. Evidence of IRB approval, along with copies of the LPS, Therapist Satisfaction Scale (Conte et al., 1994), Agnew Relationship Measure (Agnew-Davies et al., 1998), and Social Desirability Scale-17 (Stöber, 2001) was sent to the APAGS program coordinator. A short discussion of the target population, methodology, procedures, purpose of the research, plans for analysis, and description of funding used to help support research was also included in the research proposal.

Prior to obtaining APAGS approval, all survey instruments were posted on the Internet via Psychdata, a web-based company that permits users to custom-design surveys. These instruments were posted online in order to maximize user-friendliness and efficiency, as well as to minimize confusion for participants. A feature called "Question Logic" was used to forward participants to appropriate parts of the LPS

without having to instruct them to skip to different parts of the survey based on their responses to particular items (LPS questions 4 and 24, as described below), as a paper-and-pencil survey would have required. Instead, participants saw only the items that they were meant to answer.

After APAGS approval was obtained, the APAGS program coordinator sent an e-mail that briefly introduced the purpose and nature of the present study, invited participation, and provided a link to the survey to members of the APAGS listserv (see Appendix A). The author's contact information was provided, and interested individuals were encouraged to contact the author with any questions, comments, or concerns. The contact information for the researcher's faculty advisor and members of the Auburn University IRB were also included in the introduction letter. Participants were informed that their responses to the survey were anonymous, and that if they choose to register to receive one of six randomly selected $50 drawings there would be no way for their responses to be linked to their e-mail addresses.

After completing the LPS, participants were directed to take the TSS, ARM, and SDS-17 (see Appendixes B – I). They were then directed to the final section of the survey (see Appendix J), where they could enter their e-mail addresses (if interested in registering to receive one of the six random $50 drawings) and had the opportunity to answer an optional question ("Please feel free to add any additional thoughts you have which might help us better understand lying in psychotherapy."). This final item was included in order to obtain feedback from participants who were interested in providing additional thoughts on lying in psychotherapy and/or giving feedback on the surveys.

After all data were collected, six e-mail addresses were randomly selected, and those individuals were contacted via e-mail in order to notify them that their e-mails were selected and to request mailing information. Money orders were obtained and sent to these six individuals.

Prior to conducting data analyses, raw data were reviewed and converted from the Psychdata website to an SPSS data file. Missing responses on the TSS, ARM, and SDS-17 were examined for patterns. Because there were no patterns in the missing data (i.e., there were no particular items that were omitted more frequently), missing items were replaced with the average score for that item.

Predictor and Criterion Variables

The predictor variables in the present study varied by hypothesis. In Hypothesis One it was predicted that, after removing the effects of social desirability, individuals who rated their therapeutic relationships and therapist characteristics less positively would be more likely to report that they lied to their therapists than individuals who rated their therapeutic relationships and therapist characteristics more positively. The predictor variables for this hypothesis were the Therapist Satisfaction Scale and Agnew Relationship Measure. The criterion variable for this hypothesis was lying or not lying to a therapist. A social desirability instrument, the SDS-17, was included to examine the possibility of social desirability confounding the relationship between lying in psychotherapy and therapist and therapeutic relationship characteristics.

Hypothesis Two predicted that individuals who lied to their therapists would report being less satisfied with treatment outcome than individuals who did not lie to

their therapists. The predictor variable in this hypothesis was lying/not lying to therapists, as assessed in question four of the LPS ("Since your 18th birthday, OTHER THAN DURING AN INTAKE SESSION, have you ever lied to a therapist during a therapy session?;" See Appendix B). Participants could respond "yes," "no," or "can't remember" to this item. Only the data for individuals who responded yes or no to this item were used in the analyses. The phrase "other than during an intake session" was included in this item because the researcher was interested in lying that occurs after therapy has formally been initiated, as opposed to lies that occur only during the first meeting (or intake) with the therapist. The criterion variable for Hypothesis Two was participants' responses to LPS question 22 ("Which of the following best describes your satisfaction with treatment outcome for the therapy you are describing in this survey?").

Measures

The Lying in Psychotherapy Survey

Prior to the construction of the Lying in Psychotherapy Survey, no instrument intended to gather information on lying in psychotherapy existed. In order to collect information on this phenomenon, a survey that explores lying in psychotherapy from a client's perspective was developed by the researcher, in collaboration with the dissertation committee and feedback from pilot testing. The Lying in Psychotherapy Survey (LPS, see Appendixes B-F) is comprised of Likert-type items, multiple choice items, and open-ended questions.

The length of the Lying in Psychotherapy Survey varies depending on the responses of participants. All participants respond to items 1-4 of the LPS (see

Appendix B), which ask for demographic information (age, sex, and ethnicity), and then ask participants to indicate whether or not they have ever lied to a therapist. Participants who report that they *have lied* to a therapist before (by answering "yes" to Question 4; see Appendix B) are then directed (via Psychdata's "Question Logic") to Questions 5-22 of the LPS (see Appendix C), where they are asked a series of questions pertaining to lying in therapy. Participants who indicate that they have never lied to a therapist before are instead directed to questions Question 23 and 24 of the LPS (see Appendix D). Individuals who reveal that, although they have never previously lied to a therapist, they recall being tempted to do so (in response to LPS Question 24) are then directed to answer LPS Questions 25-31 (see Appendix E). Participants who indicate that they had never been tempted to lie to a therapist or do not recall being tempted to lie, answer questions 32-35 of the survey (see Appendix E).

LPS Questions Asked of All Participants

Although individuals taking the LPS respond to different items on the survey depending on their responses to LPS Questions 4 and 24, all participants are asked to respond to particular items. As noted above, the first three items on the survey ask all participants to identify their age, sex, and ethnicity. In question form, they are then asked whether or not they have ever lied to a therapist.

In addition to responding to LPS questions one through four, all participants are also asked to indicate the presenting problems for which they had sought or were seeking treatment, as well as the number of sessions they had with the therapist they are asked to describe in the survey. A question that asks participants to indicate the degree to which their treatment involved pressure/coercion from others was included on the

LPS in order to examine whether or not level of coercion was related to lying/not lying in psychotherapy. Finally, in order to examine whether or not lying in therapy was related to differences in treatment outcome, participants were asked to rate their satisfaction with treatment outcome, as previous studies (e.g., Kelly 1998; Pope & Tabachnick, 1994; Wright et al., 1985) have linked secret keeping and withholding information to treatment outcome.

LPS Questions 5-22: Questions for Lying Group

Because a major aim of the present study was to gather information on factors that contribute to lying in psychotherapy, items were included on the LPS for participants who reported that they had lied to a therapist (LPS Questions 5-22; see Appendix C) that were not asked of individuals who did not lie. Specifically, these questions focused on the content of lies told, motivations for lying, characteristics of therapists and/or therapeutic relationships that contributed to participants' decisions to lie to their therapists, whether or not (and how) lies were revealed, amount of consideration given to the lies told, and whether or not and how lying was perceived to have impacted the therapeutic relationship and treatment outcome.

The inclusion of the majority of items asked of participants in the Lying sample was informed by the literature on lying in everyday life, as well as the literature on secret-keeping and withholding information in psychotherapy (see, for example, Camden et al., 1984; DePaulo & Bell, 1996; DePaulo et al., 1993; DePaulo & Kashy, 1998; Gediman & Lieberman, 1996). For example, a question about therapist and therapeutic relationship characteristics that influenced participants' decisions to lie was included because the literature had previously suggested that different therapist characteristics,

such as being perceived as judgmental (Marcos, 1972), may impact a client's decision to lie. Other questions were included in order to examine whether or not motivations for lying in therapy mirror those that occur in everyday life (e.g., as observed by DePaulo et al., 1996; Hample, 1980), doctor/patient relationships (Bilney & D'Ardenne, 2001; Burgoon et al., 1994), and/or secret keeping and withholding information in psychotherapy (Hill et al., 1993; Kelly, 1998; Regan & Hill, 1992). Because several scholars have found that lying occurs in response to prompts (Lippard, 1988; Metts, 1989) and can occur spontaneously and without much thought given to the lie (Hample, 1980) questions concerning whether or not lies were prompted by therapists and the degree of planning involved in lying were asked of participants.

LPS Questions 23-31: Questions for the Tempted Group

The primary aim of the present study was to gather information on lying in psychotherapy and compare individuals who had previously lied to therapists with individuals who had never lied before. A secondary aim, however, included gathering information which might explain why people to are tempted to lie to therapists, and what prevents them from lying when they are tempted to do so. Items asking questions of this nature were included on the LPS so that similarities and differences could be examined among individuals who had been *tempted* to lie to therapists, individuals who *had lied* to their therapists, and individuals who *had never lied or been tempted* to do so. As a result, an item was included on the LPS (LPS Question 24) that asks individuals whether or not they recall ever having been tempted to lie to a therapist. Individuals who report that they had previously been tempted to lie are then asked a series of questions similar to those asked of the Lying group (see Appendix E). These questions ask participants to

indicate what they were tempted to lie about, what prevented them from lying when tempted, and therapist/therapeutic relationship characteristics that influenced decisions to tell the truth when participants were tempted to lie.

LPS Questions 32-35: Questions asked of the No Lie/No Tempt Group

The items included on the LPS for individuals who report that they have never previously lied to a therapist and were never tempted (or cannot recall having ever been tempted) may be found in Appendix F. Individuals in this group (the No Lie/No Tempt group) do not answer any questions that are unique to this group: they are asked to indicate the number of sessions they had with their therapists, their presenting complaints, the level of coercion involved in their therapy, and their satisfaction with treatment outcome.

Pilot Testing

Results of pilot testing on the LPS (*n*=6) indicated that participants took an average of 17 minutes to complete the items making up the longest survey, which is for participants who reported that they had previously lied to a therapist (see Appendixes B-C). The time taken to complete the survey for participants in this subsample ranged from 9-25 minutes.

The Therapist Satisfaction Scale

The Therapist Satisfaction Scale was developed by Conte and her colleagues (1994; see Appendix G) in order to assess clients' "perceptions of their therapists and the degree of satisfaction implied by these perceptions" (Conte et al., 1994; p. 215). The scale is comprised of 18 items that describe characteristics and behaviors of therapists. Examples of items on the scale include "was likeable," "respected me," and "made me

nervous." Respondents indicate on a 3-point scale which item best applies to their perceptions of their therapists. The three choices are "not at all" "a little" and "a lot." Twelve of the therapists characteristics and behaviors described by the scale have positive connotations (for example, "understood me," and "accepted me"), and six of the items have negative connotations (for example, "avoided certain topics" and "argued with me").

Conte and colleagues (1994) reported a coefficient alpha of .93 for the Therapist Satisfaction Scale, indicating good internal consistency among the items. Moderate concurrent validity (r=.80) was reported. Results of their study indicated that various items, including therapists' respect for the clients, likeableness, and trustworthiness were significantly and positively correlated with client's report of overall satisfaction with the therapists.

The Therapist Satisfaction Scale was selected to be used in conjunction with the Lying in Psychotherapy Survey in order to provide more information about how therapist characteristics may be related to whether or not clients choose to lie to their therapists. Although the Lying in Psychotherapy Survey asks respondents to describe therapist characteristics that contributed to their decisions to lie to their therapists (Appendix C) or to tell the truth in a situation in which they were tempted to lie (Appendix D), these questions are open-ended and may leave some room for interpretation.

The Agnew Relationship Measure

The Agnew Relationship Measure (ARM; Agnew-Davies et al., 1998; see Appendix H) was developed to assess the alliance between clients and their therapists.

The authors of this instrument used a mixed conceptual-empirical approach and included items that were designed to incorporate the content of previous alliance measures, such as the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986, 1989; Stiles et al., 2002). The ARM was developed in parallel forms for clients and therapists. Because the present study will utilize an adapted version of the ARM for clients, the following discussion refers to the client items only.

The ARM is comprised of 28 items rated on a 7-point scale anchored with the terms "strongly disagree," "moderately disagree," "slightly disagree," "neutral," "slightly agree," "moderately agree," and "strongly agree." With the exception of items 18 and 28, each item contributes to one of five subscales on the ARM: the Bond, Partnership, Confidence, Openness, and Client Initiative subscales (subscales are described in the following paragraph). Eleven of the items on the ARM concern the client (e.g., "I feel free to express the things that worry me."), 12 items concern the therapist (e.g., "My therapist accepts me no matter what I say or do."), and five items concern the relationship (e.g., "My therapist and I are willing to work hard together."). Some of the items are positive (e.g., "I feel friendly towards my therapist.") and some are negative (e.g., "I feel critical or disappointed in my therapist."). Two of the items, "My therapist is a persuasive person" (item 18) and "My therapist and I are clear about our roles and responsibilities when we meet," (item 28) do not contribute to any of the scales. Analyses revealed that items 18 and 28 were used differently by clients and therapists: while item 18 encompassed a single-item component for clients, it was linked with the Confidence scale for therapists. Item 28 was linked to item 11 for clients ("I

look to my therapist for solutions to my problems"—an item on the Initiative scale), but was linked to the Partnership scale for therapists.

The Bond scale of the ARM contains six items (questions 2, 13, 15, 16, 19, & 22; see Appendix G) that refer to the friendliness, support, and understanding in the therapeutic relationship (Agnew-Davies et al., 1998). The four items on the Partnership scale (questions 20, 24, 26, & 27) concern working together on therapeutic tasks, and the seven items comprising the Confidence scale (questions 6, 7, 9, 12, 14, & 17) relate to optimism and respect for the therapist's professional competence. The Openness scale contains five items (questions 1, 3, 5, 8, & 10) that pertain to the clients' experiences of feeling free to disclose personal concerns to the therapist without embarrassment or fear. The Client Initiative Scale comprises 4 items (Questions 4, 11, 23, & 25) which relate to the "client's taking responsibility for the direction of therapy" (Agnew-Davies et al., 1998).

Agnew-Davies et al. (1998) reported that the Bond, Partnership, and Confidence subscales overlapped statistically ($r > .80$ for comparisons). This finding was consistent with those of previous studies (e.g., Horvath & Greenberg, 1989; Marmar, Weiss, & Gaston, 1989). Although some authors (e.g., Kivlighan & Shaughnessy, 2000) have suggested on the basis of such high intercorrelations that they should be collapsed into a single scale, others (e.g., Agnew-Davies et al., 1998; Horvath & Luborsky, 1993) have recommended retaining the distinction among these dimensions. Agnew-Davies and colleagues (1998) proposed that the scales remain distinct because they appear to represent different conceptual clusters. They also appear to relate differentially with other variables (Stiles et al., 1998). The items comprising the Openness scale

represented a fairly independent factor, while the items on the Client Initiative scale had low internal consistency (α=.55). Correlation coefficients for the internal consistencies of the Bond, Partnership, Confidence, and Openness subscales were .82, .80, .87, and .77, respectively, for client ratings.

In a study examining the convergent validity of the ARM with an instrument frequently used to assess the therapeutic alliance, the WAI (Horvath & Greenberg, 1986, 1989), Stiles and colleagues. (2002) found strong correlations between the ARM's core alliance scales of Bond, Partnership, and Confidence and the WAI's scales of Bond, Tasks, and Goals. When examined within client and therapist perspectives, all correlations were in the .80s and .90s, demonstrating good convergent validity. Some evidence for discriminant validity of the WAI and ARM was found in the relatively lower correlations of the WAI scales with the ARM Openness and Initiative scales. These results suggested that the ARM assesses aspects of the alliance, such as the client's sense of freedom in disclosing personal information, that the WAI does not address. The authors concluded that the ARM and WAI measure some of the same core constructs and that, while both instruments could appropriately be used to obtain a global alliance measure, the ARM would be more appropriate to use when a multidimensional view of the alliance is desired.

The ARM has been selected for use in the present study due to its sound reliability and validity data, as well as its ability to assess the quality of the therapeutic alliance. It has several advantages over other instruments designed to assess the alliance, including its brevity and the inclusion of a subscale (the Openness subscale) that

assesses an individual's perceptions of freedom to disclose personal information in therapy.

In the present study, the Client Initiative subscale of the ARM, as well as the two items (items 18 & 28) not included in any scale (described above), were omitted. These items will be omitted because, in addition to the fact that their content is not of interest in the present study, the Client Initiative scale and items 18 and 28 were found to be relatively weakly correlated with the other scales on the ARM (Agnew-Davies et al., 1998; Stiles et al., 1998).

The Social Desirability Scale-17

The Social Desirability Scale-17 (SDS-17; see Appendix I) is a 17-item instrument that measures social desirability (Stöber, 1999). Individuals taking the SDS-17 are asked to read a list of 17 statements and indicate whether or not each statement describes them. They are asked to mark "true" for accurate statements and "false" for inaccurate statements. The items on the SDS-17 contain statements with both non-absolute and absolute qualifiers. For example, item 1, which states "I sometimes litter," contains a non-absolute qualifier (*sometimes*) and item 16 "I always eat a healthy diet" contains an absolute qualifier (*always*). Items are scored 1 for "true" responses and 0 for "false" responses, with the exception of items 1, 4, 6, 7, 11, 15, & 17, which are reverse scored.

Stöber developed the SDS-17 in response to his concern that some of the items on the Marlowe-Crowne Scale (Crowne & Marlowe, 1960), one of the most frequently used social desirability assessment instruments, were outdated (Stöber, 2001). He followed Crowne and Marlowe's (1960) criteria for item selection, and retained the 17

items that make up the scale due to their demonstration of "item difficulties between .20 and .80, corrected item-total correlations greater than .20, and significant correlations with the Marlowe-Crowne scale" (p. 223). Subsequent preliminary studies demonstrated adequate reliability of the SDS-17, as well as significant convergent validity with the Marlowe-Crowne Scale (.74).

Although preliminary studies suggested that the SDS-17 was a reliable and valid alternative to the Marlowe-Crowne Scale, Stöber (2001) conducted further analyses in order to demonstrate convergent validity with other current social desirability instruments, show discriminant validity of the SDS-17 with other personality traits, and examine the validity of the SDS-17 for use with individuals of varying ages (Stöber, 2001). He was able to demonstrate the convergent validity of his instrument in a study that showed a substantial correlation between the SDS-17 and the Lie Scale of the Eysenck Personality Questionnaire (Cronbach's a=.60, p< .001; EPQ; Eysenck & Eysenck, 1991). Additional studies revealed significant correlations of the SDS-17 and other instruments designed to measure social desirability and/or similar concepts, including the Sets of Four Scale (Borkenau & Ostendorf, 1992) and the impression management scale of the Balanced Inventory of Desirable Responding (BIDR, Palhaus, 1994). Cronbach's alpha correlations of the SDS-17 with these instruments were a=.82 and a=.68, respectively. Results of these analyses also suggested that the SDS-17 was more sensitive to social-desirability provoking situations than the EPQ Neuroticism scale (Stöber, 2001).

Evidence of the discriminant validity of the SDS-17 emerged in studies that demonstrated nonsignificant correlations of this instrument with the Neurotocism,

Extraversion, and Psychoticism scales of the EPQ with the SDS-17. Correlations of the SDS-17 and NEO Five Factor Inventory (FFI) (Costa & McCrae, 1992) also revealed high discriminant validity with respect to the dimensions of neuroticisim, extraversion, and openness to experience (Stöber, 2001). In regards to the Agreeableness and Conscientiousness scales of the FFI, however, Stöber (2001) reported that discriminant validity was "lower than would be desirable for a measure designed to capture social-desirability *bias* in self reports" (p. 230). He indicated that the correlations of the SDS-17 with the Agreeableness and Conscientiousness scales of the FFI might be interpreted as "convergent validity or as lack of discriminant validity" (p. 226), and explained that other researchers (e.g., Borkenau & Ostendorf, 1992; Paulhus, 1994) have also found substantial correlations for scores on their social desirability scales with self-ratings for agreeableness and conscientiousness.

In studies designed to examine the suitability of using the SDS-17 with individuals of varying ages, Stöber (2001) found the internal consistency of SDS-17 scores to be highly significant (a=.80), with scores varying little between age groups. The convergent validity of this instrument with the Marlowe-Crowne scale across ages (range of 18-89, with a mean of 54.7 years) was satisfactory (r=.68, p<.001). Stöber found that correlations between the SDS-17 and Marlowe-Crowne Scale were near zero for participants 80 and older, and cautioned against using the SDS-17 with individuals in this age group as a result. Gender was found to have no significant effects on SDS-17 scores.

After conducting the studies described above, Stöber (2001) concluded that the SDS-17 is an instrument with substantial validity, and that the instrument is appropriate

for use with individuals 18-80 years of age. For these reasons, as well as for the user-friendliness and brevity of the instrument (17 questions), it was selected to be used in the present study.

Participants

Individuals who were on the APAGS listserv and who reported that they had formerly been or currently were clients in psychotherapy were selected to be participants in the present study. These individuals were selected to participate in the present study for two primary reasons. First, authors such as Dearing, Maddux, and Tangney (2005) and Holzman, Searight, and Hughes (1996) have noted that many graduate students in psychology graduate programs undergo personal therapy. As a result, it was expected that a large number of individuals on the APAGS listserv would have been (or would currently be) clients in psychotherapy, thus making them eligible for participation. Second, the listserv provided access to a large number of individuals who could choose to take the surveys, which asked participants to reveal personal and sensitive information, in anonymity and at their own convenience. It was therefore convenient for the researcher and participants. Finally, the survey contained some psychological terminology (e.g., the "therapeutic relationship" and "satisfaction with treatment outcome") that are not typically used in everyday vernacular. It was expected that graduate students in psychology and related fields would be familiar with such language, thus negating the need to clarify various terms and possibly add confusion to the lengthy instruments.

The APAGS Program Coordinator forwarded an e-mail from the researcher (see Appendix A) to the 2,634 individuals on the APAGS listserv. This e-mail served as an informed consent letter and invited individuals who had been or currently were clients in psychotherapy since age 18 to participate in the present study. Individuals wishing to participate in the study clicked on a link provided in the informed consent e-mail, which directed them to the surveys hosted by Psychdata. One hundred and ninety one individuals responded to the survey, resulting in a 7.3% return rate. Seventy-four (39%) of the participants who responded indicated that they had lied to a therapist before. Ninety-one participants (48%) reported that they had never lied to a therapist before, and 26 (14%) of the respondents reported that they could not remember whether or not they had ever previously lied to a therapist.

Fifty-four of the participants who began responding to the LPS discontinued the survey after answering the first four questions, or at various points beyond LPS question four. Because the hypotheses of the present study could not be tested with these individuals, their data were excluded from analyses. Results for the 18 respondents who said that they could not remember whether or not they had ever lied to a therapist were excluded as well, since this data could not be used to test the hypotheses of the present study.

After reviewing the answers to open ended-questions for the group of participants who reported that they had lied to a therapist before, it became clear that some individuals had not told a lie in accordance with the definition of "lie" given at the beginning of the survey ("*statements (written or spoken), told to a therapist, which you knew at the time were not true*"; See Appendix B); most of these individuals indicated

that they had withheld information from therapists, as opposed to making overt, false statements. As a result, the data for these 10 individuals were excluded. Finally, one participant took the survey three times but completed it only once (as evidenced by having the same answers for all LPS questions); only the completed data set for that individual was included in the analyses.

Excluding the data of the 82 participants described in the preceding paragraphs left a total of 109 participants. The majority of participants were female (*n*=96; 88%). Ninety-one (84%) of the participants identified their ethnicity as Caucasian, seven (6%) identified as Asian/Pacific Islander, four (3%) identified as Hispanic/Latino/a, two (2%) identified as Black/African American, one (1%) identified as Native American/American Indian, and four (4%) identified as "other." One individual (1%) did not provide data for this question. The ages of participants ranged from 22 to 55, and the average age was 31.14 (SD=7.55).

CHAPTER IV

RESULTS

In this chapter, results of hypotheses testing and supplementary analyses are described. In each of the following analyses, an alpha level of .05 was used, and groups are defined in the following way: individuals who reported that they had previously lied to a therapist will be referred to as the *Lying* group, and individuals who reported that they never lied to a therapist will be referred to as the *Non Lying* group. Occasionally, the Non Lying group will be further separated into two groups: participants in the *Tempted* group are those who indicated that, although they had never previously lied to a therapist, they had been tempted to do so (in response to the Lying in Psychotherapy Survey (LPS) question 24, see Appendix D). Individuals in the *No Lie/No Tempt* group are those who indicated that they had never previously lied to a therapist and were never tempted to do so (or could not remember having ever been tempted).

As described in the Chapter III, the data for participants who had either discontinued taking the surveys or indicated that they could not remember whether or not they had ever lied to a therapist were excluded from the analysis. This left a total of 109 individuals who reported the following: 40 participants (37%) indicated that they had previously lied to a therapist, and 69 (63%) reported that they had never lied to a therapist. Of the 69 individuals who indicated that they had never lied to a therapist, 29

(42% of the Non-Lying sample and 27% of the total sample) reported that they had previously been tempted to lie to a therapist but had refrained from doing so, while 40 (58% of the Non-Lying sample and 37% of the total sample) indicated that they had either never been tempted to lie to a therapist or could not remember whether or not they had ever been tempted.

Hypothesis Testing

Hypothesis One

The researcher hypothesized that, after removing social desirability effects, individuals having less positive perceptions of their therapists and therapeutic relationships would be more likely to report that they had previously lied to a therapist than individuals having more positive perceptions of their therapists and therapeutic relationships. As described in previous chapters, perceptions of therapist characteristics were assessed with the Therapist Satisfaction Scale (TSS) (Conte, Buckley, Picard, and Karasu, 1994), and perceptions of the therapeutic relationship were assessed using the Agnew Relationship Measure (ARM) (Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998). Social desirability was assessed by the Social Desirability Scale-17 (SDS-17) (Stöber, 2001).

Prior to testing Hypothesis One, bivariate correlation coefficients were obtained for lying/not lying and scores on the TSS, ARM, and SDS-17 in order to examine the relationships among these four variables. While neither the relationship between the TSS and SDS-17 (r=.07, p=.45) nor the relationship between the ARM and the SDS-17 (r=.09, p=.37) was significant, the association between the TSS and the ARM was

revealed to be a strong and significant direct relationship (r=.88, p < .001, two-tailed). As a result, a multicollinearity check was conducted for the TSS and the ARM to examine the overlap between these variables. The variance inflation factor indicated a significant amount of overlap between the TSS and the ARM, VIF=4.55, tolerance=.22. Consequently, the TSS was dropped as a covariate. The ARM was retained over the TSS because the internal consistency of the ARM items included in the present study (α=.91) was higher than the internal consistency of the TSS (α=.89). Zero-order correlations are presented in Table 1.

Table 1

Zero-Order Correlations for Lying/Not Lying, TSS, ARM, and SDS-17 Scores

Variable		LPS 4	TSS	ARM	SDS-17
LPS 4	Pearson Correlation Significance (2-tailed)	--			
TSS	Pearson Correlation Significance (2-tailed)	.210* .028	--		
ARM	Pearson Correlation Significance (2-tailed)	.225* .019	.883** .000	--	
SDS-17	Pearson Correlation Significance (2-tailed)	.152 .119	.074 .449	.088 .370	--

* Correlation is significant at the .05 level
** Correlation is significant at the .01 level
LPS 4 = Lying in Psychotherapy Survey Question 4: Lying = 0, Not Lying = 1
TSS = Therapist Satisfaction Scale
ARM = Agnew Relationship Measure
SDS-17 = Social Desirability Scale-17

As revealed in Table 1, the relationship between the SDS-17 and Lying/ Not Lying was not significant (r=.15, p=.12). In addition to being non-significant, the direction of the relationship was positive. Individuals having lower scores on the social desirability scale ("lower" social desirability) were more likely to indicate that they *had*

lied to a therapist (Lying was coded as a "1" in SPSS, while Not Lying was coded as "2"), and individuals having higher scores on the social desirability instrument were more likely to indicate that they *had not* lied to a therapist.

After participants' TSS scores were dropped due to their overlap with the ARM scores, a logistic regression analysis was conducted to test Hypothesis One. Logistic regression was selected partially as a result of the binary nature of the criterion variable (lying/not lying). As scholars such as Lewis-Beck have revealed, logistic regression has become "the data analytic tool of choice when the equation to be estimated has a dichotomous dependent variable" (Pampel, 2000, p. v). In addition, logistic regression allows the researcher to control for potentially confounding variables in order to evaluate the "pure" relationship between the predictor variable of interest and the criterion variable (Huck, 2000). For each predictor variable entered into the logistic regression model, responses are regressed on other terms in the model. Residuals from that regression are then regressed on the variable of interest in order to determine the presence of unique linear effects of each predictor variable on the response (J. Grego, personal communication, October 23, 2006).

In the logistic regression analysis, lying/not lying (participants' responses to the Lying in Psychotherapy Survey question 4) was entered as the dependent variable, and the ARM and SDS-17 scores were entered as covariates (SPSS dialogue uses the term "covariates" for all non-dependent variables entered into the logistic regression equation). SDS-17 scores were retained in the model despite nonsignificant findings in the bivariate analysis because previous studies (e.g., Bilney & D'Ardenne, 2001) have found a relationship between social desirability and lying. Results of the logistic

regression analysis were significant, R^2=.067(Cox), χ^2(2, N=107)=7.404, *p*=.025, suggesting that the model was a significant predictor of lying/not lying in psychotherapy. As indicated by the Cox and Snell R square statistic, the covariates in the model (the ARM scores *and* SDS-17 scores) accounted for nearly 7% of the variance in lying/not lying to a therapist (R^2=.067). ARM scores were a significant predictor of lying/not lying in psychotherapy (*p*=.032). Social desirability, however, did not serve as a significant predictor of lying or not lying (*p*=.159).

As predicted, individuals having less positive perceptions of their therapeutic relationships were more likely to report that they had lied to their therapists than individuals having more positive perceptions of their relationships. For each one-point increase on ARM scores, the odds of not lying to a therapist increased by 1.8% (odds ratio=1.018, 95% CI=1.002 – 1.035). Results of the logistic regression analysis are presented in Table 2.

Table 2

Logistic Regression Analysis of SDS-17 and ARM Scores for Lying and Non Lying Groups

Variable	*B*	*S.E.*	*Wald*	*p*	*Exp(ß)*	*95% CI*
SDS-17	.107	.076	1.981	.159	1.113	.959-1.293
ARM	.018	.008	4.579	.032*	1.018	1.002-1.035
Constant	-1.980	1.014	3.816	.051	.138	

* *P*<.05
SDS-17 = Social Desirability Scale-17
ARM = Agnew Relationship Measure

The model was 65.4% accurate in classifying participants into the Lying and Non Lying groups. Accuracy of classification was 25.0% for the Lying group and 89.6% for the Non Lying groups. The percentage of responses correctly predicted by the model with SDS-17 scores and the ARM scores entered as covariates was only slightly higher than the percentage of responses correctly predicted when only the constant was entered in the model, however. When only the constant was entered, the model was 62.6% accurate in classifying participants into the Lying and Non Lying groups, with accuracy of classification 0% for the lying group and 100% for the non-lying group. Thus, although the model was a significant predictor of lying or not lying in psychotherapy, the accuracy of prediction was improved only slightly by entering the ARM and SDS-17 scores into the model.

Hypothesis Two

Hypothesis two predicted that individuals who had lied to their therapists would report being less satisfied with treatment outcome (as assessed in LPS question 22; see Appendix C) than individuals who did not lie. In order to test the null hypothesis—that there would be no statistically significant difference in satisfaction with treatment outcome between the Lying and Non Lying groups—an independent samples *t* test was conducted. The data for all participants who indicated that the therapy they had been describing was ongoing were excluded from the present analysis, as these individuals were unable to comment on their satisfaction with treatment outcome. As a result, the data for 97 participants were included in the *t* test, and data were excluded for 12 participants (11% of the group), as one person did not respond to LPS question 22 and another 11 responded "Not sure—therapy is ongoing" to LPS question 22 ("Which of

the following best describes your satisfaction with treatment outcome for the therapy you are describing in this survey?"). Thirty-six percent of the participants in this group (*n*=35) were in the Lying group, and 64% (*n*=62) were in the Non Lying group.

Results of the independent samples *t* test revealed that the two groups (Lying and Non Lying) differed significantly with regard to their ratings of satisfaction with the outcome of therapy: *t*(95)= -2.122, *p*=.036. The Levene's statistic (*p*=.008) indicated that the assumption of homogeneity of variance could not be maintained; however, when equal variances were not assumed the results remained statistically significant, *t*(59.408)= -2.003, *p*=.05. These results are presented in Table 3 below.

Table 3

Results of t-test for Equality of Means for Lying/Not Lying and Satisfaction

Equal variances	t	df	*p*	Mean difference
Assumed	2.12	95	.04	.61
Not assumed	2.00	59.41	.05	.61

Thus, participants who lied to their therapists were less satisfied with treatment outcome than participants who did not lie. The average score for participants in the Lying group (M=3.49, SD=1.541) was lower than the mean for participants in the Non Lying group (M=4.10, SD=1.251). Points on the scale consisted of 1="Very unsatisfied," 2="Not satisfied," 3="Fairly satisfied," 4="Satisfied," 5="Very satisfied" in relation to satisfaction with treatment outcome (see Appendix C, question 22). Table 4 shows the distribution of responses for the Lying group, Non Lying group, and total.

Table 4

Satisfaction with Treatment Outcome for Lying, Non Lying, and Total Groups

Level of Satisfaction	Lying Group	Non Lying Group	Total
Very Unsatisfied	12.5% (*n*=5)	5.9% (*n*=4)	8.3% (*n*=9)
Not Satisfied	15.0% (*n*=6)	8.8% (*n*=6)	11.1% (*n*=12)
Fairly Satisfied	15.0% (*n*=6)	4.4% (*n*=3)	8.3% (*n*=9)
Satisfied	7.5% (*n*=3)	23.5% (*n*=16)	17.6% (*n*=19)
Very Satisfied	37.5% (*n*=15)	48.5% (*n*=33)	44.4% (*n*=48)
Not Sure/Therapy Ongoing	12.5% (*n*=5)	8.8% (*n*=6)	10.2% (*n*=11)

Note. Results in this table are presented in terms of Valid Percent; results for one participant (0.9% of the group) are missing.

Testing was then conducted to ensure that the groups (Lying and Non Lying) did not differ on gender, age, or ethnicity. A chi-square analysis was used to test whether the groups differed in terms of gender and ethnicity; results were non-significant (for gender, $\chi^2(1, n=109)=2.886$, $p=.089$, $\varphi=.163$; for ethnicity, $\chi^2(1, n=108)=.503$, $p=.478$, $\varphi=.068$). A *t* test was conducted to ensure that the ages of participants were similar across groups; results of this test were non-significant as well (t (107)=.828, $p=.410$.

Supplementary Analyses

Quantitative Analyses

Number of Therapists Seen by Participants

Thirteen observations were missing for the LPS question that asked participants to indicate the number of therapists they had seen (LPS question 5; see Appendix C). The expectation-maximization (EM) method was used to input missing values with estimated values by an iterative process. The average number of therapists seen was 2.89 (SD=1.788), the minimum number of therapists seen was one and the maximum number was eight.

A chi-square statistic was computed to ascertain whether or not there was a statistically significant difference in the number of observed frequencies and the number of expected frequencies of seeing a therapist between participants in the Lying group and those in the Non Lying group. Results of the test indicated that there was a statistically significant difference in number of therapists seen between the Lying and Non Lying groups, χ^2 (1, n=109) = 67.972, p <.000. Participants in the Lying group saw significantly more therapists on average (M=3.77, SD=2.030) than did participants in the Non Lying group (M=2.38, SD=1.416).

Lying/Not Lying and Level of Coercion

A chi-square analysis was conducted in order to examine the presence of any relationship between lying/not lying and the level of coercion involved in participants' therapy (as assessed by LPS question 21 "…To what degree would you say the therapy you are describing involved coercion from others?"). Prior to running this analysis, descriptive statistics for "level of coercion" were examined, with the following results.

As shown in Table 5, the majority of participants indicated that their therapy involved little or no coercion from others (84%; *n*=89), 10% of participants (*n*=11) indicated that their therapy involved some pressure from others, 4% (*n*=4) reported that their therapy involved significant pressure from others, and 4% (*n*=4) indicated that strong pressure or coercion from others was involved. In order to increase power on this analysis**,** the responses of individuals who reported that their therapy was mandated or involved strong, significant, or some pressure was combined. Just over 17% (*n*=19) of participants indicated that their therapy had been mandated, or involved significant, strong, or some pressure, while just over 82% (*n*=89) indicated that their therapy had involved little or no pressure. One individual (1% of the group) did not answer this question. Table 5 below presents a summary of the responses to LPS question 21, as well as the totals for the groups ("mandated, strong, significant, or some pressure" vs. "little or no pressure."). This table reveals that the Lying and Non-Lying groups were equal in terms of the numbers of participants that fell each group.

Results of the chi-square analysis revealed no significant difference (and essentially no difference at all) between level of coercion involved in therapy and lying/not lying to therapists: χ^2 (1, *n*=108) = .000, *p*=.985, φ= -.002. For participants in the present analysis, level of coercion/voluntariness of treatment was not related to whether or not participants lied or did not lie to their therapists.

Table 5

Level of Coercion across Groups

Level of Coercion	Lying Group	Non Lying Group	Total
Mandated/Strong Coercion	2.5%	4.4%	3.7%
Significant Pressure	7.5%	1.5%	3.7%
Some Pressure	7.5%	11.8%	10.2%
Little/No Pressure	82.5%	82.4%	82.4%
Total Mandated, Strong, Significant or Some Pressure	17.5%	17.7%	17.6%
Total Little or No Pressure	82.5%	82.4%	82.4%

Note. Results in this table are presented in terms of Valid Percent; results for one participant (0.9% of the group) are missing.

ARM Scores for Lying, Tempted, and No Lie/No Tempt Groups

In Hypothesis One, a logistic regression analysis was conducted in order to examine if perceptions of the therapeutic relationship could be used to predict whether or not an individual lies to their therapist. After it was revealed that ARM scores were significantly related to lying/not lying in therapy, the researcher examined the relationship between ARM scores and group membership in a different way. Particularly of interest were the ARM scores of the Lying, Tempted, and No Lie/No Tempt groups. Although the ARM scores were the predictor variable and lying/not lying served as the criterion variable in Hypothesis One, the researcher conducted a supplementary analysis with the three groups (Lying, Tempted, and No Lie/No Tempt) serving as the predictor variable and ARM scores as the criterion variable in order to

examine if there were any significant differences in perceptions of the therapeutic relationship among these groups. The data for the four individuals who could not remember whether or not they had ever been tempted to lie were excluded from this analysis, resulting in 40 (38.5%) participants in the Lying group, 29 (27.9%) in the Tempted group, and 35 (33.7%) in the No Lie/No Tempt group.

A one-way analysis of variance (ANOVA) statistical procedure was conducted with Lying, Tempted, and No Lie/No Tempt as the levels of the factor and ARM scores as the dependent variable. Results revealed that the means for the groups differed significantly, $F(2, 101)=13.982$, $p < .001$. Results of the Levene statistic, 6.471, (2,101), $p=.002$, however, revealed that equal variances could not be assumed. Scheffe post hoc tests were conducted as a result. The Scheffe post hoc tests revealed statistically significant differences between the Lying and No Lie/No Tempt groups (mean difference=23.51, $p < .000$). Differences in the ARM scores between the Tempted and No Lie/No Tempt groups were also statistically significant (mean difference=26.48, $p <.000$). Differences in the ARM scores between the Lying and Tempted groups, however, were not statistically significant (mean difference=2.97, $p=.866$).

Overall, the average scores on the ARM were lowest for individuals in the Tempted group (M=102.88, SD=26.07). Scores of participants in the Lying group were slightly higher than those of the Tempted group (M=105.85, SD=26.07). Individuals in the No Lie/No Tempt group had the highest average scores on these instruments (M=129.36, SD=13.75). See Table 6 for the mean scores, standard deviations, and

ranges for the Lying, Tempted, No Lie/No Tempt groups and for all groups combined on the ARM.

Table 6

Agnew Relationship Measure Means, SDs, and Ranges for Lying, Tempted, and No Lie/No Tempt Groups

Group	M	SD	Min.	Max.	Range
Lying	105.85	26.06	28	146	118
Tempted	102.88	26.07	34	134	100
No Lie/No Tempt	129.36	13.75	93	149	56
Total	112.93	25.38	28	149	121

Logistic Regression for Lying and No Lie/No Tempt

After it was determined that the ARM scores of individuals in the Tempted group more closely resembled those of individuals in the Lying group than those of participants in the No Lie/No Tempt group, an additional logistic regression analysis was conducted which excluded data from individuals in the Tempted group. This test was performed in order to examine the relationship between individuals who had previously lied and individuals who had not, without the influence of individuals who had been tempted to lie to therapists, since the scores of individuals in the Tempted group clearly lowered the averages in the Non Lying group. Group sizes were nearly even on this measure, with data from 40 individuals in the Lying group and 38 individuals in the No Lie/No Tempt group. A logistic regression analysis was conducted, with lying/not lying serving as the

criterion variable and the ARM and SDS-17 scores entered as covariates. After removing the data of individuals in the Tempted group, the relationship between scores on the ARM and lying/not lying was stronger than that which was revealed when Hypothesis One was tested. For this new analysis, R^2=.248 (Cox), $\chi^2(1, N=78)=22.214$, $p < .001$. Additional data for this analysis are presented in Table 7.

Table 7

Logistic Regression Analysis of SDS-17 and ARM Scores for Lying and No Lie/No Tempt Groups

Variable	*B*	*S.E.*	*Wald*	*p*	*Exp(ß)*	*95% CI*
SDS Total	.10	.10	.96	.33	1.10	.91-1.35
ARM	.06	.02	13.96	.00*	1.03	1.03-1.09
Constant	-7.25	1.94	13.94	.00*	.00	

* *P*<.05
SDS-17 = Social Desirability Scale-17
ARM = Agnew Relationship Measure

Scores on the ARM served as a better predictor of lying/not lying to therapists when the data for individuals in the Tempted group were excluded. The odds of not lying to a therapist increased at least 3% for every one-point increase on the ARM (odds ratio=1.03, 95% CI=1.03 – 1.09). The percentage of responses correctly predicted for lying/not lying was 70.0% and 71.1%, respectively, and the overall percentage predicted correctly was 70.5%.

One-Way ANOVA for Lying, Tempted, No Lie/No Tempt and Treatment Outcome

In order to further explore differences between the Lying, Tempted, and No Lie/No Tempt groups, a one-way ANOVA was conducted, with group (Lying, Tempted,

or No Lie/No Tempt) as the factor and satisfaction with treatment outcome as the dependent variable. Results of this analysis revealed significant between-groups differences for satisfaction with treatment outcome F (2, 101)=4.43, p=.01 η^2=.08. The Levene's statistic for this a priori analysis was 10.93 (2, 101), $p < .001$, which revealed that the assumption of homogeneity of variance could not be maintained between the groups. Dunnett's C post hoc tests were conducted as a result. These post hoc tests revealed statistically significant differences in satisfaction with treatment outcome between the Lying and No Lie/No Tempt group (mean difference= -.84, $p \leq .05$). Differences in satisfaction scores between the Tempted and No Lie/No Tempt groups were also statistically significant (mean difference= -.93, $p \leq .05$). Differences in satisfaction scores between the Lying and Tempted groups, however, were not statistically significant (mean difference=.09, $p > .05$).

The average treatment satisfaction scores were lowest for individuals in the Tempted group (n=28, M=3.71, SD=1.51), followed closely by individuals in the Lying group (n=40, M=3.80, SD=1.67). Individuals in the No Lie/No Tempt group had the highest reported satisfaction with treatment outcome (n=36, M=4.64, SD=1.02).

One-Way ANOVA for Lying, Tempted, No Lie/No Tempt and SDS-17 Scores

The Lying, Tempted, and No Lie/No Tempt groups were included in an additional ANOVA to examine whether or these groups differed in social desirability. Again, group membership was entered as the factor and SDS-17 scores served as the dependent variable. Differences in SDS-17 scores among the three groups were not statistically significant F (2, 100)=1.59, p=.21 η^2=.03. In this analysis, the Levene's statistic (1.78 (2, 100), $p < .17$) revealed that the assumption of homogeneity of variance

could be maintained between the groups, so no additional tests were conducted. Average SDS-17 scores were lowest for individuals in the Lying group (M=3.98, SD=2.43), followed by individuals in the No Lie/No Tempt group (M=5.03, SD=2.90) and individuals in the Tempted group (M=5.03, SD=3.48).

Descriptive Information for the Lying Group

Individuals who reported that they had previously lied to a therapist were asked to respond to a series of queries that were not asked of the Non Lying group (see LPS questions 6-20 in Appendix C; however, individuals in the Tempted group were also asked some questions that were not asked of individuals in the Lying or No Lie/No Tempt group: see LPS questions 25-29 in Appendix E). Descriptive results of the multiple-choice questions asked of participants in the Lying group are reviewed in the following section; answers to open-ended questions are examined in the "Open-Ended Questions" subsection at the end of this chapter.

LPS question 6 asked participants in the Lying group to indicate the number of therapists to whom they had told a lie. The range for number of therapists participants indicated they had lied to was one through nine (although the highest number of therapists seen in LPS question 5 was reported to be eight), and the mean was nearly three therapists lied to per participant (M=2.59; SD=2.13). Just over 25% of participants indicated that they had lied to every therapist they had seen (*n*=11, range=1–7), and 65% of the 31 individuals who had seen more than one therapist had also lied to more than one (*n*=20). Five participants did not provide data for this question.

Participants were asked to indicate the number of sessions they had with the therapist they were describing and the approximate session number in which they *first*

told the lie they were describing in the LPS. Over one half of the individuals in the Lying group indicated that they had lied to their therapists within the first one half of their treatment duration (*n*=26, 65%). One quarter of the participants in the Lying group (*n*=10) lied to their therapists during the first therapy session, while an additional one-third (*n*=15) lied at other points during the first quarter of their therapy relationships. Fifteen percent of individuals in the Lying group (*n*=6) indicated that they first lied to their therapists in a session that was beyond the half-way point in their treatment. Eight individuals (20% of the Lying group) were unable to say when they had first lied to their therapists.

In response to the question "In your opinion, was the material you lied about relevant to the problem for which you were seeking treatment?" (LPS question 12), the majority of participants (*n*=38/40; 95% of participants in the Lying indicated that they had lied about information that was at least somewhat relevant to treatment. Thirty-five percent (*n*=14) of these individuals felt that they lied about *highly relevant* information, 37.5% (*n*=15) felt the information was *relevant,* 22.5% (*n*=9) reported that they believed they lied about information that was *somewhat relevant* to their treatment, and 5% (*n*=2) reported that they believed the material was *not very relevant* to their treatment. No participants in the group of individuals who reported that they had previously lied to a therapist indicated that they believed that the material they lied about was *not at all relevant* to their treatment.

In response to the question "How much consideration did you give prior to telling the lie you are describing?," (LPS question 13), nearly one half of the participants in the Lying group indicated that the lies they told were completely spontaneous (45%;

n=16/40). One half of the participants reported that they had given at least some prior thought to telling the lie (50%, *n*=20): 40% of these individuals (*n*=8) reported that they made the decision to lie during the same session in which the lie was told, and 60% (*n*=12) had decided to lie prior to the session in which the lie was told. Five percent of the participants in the lying group (*n*=2*)* could not remember when they decided to lie. `

Answers to LPS question 14 ("When you told the lie, was it prompted by a comment or question from the therapist?") revealed that 60% (*n*=24) of the lies participants described in the study were prompted by a direct question from the therapist, 20% (*n*=8) were prompted by an indirect therapist question or comment, 2.5% (*n*=1) were told voluntarily or without a therapist prompt, and 17.5% (*n*=7) of participants could not remember whether or not the lie had been prompted.

In response to the question "Do you believe the lie or lies you told your therapist affected the therapeutic relationship?" (LPS question 15), nearly one half of the participants in the Lying group responded in the affirmative (47.5%, *n*=19). Just over one half of the individuals in the Lying group said that they did not believe that telling lies had affected their relationships with their therapists (52.5%, *n*=21). No individual in the Lying group responded that they could not remember whether or not lying had affected their therapeutic relationships. Participants were asked to describe the ways in which therapeutic relationships were affected by lying in LPS question 16; these results are described under the subheading "How lies affected the relationship."

Forty percent of individuals in the lying group (*n*=16) reported that they believed that lying to their therapist had affected the therapeutic outcome (LPS question 17). Nearly 43% (*n*=17) of participants did not believe that lying had impacted therapeutic

outcome, and 17.5% (*n*=7) said that they were "not sure/therapy is ongoing." One participant (2.0% of this group) did not respond to this question. LPS question 18 asked individuals to describe how therapeutic outcomes were affected by lying. Answers to this open-ended question are described under the subheading "How lies affected therapeutic outcome."

Most of the lies described by the 40 participants in the lying group were never revealed to therapists (65%, *n*=26). Of the 35% of individuals whose lies were revealed to their therapists (*n*=14), most of these participants voluntarily admitted to their therapist that they had lied (*n*=12, 86% of the group whose lies were revealed to therapists; LPS question 20). One participant (2.5% of this group) admitted the lie in response to a therapist question, comment, or query. Two individuals indicated that their lies were admitted in another way, although three responded to the open-ended question that asked them how the lies were revealed (see Appendix S for these responses). While the manner in which the lies told by these individuals were revealed to their therapists differed, the responses indicated that lies were revealed as therapy progressed. For example, one individual noted "As my trust in her grew, it became less necessary to lie, besides it was apparent."

Open-Ended Questions

Many of the questions on the LPS were open-ended, and participants' answers to those questions are briefly reviewed in the following discussion. Participants' responses to open ended questions are included in Appendixes K-Y.

Presenting Complaints

In order to group the presenting complaints noted by participants (most of the 109 participants noted more than one presenting complaint), Pope and Tabachnick's (1994) categorization for their participants' "Major Focus of Therapy" (p. 249) was utilized and amended as appropriate. Across all three participant groups (the Lying, Tempted, and No Lie/No Tempt groups), depression or general unhappiness was the presenting complaint noted most frequently in response to the LPS question "What was/were your presenting complaints in the therapeutic relationship that you are describing?" (*n*=41; see Appendix K). Anxiety was the second most common presenting complaint noted by participants across groups (*n*=25), followed by relationships/ interpersonal conflict (*n*=15), career, work, school, or studies (*n*=10) and adjustment/transition issues (*n*=10). Problems with family (*n*=8), trauma and post-traumatic distress symptoms (*n*=7), and self-esteem/self-confidence/self-concept concerns (*n*=6) were also among the most commonly reported presenting concerns of participants.

Although many participants cited anxiety in general as a presenting complaint, when more specific forms of anxiety were noted, such as social anxiety, post-traumatic stress disorder, and obsessive-compulsive disorder, these presenting complaints were grouped into and tallied under separate categories. This was also true for relationships: when individuals noted "relationships" in general as a presenting complaint, this was tallied in the "relationship" category. However, when these individuals noted that relationships with specific individuals or in specific contexts (e.g., w/ a spouse or parent) were their presenting concerns, separate categories were formed (following Pope and

Tabachnick, 1994) and responses were tallied under these categories in order to get the most accurate information on presenting concerns as possible. Responses that were noted only once were grouped into a "miscellaneous" category (*n*=22), along with blank and inappropriate responses (e.g., on four occasions, participants did not answer the question that was asked).

Appendix L lists the verbatim responses of each participant. Responses in this table were grouped into Lying, Tempted, and No Lie/No Tempt groups**.** Although groups differed in their numbers of responses for each presenting problem category (see Appendix K), there did not appear to be any major differences in presenting complaints between the groups.

Lying Group: Responses to Open-Ended Questions

Content of lies told. After reviewing the content of lies told (participants' responses to LPS question 8: "Please describe the content of the lie you told your therapist. In other words, what did you lie about?"), it was decided that neither the taxonomy developed by DePaulo and colleagues (1996; as described in Chapter II) on content of lies nor that developed by Pope and Tabachnick (1994) on content of secrets kept in therapy were appropriate for use in the current study. Therefore, a new list of all lie content described by participants was developed, and similar responses were then grouped together (see Appendix M).

Lies about the nature of and/or participants' involvement in relationships emerged as the topic that lies were most often told about (*n*=7). Six participants indicated that they had lied to therapists about substance use, abuse, and/or dependence; five reported having lied about symptoms and/or symptom severity (magnifying or

minimizing symptoms, or making symptoms up all together). Four individuals noted that they had lied about feelings or thoughts in general, and another four participants lied about sex and/or sexual behavior. Three participants reported having lied about the following three topics: abuse (involvement in abusive relationships/history of abuse) medication, and self-injury. Appendix N lists all written responses of participants in regards to content of lie told; Appendix M lists the categorized responses.

Motivation for lying. LPS question 9 asked participants "To the best of your knowledge, at the time you lied to your therapist, what did you conceive was your motivation for doing so?" The overwhelming majority of participants' answers to this query (see Appendix O) would be classified as *self-oriented* motivations (lies told in order to benefit the individual telling the lie), according to DePaulo and colleagues' (1996) classification of reasons for lying. Almost every reason for lying that participants cited involved some benefit to them. Most of these self-oriented lies were told for psychological reasons (e.g., "to avoid embarrassment and judgment from others"), although several individuals reported lying for reasons of personal advantage (e.g., "I didn't want her to raise her fees once I paid off the full balance.").

Several individuals in the Lying group reported *other oriented* (or at least partially other-oriented) motivations for lying to their therapists. These other-oriented motivations included not wanting the therapist to worry or be concerned about the client. A more thorough discussion of participants' reported motivations for lying follows in Chapter V (see the "Motivation for Lying" subsection).

Therapist/therapeutic relationship characteristics for participants who lied. The responses for LPS question 10 ("What, if any, therapist characteristics and/or qualities of

the relationship you had with your therapist influenced your decision to lie?") were classified as being positive, negative, or neutral characteristics (see Appendix P). A "none" category was also created for responses that were either left blank or implied characteristics of the client (rather than the therapist or therapeutic relationship). For example, several participants implicated personal characteristics in their decisions to lie but made no reference to their therapists (e.g. "I think the lying was pretty much an effect of my personality issues"). Responses stating that no therapist characteristics had influenced decisions to lie also fell into the "none" category. Responses categorized as positive were those that favored or spoke well of the therapist or the relationship, or that implied otherwise helpful and beneficial qualities. Characteristics were considered negative if they implied off-putting, unhelpful, harmful, or otherwise unconstructive qualities. Responses that held no positive or negative connotations, or from which positive or negative inferences could not be made, were classified as neutral. Factors such as the gender and age of the therapist, as well as the timing in the therapeutic relationship (early in the relationship or near termination), were considered neutral.

After classifying responses as positive, negative, and/or neutral (some responses contained more than one valence), the following results were obtained: nine responses had a neutral connotation (e.g., "He was of the opposite gender."), 10 had a positive connotation ("The relationship was important to me, and did not want her to disapprove"), and 12 had a negative connotation (e.g., "lack of trust…"). The responses of nine individuals were included in the "none" category.

How lies affected the relationship. Of the 19 individuals in the Lying group who indicated that they believed their lies had affected the therapeutic relationship (LPS

question 15), most (*n*=14; 74% of this sample) indicated that lying affected the relationship in a negative way (LPS question 16, see Appendix Q). Two participants (11% of this sample) indicated that they believed lying may have ultimately strengthened the therapeutic relationship, and three individuals (15% of this sample) gave responses that did not contain positive or negative valence. For example, one participant stated that lying had affected the relationship "only on my part because I knew there was something I was privy to in the relationship that she did not know," but did not describe whether or not this was viewed as a positive or negative consequence of lying.

How lies affected therapeutic outcome. Of the 16 participants (40% of the Lying group) who indicated that they believed the lies they told therapist had affected the therapeutic outcome in LPS question 17, most of these participants (*n*=14; 88% of this sample) remarked that they believed their therapy was impacted in a negative way as a result of having lied (see Appendix R for a list of all responses to this item). Two participants (13% of this sample) indicated that they believed lying had ultimately improved the therapeutic outcome.

Tempted Group: Responses to Open-Ended Questions

What participants were tempted to lie about. The responses of the twenty-nine participants who reported that they had never lied to a therapist but had been tempted to lie fell into 18 categories (LPS question 26, "What were you tempted to lie about?"; see Appendix T). Information relating to participants' families and/or home made up the most popular category of content that individuals were tempted to lie about (*n*=4), and sexual behavior was the second most frequently cited category that participants were

tempted to lie about (*n*=3). Completion of homework/assignments, details of events and experiences, information about third parties, relationships, substance use, and symptom severity made were cited by two participants in each category as information they had been tempted to lie to a therapist about. Five individuals gave inappropriate responses (e.g., "yes") or failed to respond to this question. The written responses of all participants to LPS question 26 may be found in Appendix U.

Appendix V compares the content of information that individuals did lie about to therapists about with the content that individuals were tempted to lie about. Relationships (*n*=9), substance use/abuse/dependence (*n*=8), symptoms/symptom severity (*n*=7), and sexual behavior (*n*=7) comprised the four categories with the highest combined totals.

What prevented lying when tempted. LPS question 27 asked individuals who had been tempted to lie but refrained from doing so to "Please describe what prevented you from lying when you were tempted to tell a lie." The major theme that emerged in response to this question concerned participants' realizations that lying could result in harmful consequences or otherwise hinder the therapeutic process (see Appendix W for a list of all responses to LPS question 27). Personal standards, such as "conscience," prevented several participants from lying. Two individuals cited therapist traits as preventing them from lying when tempted.

Several individuals reported that they were prevented from lying to their therapists because the material that they were tempted to lie about had never been brought up in therapy. Thus, these individuals were able to avoid lying because the information they were tempted to lie about was not brought up by the therapist. One

participant intentionally distracted their therapist from discussing a topic, and two others omitted information from their therapists but did not tell an overt lie.

Therapist/therapeutic relationship characteristics that influenced truth-telling. The majority of participants who refrained from lying to their therapists despite being tempted to do so indicated that positive qualities of the therapist and/or the therapeutic relationship influenced truth telling (See Appendix X). Of the 29 participants who reported that they had never lied but had been tempted to do so, 18 (62%) described positive traits in response to LPS question 28 ("What, if any, therapist characteristics and/or qualities of your relationship with your therapist influenced your decision to tell the truth in a situation in which you were tempted to lie?").

Of the 11 individuals who did not cite positive therapist/therapeutic relationship characteristics as influencing them to be honest in situations they were tempted to lie in, seven (24% of the Tempted group) either left LPS question 28 blank or did not address therapist or relationship characteristics in their response (e.g., "in this case it was my own boundaries that influenced the truth telling"). One individual noted that s/he did not lie because s/he "knew [the therapist] would be disappointed in me if I lied." Since it could not be determined from this response whether positive, negative, or the participant's own personality traits led to this assumption, the response was coded as neutral.

One participant indicated that a negative quality of the therapist had influenced truth-telling when they were tempted to lie. This individual remarked that s/he "felt that [the therapist] was not really getting what I was trying to say." Two other participants reported that negative traits of the therapist or the relationship had caused them to want

to lie initially. One of these participants noted "none – the therapist's characteristics influenced me to want to lie" and the other stated "I wish I had lied. The therapist was demeaning and not helpful to my true problems." in response to LPS question 28.

CHAPTER V

DISCUSSION

The primary goal of the present study was to gather information on lying in psychotherapy from current or former therapy clients. It was predicted that, after removing the effects of social desirability, individuals with less positive perceptions of their therapists and therapeutic relationships would be more likely to report that they had lied to their therapists than individuals having more positive perceptions of their therapists and therapeutic relationships. It was also expected that individuals who reported that they had lied to their therapist would report being less satisfied with treatment outcome than individuals who did not lie.

The present study is important to the field of psychology and the practice of psychotherapy for multiple reasons. First, there have been numerous scholars and theorists in psychology and related fields who have speculated that lying in psychotherapy is not an uncommon occurrence (see, for example, Gediman and Lieberman, 1996; Newman and Strauss, 2003). Such authors have also considered possible causes and consequences of lying to therapists. Information on the topic of lying in psychotherapy, however, has been predominantly limited to theoretical and philosophical discourse, and has been neglected by research pursuits. Second, authors such as Kelly (1998) and Pope and Tabachnick (1994) have studied similar phenomena,

such as secret keeping and withholding information in therapy, and have revealed that these occurrences are both common and appear to be related to treatment outcome in some way (although these authors' findings differed in the ways that treatment was affected). It seemed important, therefore, to gather information on the ways that lying in psychotherapy might affect therapeutic outcome. In addition, it was necessary to collect data on perceived characteristics of the therapist and the therapeutic alliance in order to examine how these factors might be related to whether or not clients lie in therapy. In this way, practitioners can begin to gain awareness of how their own characteristics and relationships with clients impact how honest clients choose to be with them. If the goal of psychotherapy is to assist individuals in addressing problems and making positive changes, then it is important to understand how therapists can best help clients. If practitioners bring particular qualities to the therapy session and the therapeutic alliance that prevent clients from being completely honest with them (and prevent clients from getting the help they need as a result), then we need to become aware of this and do what we can to help our clients feel safe in being honest.

Hypotheses

Hypothesis One

After dropping the Therapist Satisfaction Scale scores (TSS) (Conte et al., 19994) from the statistical analysis of Hypothesis One due to their high correlation with the Agnew Relationship Measure scores (ARM) (Agnew-Davies et al., 1998), results revealed that individuals having lower scores on the ARM were significantly more likely to report that they had previously lied to a therapist than were participants having higher

scores on this measure. The analysis thus provided support for the hypothesis that, after removing social desirability effects, individuals having less positive perceptions of the therapeutic relationship would be more likely to report that they had lied to therapists than individuals having more positive perceptions of their relationships with their therapists.

Several possibilities might help explain why participants having less positive perceptions of their therapeutic relationships were more likely to lie to their therapists than were participants having more positive perceptions of their therapeutic relationships. First (as was the premise of this study), it could be that therapists bring certain qualities and/or dynamics into therapy and the therapeutic relationship that cause clients to feel unsafe and/or concerned about being judged or punished in some way, should they be honest when sharing particular information. As a result, they may choose not to reveal certain truths to therapists. This possible explanation for the observed findings was supported by some of the participants' responses to the Lying in Psychotherapy Survey (LPS) questions 9: "To the best of your knowledge, at the time you lied to your therapist, what did you conceive was your motivation for doing so?" and 10: "What, if any, therapist characteristics and/or qualities of the relationship you had with your therapist influenced your decision to lie?" (see Appendixes O & P). Many participants revealed that they had lied because they did not trust their therapist, feel safe to tell the truth, and/or were concerned about the consequences of being honest. These individuals identified their therapists as appearing judgmental, having a "cold demeanor" being "smug," "very confrontive," and "too condescending." Based on responses such as these, it appears safe to conclude that lying *can be* impacted by therapist and/or

therapeutic relationship characteristics, such as therapist demeanor and the level of rapport established in the relationship.

The observation that participants having more positive perceptions of their relationships were less likely to report that they had lied to their therapists is consistent with results of a study by DePaulo and Kashy (1998). These authors found that individuals lied less to those with whom they were emotionally closest. DePaulo and Kashy concluded that lies are told less often to people to whom individuals are close because lying violates the openness and authenticity in relationships. Anderson and colleagues (1999) also suggested that people may be less likely to lie to those with whom they are close, as lying could result in negative consequences for the relationship.

Although it is certainly the case that individuals may lie to their therapists because they do not have good relationships with them, it also seems evident that some clients lie to their therapist for the opposite reason. That is, some participants in the present study indicated that they lied to their therapists *because* they had such good relationships with them, and wished to preserve these relationships. In cases such as this, lying may be perceived as a method by which the positive relationship can be maintained, as clients are able to lie about material that, in their perception, might negatively affect their therapists' images of them and/or their relationships with their therapists.

The understanding that clients' decisions to lie to their therapists may be influenced by very good therapeutic relationships and positive therapist characteristics (as perceived by clients) emerged after analyzing participants' quantitative and qualitative data. The quantitative data revealed that the range of scores on the ARM was

greater for individuals in the Lying sample than it was for participants in the No Lie/No Tempt sample. Thus, while ARM scores were on average lower for participants who had previously lied to their therapists, there were also some very high scores for participants in this group—not everyone who lied to their therapists had poor relationships with them or viewed their characteristics poorly. Clearly, some individuals chose to lie to their therapists when they felt positively about them and the quality of their relationships.

The qualitative data that led to the explanation that participants may lie to their therapists *because* they like them so much were derived from open-ended questions on the LPS that asked individuals to describe their motivations for lying and therapist/ therapeutic relationship characteristics that had influenced their decisions to lie (LPS questions 9-10; see Appendixes O-P). Several participants noted that a wish to conserve their therapists' positive views of them motivated their decisions to lie in therapy. One participant, for example, revealed "I thought well of my therapist, and did not want to disappoint her" (see Appendix O). In a similar manner, several participants also noted that positive qualities of the therapist and/or therapeutic relationship influenced their decisions to lie. For example, one noted that "a dynamic of equality and mutual respect. an alliance that I did not want to injure in any way" was a characteristic that had influenced his/her decision to lie, and another reported that a "high level of trust and therapist's positive perceptions of me - I didn't want to be a 'bad' client" had influenced his/her decision to lie (see Appendix P).

After analyzing participants' responses to open-ended LPS questions and scores on the ARM, it is evident that lying in psychotherapy may be influenced by clients'

perceptions of their therapists and relationships with their therapists. Although poor perceptions of therapeutic relationships appear to be related to lying in psychotherapy, for some clients, the opposite may be true. That is, positive client perceptions of the therapeutic relationships may make it more likely that some clients will lie to their therapists, in order to (in the image of the clients) protect their therapeutic relationships and therapists' views of them (the clients).

There are several important implications of the finding of a relationship between clients' perceptions of their therapeutic relationship and lying/not lying to therapists. First, it is clear that practitioners of psychotherapy need to be aware of how their personal characteristics are perceived by clients, and how these perceptions might affect the level of honesty clients choose to use in therapy. Practitioners might do well to heighten their own awareness of how they are perceived by clients, for example, by asking clients to fill out surveys such as the TSS and/or ARM anonymously, so that they can feel free to express their views honestly. Providing clients the opportunity to offer honest feedback can give therapists the occasion to identify personal strengths and weaknesses. They can then identify and work on areas that need improvement, in order to improve their clinical skills and relationships with clients.

After reading participants' responses to various open-ended LPS questions and examining ARM survey data, it appears that therapists have some influence in whether or not clients lie to them in psychotherapy. Facilitating trust and openness in the relationship, as recommended by Rankin (1990), as well as communicating unconditional positive regard to clients, may be helpful in decreasing the probability that clients will lie. Rankin noted that it is important to be open and "scrupulously honest"

(p. 108) with clients in order to create trust and reliability in the therapeutic relationship. In this way, clients can learn what types of reactions to expect from their therapists. Rankin also suggested that the probability of lying can be decreased if therapists communicate realistic expectations about progress to clients, reinforce honesty, and time questions about clients' honesty appropriately.

Support for Rankin's suggestions for decreasing the probability of lying in therapy was provided by several participants in the present study. These participants noted that a lack of factors such as trust and unconditional positive regard influenced their decisions to lie in therapy. For example, one individual noted that "If [the therapist] had been better at conveying unconditional positive regard, I would have felt comfortable disclosing my decision," while another reported "lack of trust, owing to the fact that it was the first session and was possibly exacerbated by her demeanor, which I felt was cold and did not induce a feeling of comfort" had influenced his/her decision to lie. Other participants said that they had lied to their therapists because they liked them very much, and feared disappointing therapists if they were honest. It appears that we might do much to prevent lying in psychotherapy if we make it clear to our clients that we will value and respect them under any and all circumstances. Sending clients the message, in our words and actions, that they will be supported *no matter what they tell us* may help foster truth-telling (and thus allow us to better help our clients). In addition, we may also permit clients to be more honest in therapy if we normalize and validate the notion that they will be asked to share difficult and painful material, some of which they may not be ready to discuss. Boundaries for discussing material that clients may not be ready to divulge should be established, so that clients can feel comfortable to express

their discomfort and/or lack of readiness, rather than lie to therapists or go out of their way to avoid certain topics.

It should be noted that lying in psychotherapy is certainly not always impacted by (or a result of) therapist and therapeutic relationship characteristics. Several participants in the current study indicated that they felt therapist/therapeutic relationship characteristics had nothing to do with their decisions to lie in therapy, and some indicated that it was their own personality characteristics and/or desire to please the therapist that had impacted their decisions to lie (see Appendix P).

One final note regarding lying/not lying in therapy and clients' perceptions of therapist and therapeutic relationship characteristics deserves mention. Although differences on ARM scores were significantly related to lying/not lying in psychotherapy, the size of the predicted effects was small. Less than 7% of the variance in lying/not lying to a therapist was accounted for in the logistic regression analysis. As a result, caution should be taken in interpreting results, and research designed to identify additional variables that account for the variability in lying/not lying to therapists is necessary. In spite of the fact that the effect size of the present study was small, a message from Kashy and DePaulo (1996) might be useful to consider. These authors suggested that "because lying is indeed an everyday event, even personality variables that account for just a small amount of the variance in lie-telling can be of great consequence over time" (p. 1050). If we substitute "therapist and therapeutic relationship variables" for Kashy and DePaulo's "personality variables," it seems that anything we can learn about lying in psychotherapy at the present time, regardless of effect size, is useful information.

Hypothesis Two

In Hypothesis Two, it was predicted that individuals who lied to their therapists would report being less satisfied with treatment outcome than those who did not. This prediction was supported by the results of the *t* test, which revealed a statistically significant difference between the average scores for individuals who had previously lied and individuals who had not lied to their therapists. Overall, individuals who had previously lied to their therapists reported being less satisfied with treatment outcome than individuals who did not lie to therapists.

One possible explanation for the observed difference in treatment satisfaction between individuals who lied and individuals who did not lie to their therapists is that individuals who lied were unable to fully address information that was pertinent to their treatment. As a result, they were not able to process and explore material in therapy that may have benefited them and helped them improve in the ways they had hoped to change in therapy. Indeed, most (95%) of the participants in the present study who indicated that they had formerly lied to a therapist indicated that they lied about something that was at least *somewhat relevant* to the problem for which they were seeking treatment, and more than one half of these participants stated that they had lied about material that was *relevant* or *highly relevant*. None of the participants believed they had lied about information that was not at all relevant to their treatment. If clients are not being truthful about information that is relevant to their presenting concerns, it seems reasonable to assume that important information is not being adequately addressed in therapy.

The explanation that lying can lead to less satisfaction with treatment outcome because important information is not being shared and addressed with therapists was supported by some participants' responses to LPS question 18 (see Appendix R). This question asked individuals who indicated that they believed that lying to their therapists had affected their therapeutic outcome (in LPS question 17; see Appendix C) to describe how outcomes had been affected. Participants' responses to this question included statements such as "The therapy would have probably been more effective if I had been able to tell the truth about the original experience," and "the direct reason for referral was never addressed or attended to." The prevailing theme of responses to LPS question 18 was that participants did not get the help that they wanted or needed as a result of lying to their therapists.

While it may be tempting to conclude from the above results that lying leads to less satisfaction with treatment outcome in therapy, there are alternative explanations for the findings. It is possible, for example, that individuals who lied to their therapists concluded that they must not have been satisfied with treatment outcome, as a result of having lied to their therapists. It may also be that other variables are causally related to either or both lying and satisfaction with outcome. For example, clients' personal characteristics (such as pessimistic attitudes, lack of insight, and/or using defense mechanisms like denial or avoidance) may influence individuals' decisions to lie to their therapists and may also affect their sense of satisfaction with the outcome of therapy.

Another plausible explanation for the finding that individuals who lied to their therapists reported being less satisfied with treatment outcome than participants who did not lie involves two additional variables: therapist characteristics and the therapeutic

alliance. The quality of the therapeutic relationship and participants' perceptions of their therapists may have been causally related both to lying and satisfaction with treatment outcome in the present study. In other words, poor therapeutic relationships and less positive views of therapist characteristics may have impacted both clients' decisions to lie to therapists and their satisfaction with treatment outcome. This possible explanation was the premise of the present study, and was developed as a result of a review of the literature commenting on the correlations of the therapeutic alliance and therapist characteristics with treatment outcome. Numerous scholars (see, for example, Ackerman, Benjamin, Beutler et al, 2001; Orlinsky, Grave, & Parks, 1994; Strupp, Fox, & Lessler, 1969) have noted that therapist characteristics and strong therapeutic alliances are related to improvement in psychotherapy. Lambert and Barley summed up the findings of studies on the therapeutic relationship and treatment outcome nicely, stating that:

> Decades of research indicate that the provision of psychotherapy is an interpersonal process in which a main curative component is the nature of the therapeutic relationship. Clinicians must remember that this is the foundation of our efforts to help others. (2001, p. 357)

The implications of the findings that lying in psychotherapy is related to lower satisfaction with treatment outcome are similar to those noted above in the discussion of the "Hypothesis One" subsection. Namely, psychotherapy practitioners need to: (1) be made aware of their own personal and relationship characteristics that might cause clients to feel unsafe if they are completely honest in therapy and make them more likely to lie; (2) strive to convey warmth and unconditional positive regard to their clients; and

(3) understand (and help clients understand) the nature of the relationship between being honest in therapy and treatment outcome.

Although results of the present study on the relationship between lying/not lying and satisfaction with treatment outcome cannot be used to determine causal factors, it is appears that, for participants in the present study, there were differences in satisfaction with treatment outcome between individuals who did and did not lie to their therapists: clients who lied to therapists reported being less satisfied with therapy outcome than clients who did not lie. This finding is similar to those of Pope and Tabachnick (1994), who revealed that participants in their study who abstained from secret-keeping in psychotherapy had more positive treatment outcomes than participants who did withhold important information from therapists. It differs, however, from the findings of Kelly (1998), who suggested that secret-keeping and withholding information in psychotherapy was related to more positive therapy outcomes.

It is important to mention that, while there were differences in overall satisfaction with treatment outcome for individuals in the Lying and Non Lying samples, not everyone in the Lying group believed that lying had affected the therapeutic outcome. In fact, only approximately one half of the individuals in the Lying sample who were able to comment on whether or not they believed lying had affected treatment outcome said that they believed this had been the case (some individuals in the Lying sample had not yet terminated treatment; therefore, they were unable to comment on their satisfaction with treatment outcome). Thus, one half of the participants indicated that they did not believe lying had affected the therapeutic outcome. These results (participants' responses to LPS question 17) provide an interesting contrast to the results of LPS

question 22, which asked them to rate their satisfaction with treatment outcome (see Appendix C). Thus, although not everyone in the Lying sample indicated that they believed their treatment outcome had been affected by lying in psychotherapy, they were regardless less satisfied with therapy outcome than individuals in the Non Lying sample.

A limitation in the assessment of client satisfaction with treatment outcome used in the present study merits attention: one Likert-type self-report question was used to assess participants' satisfaction (see LPS question 22 in Appendix C), rather than a validated instrument for measuring this construct. Future studies may do well to assess satisfaction with treatment outcome using a validated and reliable instrument, such as the Client Satisfaction Questionnaire (Larsen, Attkisson, Hargreaves, and Nguyen, 1979), in order to improve validity and reliability in assessing clients' satisfaction.

Results and Implications of Additional Analyses

Below, the results of supplementary analyses, including open-ended questions, are described. As was the case in Chapter IV, groups will be described in the following ways: individuals in the *Lying* group are those who indicated that they had previously lied to a therapist. Individuals in the *Non Lying* group are those who reported that they had never previously lied to a therapist. The Non Lying group is further divided into the *Tempted* group (those individuals who did not lie to a therapist but were tempted to lie) and the *No Lie/No Tempt* group (those participants who did not lie to a therapist and indicated that they had never been tempted to lie or could not remember having ever been tempted).

Differences Between Lying, Tempted, and No Lie/No Tempt Groups

Some of the most interesting (and unexpected) results obtained in the present study emerged when the Non Lying sample was subdivided into the Tempted and No Lie/No Tempt groups, and the scores of these groups were compared with the Lying sample. Prior to data analysis, it had been unclear whether or not the scores of Tempted participants on the TSS and ARM would more closely resemble those of the Lying group or the No Lie/No Tempt group. Data analyses revealed that the average TSS and ARM scores of Tempted individuals were similar to those of the Lying group, and in fact were actually lower than the scores of individuals in the Lying group. Thus, participants who indicated that they had previously been tempted to lie to a therapist but had refrained from doing so actually had poorer perceptions of their therapist characteristics and their therapeutic relationships than did individuals who *did* lie to their therapists.

Individuals in the Tempted group also reported being less satisfied with treatment outcome than participants from the Lying and No Lie/No Tempt groups. Average scores for satisfaction with treatment outcome were highest for the No Lie/No Tempt group, indicating higher levels of satisfaction. Treatment outcome satisfaction scores (as assessed by LPS question 22; see Appendix C) for the Lying and Tempted groups were very similar (and significantly different from those of individuals in the No Lie/No Tempt group), with individuals in the Lying group indicating that they were slightly more satisfied than individuals in the Tempted groups.

What factors might account for the lower TSS, ARM, and therapy outcome scores of individuals in the Tempted group? Why were these scores even lower than

those of individuals in the Lying group? One possible explanation for these findings is that perhaps lying in psychotherapy does not necessarily result in harmful or negative consequences. For example, when client characteristics and/or therapist and therapeutic relationship factors dispose clients to want to lie, perhaps lying can serve some helpful purpose (e.g., allowing clients not to feel judged or criticized by therapists) that is not accomplished with honesty. If clients feel badly (e.g., judged, criticized, or ashamed) or believe that they have been punished (e.g., hospitalized, terminated from therapy, or scolded) as a result of being honest with therapists, this may lead to less positive perceptions of therapist and therapeutic relationship characteristics, as well as lower satisfaction with treatment outcome, than if they had chosen to lie. One participant made a comment to this effect, noting "The negative views that I now hold regarding the therapist are mostly because of how they handled the personal information that I ended up not lying about. It was a big decision for me not to lie about it and because of what resulted I wish I had lied about it" (See Appendix Y).

Lying and Social Desirability

Because some scholars have described a positive relationship between lying and social desirability (Brody, 1995; Zagon & Jackson, 1994) or related constructs such as impression management (Kashy & DePaulo, 1996), a social desirability scale (the Social Desirability Scale-17, or SDS-17, Stöber, 2001) was included in the present study. In this way, the possibility that social desirability might serve as a confounding third variable could be examined. Unlike the results of previous studies, however, social desirability scores were not significantly related to lying/not lying for individuals in the present study. In addition, although it was not significant, the direction of the

relationship between SDS-17 scores and lying/not lying was actually opposite of that found by previous researchers: individuals with lower scores on the SDS-17 (lower social desirability) were more likely to report that they had lied to a therapist than were individuals having higher scores (higher social desirability) on this instrument.

There are multiple explanations that might account for the observed lack of relationship between lying/not lying and participants' scores on the social desirability instrument. First, it could be that there is truly no relationship between these variables. This possibility contradicts what might be expected from the findings of researchers such as Bilney and D'Ardenne (2001), who observed that individuals who were more concerned with social desirability were more likely to lie than individuals who were less concerned with social desirability.

Another possible reason for the non-significant relationship between lying/not lying to therapists and social desirability pertains to the instrument used to measure the latter construct: the SDS-17 (Stöber, 2001). Although Stöber found this instrument to be a reliable and valid assessment of social desirability, the SDS-17 is a fairly obvious measure of the construct, and may therefore have been subject to social desirability effects itself, particularly among graduate students in psychology and related fields. One participant made a comment to this effect, and wrote "…the social desirability scale is very obvious and probably not going to be very sensitive, especially for people in psychology" (see Appendix Y). Future studies wishing to examine the relationship between social desirability and lying in psychotherapy may benefit from the use of more subtle, less obvious measures of this construct.

A third explanation for the observed lack of relationship between lying in psychotherapy and social desirability was briefly introduced in the preceding paragraph and relates to the population used as participants in the present study: graduate students in psychology and related fields. These individuals (along with other scholars of research) are likely to be more familiar with the concept of social desirability (and the reasons such instruments are used in research) than the general population. As a result, social desirability instruments may be less effective in assessing the social desirability of individuals in psychology and related fields than in the general population. It is possible that there is a relationship between lying in psychotherapy and social desirability that was not captured in the present study due to the instruments used with this population.

One final comment on lying and social desirability merits attention. In Chapter II, it was noted that social desirability consists of two components: impression management and self-deception (Paulhus, 1984). Future studies wishing to explore the relationship between lying, social desirability, and the two components of social desirability may do well to utilize instruments that are specifically designed to measure impression management and self-deception, as opposed to the general concept of social desirability. For example, Sabourin and colleagues (1989) indicated that The Self-Deception Questionnaire (Sackeim & Gur, 1978) is an effective assessment tool for evaluating self-deception, while the Other-Deception Questionnaire (Sackeim & Gur, 1978) is a useful tool for measuring impression management. Perhaps lying is more related to one of the two components of social desirability than it is to social desirability in general. Using instruments designed to measure the specific components of social

desirability in future studies may enable us to better understand the relationship between lying and constructs associated with social desirability.

Lying and Level of Coercion

No significant differences in the level of coercion involved in therapy (e.g., voluntary vs. mandated treatment) and lying or not lying to psychotherapists were found in the present study. The majority of participants indicated, however, that their therapy involved some, little, or no pressure from others (approximately 82%). Because the present study had limited data from individuals who had been mandated or significantly or strongly pressured to attend therapy (nearly 18%) , it is possible that a relationship between these variables does exist and was not detected due to the limited number of participants in this group.

Although no differences in lying/not lying and level of coercion involved in therapy were observed in the present study, one participant noted that s/he believed lying may be affected by the level of coercion involved in therapy. S/he remarked "I think that if someone volunteers to go to psychotherapy, it is to their advantage not to lie because they are obviously there to help themselves, however, when there are mandates set forth, then maybe the individual will be more apt to lie…" (see Appendix Y). Future research endeavors may benefit by including equal numbers of mandated and voluntary clients, in order to gather more accurate information on any potential relationship between lying/not lying and the level of coercion involved in therapy.

Number of Therapists Seen

The number of therapists seen by participants in the Lying group (an average of nearly 4 per person) was significantly higher than the number of therapists seen by

participants in the Non Lying group (an average of nearly 2.5 per person). Several possibilities might explain these results. First, it is possible that individuals who saw more therapists were more likely to report that they had previously lied to a therapist because they had had more opportunities to lie in therapy. One possible conclusion of these results, therefore, is that the likelihood of lying in therapy increases with the number of therapists seen.

Another explanation for the observed differences in number of therapists seen between participants in the Lying and Non Lying groups concerns satisfaction. If clients lie to their therapists as a result of poor therapeutic relationships and/or poor perceptions of therapists characteristics, perhaps they will be more likely to leave treatment and initiate therapy with a different therapist, in the hopes of finding a therapist whom they regard more highly. On a related note, if lying causes clients to not get the help they need in therapy and leads to dissatisfaction with treatment outcome, clients may decide to resume therapy with another therapist. Results of the present study, which demonstrated that participants who lied to their therapists reported being less satisfied with treatment outcome than participants who did not lie, lend some support to this possibility. In addition, participants' responses to open-ended questions indicated that some individuals believed that they did not receive the help they wanted in therapy as a result of having lied to their therapists. One participant noted that lying may have caused her/him to seek therapy with someone else, stating that "I realized that I'd eventually leave and try to get more work done with someone else. Things like this continued to pile up and I did leave" (See Appendix R).

Future studies wishing to learn more about lying in psychotherapy may wish to take number of therapists seen by participants into account. The possibility that number of therapists seen may serve as a confound might be controlled for by matching participants on number of therapists seen. It may also be helpful to explore whether or not lying (or poor therapy relationships and/or dissatisfaction with treatment outcome) causes clients to seek therapy with different therapists, in order to better understand why clients who lie to therapists tend to see more therapists than clients who do not lie.

Information from Individuals in the Lying Group

Individuals who indicated that they had previously lied to a therapist responded to some questions that were not asked of participants who indicated that they had not previously lied. The findings and implications of these questions are reviewed below.

Number of Therapists Lied to

For participants in the present study, it was not uncommon for individuals in the Lying group to report that they had lied to multiple therapists. More than one half of the sample had lied to more than one therapist, and one quarter of the sample indicated that they had lied to each therapist they had seen.

One possible explanation of the finding that participants who lied to one therapist were likely to indicate that they had lied to multiple therapists concerns the possibility that lying to one therapist may set a precedent to lie to other therapists, particularly if the lie "paid off" for the client. It is also possible that personality characteristics (such as defensiveness and/or a strong desire to please others) may make it likely that clients will lie to multiple therapists. Future studies may wish to assess perceived consequences (both positive and negative) of lying in psychotherapy, in order to examine perceived

effects of lying, beyond the impact on the therapeutic relationship and/or outcome. The personality traits and characteristics of clients (such as typical defense mechanisms used) should also be examined to identify their relationship to lying in psychotherapy.

Timing of Lies

Most of the participants in the Lying sample indicated that they first told a lie in therapy within the first one half of the duration of their relationships with their therapists: of the individuals who were able to remember approximately when they had first lied to their therapist, nearly a third reported that they had lied during the first session, and another one half of the participants lied at various other points within the first quarter of their treatment. Thus, for participants in the present study, lies were most likely to be first told within the first quarter of the duration of treatment, and many lies were told as early as the first therapy session.

The above results suggest that lying is likely to first occur early in the therapeutic relationship. These results support Bell and DePaulo's (1996) conclusions that individuals may be more likely to tell lies early in relationships. These authors suggested that lying may occur earlier in relationships in order to facilitate the development of the alliance. Another potential explanation for these results includes the fact that rapport is often not established at earlier points in the therapeutic relationship. A lack of rapport may influence clients' willingness to be completely truthful with therapists, while well-developed rapport (and the trust that accompanies good rapport) may serve as a buffer against lying once it has been established. One participant commented to this effect, noting "I believe in general lying and withholding decreases as the trust increases and as the relationship becomes stronger."

Anderson and colleagues (1999) provided additional explanations for the tendency to lie earlier in relationships. These authors suggested that individuals may be more likely to consider alternatives to lying in well-established relationships, as they may be more likely to get "caught" if they lie to someone who knows them well. Lying may also be perceived as posing a threat to established relationships, which may prevent individuals from lying to individuals whom they know well.

Lying and Relevance to Treatment

As noted above, most of the participants in the present study revealed that they had lied about something that was at least *somewhat relevant* to the problem for which they were seeking treatment. Over one half of the participants indicated that they lied about information that was either *highly relevant* or *relevant*, while another one-fourth indicated that they lied about material that was *somewhat relevant* to their treatment. Although a small percentage of participants stated that they lied about *not very relevant* information, no one indicated that they lied about information that was *not at all relevant* to their presenting problem. Overall, for participants in the present study, lies pertained to material that was relevant to the problem for which individuals were seeking treatment.

It is difficult to examine possible implications of the above findings, as participants in the present study were instructed to consider "the most significant lie" they had ever told a therapist, and to describe that lie and therapeutic relationship as they answered questions. Had this instruction not been included, perhaps individuals would have described lies that were less relevant to presenting problems. Thus, while it may be tempting to conclude from the present results that clients most often lie about

information that is relevant to their treatment, we must refrain from drawing any conclusion due to the limitations in generalizability resulting from the nature of the instructions participants were given. It is likely safe to conclude, however, that it is not uncommon for clients to lie about information that is relevant to the problems for which they seek treatment. Future studies interested in learning about the relevance of material lied about in therapy should avoid instructing participants to think about the "most significant" lie ever told in therapy, so that we can learn more about the relevance of lies being told in therapy without using instructions that bias clients to describe more relevant lies.

Consideration Given to Lies Told and Level of Prompting Involved in Lies

Nearly one half of the participants in the study indicated that the lies they told were completely spontaneous, and one half of them indicated that they had given some consideration to the lie prior to telling it. Almost one third of the participants decided to lie *prior to the session* in which the lie was told, and one fifth of the participants decided to lie *during the session* in which the lie was told. Most lies were told in response to a therapist question or comment: more than one half of the lies were prompted by a *direct* question from the therapist, and another fifth of the lies being described by participants were prompted by an *indirect* therapist question or comment. Thus, for participants in the present study, lies were rarely told spontaneously or without being prompted—it was typical for participants to lie after the therapist asked for information.

The present results—that lies in psychotherapy were most often told in responses to therapist prompts—are consistent with those of other researchers (Hample, 1980; Lippard, 1988; Metts, 1989), who studied lying outside of therapy. These scholars noted

that lying most often occurred in response to prompts, while a strategy of avoiding sharing information was more common when individuals were not prompted for responses. In a similar way, multiple participants in the present study alluded to a tendency to withhold or avoid sharing certain information with their therapists, rather than tell lies, when they were not prompted but did not want to discuss certain information. For example, one individual noted "I occasionally avoid sharing certain things that I'm ashamed or embarassed about," while another reported "Sometimes it's not a matter of lying per se -- but avoiding difficult topics. If the therapist does not probe in those areas, you may avoid them altogether…" (see Appendix Y). With respect to lying and prompting, therefore, it appears that lying in psychotherapy is similar to lying in relationships outside of therapy: lies typically follow prompts for information, while withholding information may be a more common strategy when individuals are not directly asked to reveal information.

Lying and Effects on Therapeutic Relationship

Just under one half of the participants in the Lying sample indicated that they believed lying *had* had an effect on their therapeutic relationships, and just over one half indicated that they *did not* believe lying affected the relationship. Thus, participants in the Lying group were almost equally divided in their beliefs of whether or not lying had impacted the therapeutic relationship.

When asked to describe how lying had impacted their relationships with their therapists, most of the participants who responded to this open-ended question indicated that their relationships had been affected in a negative way (see Appendix Q). Some of the negative themes that emerged from participants' responses included a decline or loss

of trust in the therapist, a loss of authenticity in the relationship, and/or feelings of frustration on part of the participants, therapists, or both. One participant indicated that lying "solidified for me that it wasn't going to be a very open and accepting relationship" and another stated "…I felt less respect for him…"

Although the majority of participants who indicated that lying had impacted their relationship felt that the impact had been a negative one, a couple of participants reported that they believed lying had positive effects on the therapeutic relationship. For example, one participant indicated that s/he felt the relationship was improved after "I ended up telling her and we talked about the relationship and what was going on that prompted me to lie." The other participant noted "…I paid extra attention to my motivation to improve in therapy and in this way the relationship actually improved…" For these participants, it appears that lying resulted in improvements because the client was able to process (either inter- or intrapersonally) the motivation behind the lie.

Results of the above findings suggest that, while lying in psychotherapy may often impact the therapeutic relationship, it might also do nothing to alter that relationship: for participants in the present study, one half believed that lying had affected therapy and one half did not believe lying had impacted therapy. For individuals who processed and worked through the underlying meaning of lying, some benefit to the relationship was reported. The majority of participants who noted that lying did influence the relationship, however, noted negative effects on the relationship. Clearly, the ways in which lying impacts therapeutic relationships differs among individuals. Whether or not (and how) lying affects clients' relationships with their therapists is a topic that merits further attention in research endeavors.

Lying and Effects on Therapy Outcome

Approximately one fifth of the participants in the Lying sample were unable to comment on whether or not they believed lying had impacted the therapeutic outcome, as they were still in therapy. Of the participants in the Lying group who had completed treatment with the therapist to whom they lied, the sample was divided almost equally in their responses to whether or not they believed lying had affected the therapy outcome: just under one half of these participants said that they believed therapy outcome had been impacted as a result of lying, and just over one half indicated that they did not believe therapy outcome had been impacted.

The majority of participants who indicated that they believed their therapeutic outcomes had been impacted as a result of lying in psychotherapy reported that they felt outcomes had been affected in negative ways (see Appendix R). One of the central themes that emerged in participants' responses concerned a sense that important issues were never adequately addressed, and that therapy was compromised or was not as effective as a result. For example, one participant noted that lying "prevented me from dealing with certain issues that are still problematic." Another stated that "the therapy would probably have been more effective if I had been able to tell the truth…" Several participants indicated that therapy was terminated early as a consequence of lying and the subsequent failure to develop meaningful connections with therapists.

Not all individuals believed that lying had impacted therapeutic outcome in a negative way: two participants believed that outcome may have been improved as a result of lying. Both of these individuals made reference to working hard in therapy after lying. For example, one individual stated "I examined my motives for lying and

resolved to tell the truth thereafter. I deliberately began to tell her everything I was ashamed of and began to resolve some longstanding issues."

The results of questions designed to gather information on participants' perceptions of the impact of lying on treatment outcome are similar to those described in the preceding subsection, where participants were nearly equally divided in their perceptions of whether or not lying had affected their relationships with their therapists. Nearly one half of the individuals in the Lying group who were able to respond to this question felt that lying had impacted outcome, while the other one half felt that lying had no impact on treatment outcome. Of those individuals who did believe lying affected treatment outcome, most participants felt that therapy outcome was compromised in some way. These results again suggest that, while lying in psychotherapy often has detrimental effects for clients, this is not necessarily always the case. Indeed, lying (in the perception of a client) may have no negative consequences, or may actually have a positive or helpful impact. It is clear, however, that lying can cause harmful and/or unhelpful consequences in therapy, in terms of how it impacts relationships and satisfaction with treatment outcome.

Lies Revealed to Therapists

The majority of participants in the Lying sample indicated that their lies were never revealed to their therapists. Of the one-third of participants in the Lying sample whose lies were revealed, almost all were exposed when participants voluntarily admitted that they had lied. Only one individual reported that his/her lie came to be revealed as a result of a therapist query. Thus, for participants in the present study, two-thirds of the lies told to therapists were never exposed. When lies were revealed to

therapists, clients typically admitted the lies voluntarily, as opposed to being questioned or "called out" by the therapist.

Based on the results of the present findings, it appears that lies told in psychotherapy are often never directly revealed to therapists. Whether or not these lies become apparent to therapists in other ways, however, remains an interesting topic for exploration.

Content of Lies Told to Therapists

For participants in the present study, the most common topic or general category of lies told to therapists included clients' relationships. For example, one individual noted that s/he lied about "how a particular relationship ended" while another indicated "I lied about the nature of the relationship I had with my roommate at the time…" After relationships, the categories of contents of lies most frequently cited by participants included (2) substance use, abuse, and/or dependence, (3) symptoms and symptom severity (e.g., magnifying or minimizing symptoms), (4a) thoughts and feelings (general), (4b) sex/sexual behavior, (5a) abuse (including involvement in abusive relationships and/or history of abuse), (5b) medication (including compliance with medication), and (5c) self-injury (e.g., whether or not they were engaging in self-injurious behaviors). Participants also indicated that they had lied about multiple other topics, including completion of therapy homework, eating behaviors/weight, thoughts and feelings about the therapist, and the referral concern. Participants' written responses to the question that asked them to describe the content of their lies may be found in Appendix N, a table of categories of lies is provided in Appendix M.

The content of information that participants lied about in psychotherapy are similar in some ways to the information that Pope and Tabachnick (1994) found clients in their study withheld from therapists. These authors found that participants in their study (therapists who themselves had been therapy clients) most frequently withheld information pertaining to sexual behavior, feelings about the therapist, personal history of abuse, engagement in substance abuse, eating disorder-related information, and the identity of third parties. Thus, for participants in both the present study and the Pope and Tabachnick study, information about sexual behavior and substance abuse was frequently lied about or withheld from therapists. Other scholars (e.g., Hill et al., 1993; Norton, Feldman, & Tafoya, 1974; Yalom, 1970) have found that clients often withhold information about sex, mental health, and failure. These results are also similar to those obtained in the present study: many participants reported that they lied about their symptoms (mental health); they also reported lying about progress towards goals (failure).

Because some common themes have emerged in the nature of material that clients report they tend to withhold and/or lie about in therapy, practitioners should be aware of these various "sensitive topics" in their work with clients. We can then normalize and validate clients' difficulties in being honest as we approach certain topics with them, so that they realize that it is common and perfectly acceptable for them to have difficulty sharing particular information with us. Furthermore, if we can convey to them that it may be in their best interest to be honest about anything that might be therapy-relevant, perhaps we can aide them in being truthful and forthcoming about difficult material.

It should be kept in mind that there may be instances in which clients are not yet ready or willing to share certain information with therapists. Practitioners of psychotherapy need to be mindful of this. It may be helpful to talk with clients about ways that they can let us know if we approach topics that they are not yet ready to discuss. By giving clients permission to let us know that they may not be ready to discuss particular information, we may reduce the probability that they will lie in therapy.

Motivation for Lying

Participants were asked to share their perceived motivations for lying to their therapists. Motivations for lying were categorized using DePaulo and colleague's (1996) classification of motives for lying in everyday life. As described in Chapter II, these authors broadly grouped motivations for lying as *self-oriented* (those told to benefit the self) or *other-oriented* (those told to benefit others). Self- and other-oriented lies were both further grouped into two separate categories of motivations for lying: lies told for *psychological reasons* and lies told for *reasons of personal advantage* (for self-oriented) or *for another person's advantage* (for other-oriented).

The overwhelming majority of motivations for lying described by participants in the present study were classified as self-oriented. Most of these self-oriented lies, furthermore, were told for psychological reasons, using DePaulo and colleagues' (1996) taxonomy of reasons for lying. As described in the review of the literature, such lies are told to:

> …protect the liars from embarrassment, loss of face, or looking bad; from disapproval or having their feelings hurt; from worry, conflict, or other

> unpleasantness, lies told to protect the liar's privacy; to make the liars appear better (or just different) than they are, and to regulate the liars' own feelings, emotions, and moods (p. 983).

After reviewing the self-oriented lies told by participants for psychological reasons, several themes emerged. One of these themes concerned lying in order to avoid discussing something that was too painful, or that clients were not ready to discuss. One participant noted, for example, "The original experience that I went to therapy for was too painful to actually talk about. It was much easier to talk about the made up experience instead."

The two most-often cited self-oriented motivations for lying for psychological reasons included (1) lying in order to protect oneself from shame, embarrassment, or humiliation and (2) lies told for social desirability/impression management reasons. Several participants reported that they lied to therapists in order to avoid feeling ashamed or embarrassed. One individual stated that they had lied because s/he was "ashamed of telling the truth about how the relationship ended," and another cited "embarrassment and shame" as his or her motive for lying. Many individuals also noted that they lied in order to present themselves in a different or more positive way. For example, one individual reported "not wanting to look like I needed to control things" while another said "wanted to look good." It should be noted that although social desirability and impression management were cited as motivating clients to lie, the social desirability scores of participants in the Lying group did not differ significantly from those of individuals in the Non Lying group.

Although not as commonly cited as psychological reasons, several participants described self-oriented lies told for personal advantage as motivating them to lie in psychotherapy. Some individuals wanted to avoid potential consequences/punishments of truth-telling, such as raised fees, hospitalization, or termination of therapy. One participant, for example, reported that his/her motivation for lying was that "…she had drafted a no-harm contract stating that if I had self-harmed, and I had not tried to contact her for help first, our therapeutic relationship would end." In addition to lying to avoid consequences, other self-oriented lies told for personal advantage involved lying to get sympathy and attention, to have an ally, and to direct the course of conversation to something the client was more interested in discussing. One interesting comment came from a participant who reported "I did not want her to know how well she was getting to know me, so I would often tell her she was wrong about her hypotheses that were actually correct."

Although the majority of motives for lying described by participants were self-oriented, some of the reasons for lying would be classified as "other-oriented" using DePaulo and colleagues' taxonomy. As described in the literature review, such lies are told "to protect or enhance other persons psychologically or to advantage or protect the interests of others" (DePaulo et al, 1996, p. 983). Several participants noted that a desire to avoid worrying or disappointing the therapist provided an impetus for them to lie. One participant observed, for example, "I was aware of (a) not wanting him to worry…" as one reason s/he had lied, and another noted "…did not want her to be concerned…" Several other individuals echoed that concerns of worrying or disappointing their therapists had at least partially motivated them to lie. These other-oriented lies would be

classified as told for psychological reasons using DePaulo and colleagues' (1996) categorization of reasons for lying. Appendix O lists participants' written responses to the question that asked them to describe their perceived motivations for lying.

Motivations for lying described by participants in the present study closely mirror those suggested by Rankin (1990). This author suggested that lying in psychotherapy may be motivated by several forces, including an inability to deal with anger, fear of being reprimanded by the therapist, a desire to please the therapist, and in order to avoid feeling shame. The latter three motivations described by Rankin were endorsed by multiple participants in the present study.

Therapist/Therapeutic Relationship Characteristics

Participants were asked to report what characteristics of their therapists and/or relationships with their therapists influenced their decisions to lie. As described in the preceding chapter, participants' responses to this LPS question were classified as positive, negative, and neutral characteristics. *Positive characteristics* were those that implied helpful, constructive, and/or other qualities typically perceived as beneficial, *negative characteristics* were those that implied unhelpful, harmful, and other qualities typically perceived as unconstructive, and *neutral characteristics* had neither positive nor negative implications. Positive, negative, and neutral therapist and relationship qualities were almost equally described by participants in the present study (see Appendix P). Thus, while it was suspected that clients would typically report that negative characteristics had impacted their decisions to lie to their therapists, positive and neutral characteristics were cited almost as frequently as negative characteristics for participants in the present study.

The general theme of the positive factors participants cited as influencing their decisions to lie to their therapists concerned having good relationships with the therapists that clients did not want to injure. Lying, according to these responses, was intended to protect the therapist's positive images of their clients. For example, one participant noted "A high level of trust and therapist's positive perceptions of me – I didn't want to be a 'bad' client." as influencing his/her decision to lie and another noted "I really wanted to present as better than I was because I really liked her and respected her opinion. Therefore the thought of her thinking of me as sick was unbearable…" Other positive therapist qualities influencing participants' decisions to lie included "…a genuine concern for me" and "caring and understanding."

Lack of trust and/or rapport emerged as two general themes noted by participants as negative factors in the *therapeutic relationship* that influenced lying. Therapist *characteristics* included failure to show unconditional positive regard or provide adequate comfort to clients, as well as being judgmental, condescending, "confrontive," and/or "too eager to give advice and too quick to positively reframe my negative experiences." One participant, for example, stated that his therapist "was smug and talked about herself all the time. She would tell me how great she was…and was completely unethical…" Another noted "She was VERY confrontive from the first session and I felt she was trying to push decisions on me..." Comments such as this support Marcos' (1970) assumption that non-accepting and punitive therapists may cause clients to be more likely to lie to their therapists. Rankin's (1990) notion that lying might occur when clients have not developed trust with their therapists was also supported by participants in the present study.

In terms of neutral responses, some of therapist and therapeutic relationship characteristics that emerged as themes included the age and gender of therapists, the timing in the relationship (early or near termination), and not knowing the therapist well. For some individuals, having factors in common with the therapist (such as age, gender, personality, and graduation from the same program) was cited as influencing participants' decisions to lie, while in other cases having different demographic characteristics than the therapist (e.g., gender) was cited as influencing lying.

Thus, for individuals in the present study, positive, negative, and neutral therapist and therapeutic relationship characteristics were noted in nearly equal frequencies as factors that influenced participants' decisions to lie in therapy. These results suggest that, while negative characteristics—such as a "cold demeanor" and "smug" attitude—can impact clients' honesty, positive characteristics—such as warmth and good rapport—may be equally influential, as might "neutral" factors, such as the demographic characteristics of the therapist. However, it does appear that therapist and therapeutic relationship characteristics, whether they are positive, negative, and/or neutral, can certainly impact clients' decisions to lie in psychotherapy.

Future studies wishing to learn more about the influence of therapist and therapeutic relationship characteristics on lying should gather more information on therapist/therapeutic relationship variables that are perceived (by clients) to be related to lying. Gathering information on "neutral" qualities (such as the time in the relationship during which the lie was told, the age, gender, and ethnicity of the client and therapist) may also be useful, in order to examine how these factors might be associated with lying in psychotherapy. In addition, using multiple measures (e.g., using open-ended

questions and validated quantitative instruments) may be helpful, as it is possible that there are some characteristics that may be related to lying in psychotherapy that are beyond the client's awareness. For example, while clients may understand that a condescending demeanor influenced their decision to lie to their therapist, it is possible that age or gender differences could also be related to lying in psychotherapy, without the clients' understanding that this is the case.

Information from Individuals in the Tempted Group

Individuals who reported that they had never previously lied to a therapist but had been *tempted* to lie in therapy were asked some questions similar to those asked of individuals in the Lying group, in order to gather information on what causes individuals to be tempted to lie in therapy and what prevents them from lying when they are tempted (see Appendix E). Although results were reviewed in Chapter IV, they are briefly reviewed, and implications of these results are discussed, below.

What Participants Were Tempted to Lie About

The information that participants in the Tempted group reported that they had been tempted to lie about was similar in content to that of individuals in the Lying group (see Appendixes U & V). One notable exception was the fact that individuals in the Tempted group noted that they were most frequently tempted to lie about their families or family members, while no individuals in the Lying group made specific reference to family members. Sexual behaviors, substance abuse, symptom severity, and relationships were described as information that some of the individuals in the Tempted group refrained from lying about with their therapists.

Appendix V lists the content that individuals in the Lying group lied about, along with the content that individuals in the Tempted group were tempted to lie about. In this way, patterns in the type of material that participants lied about and were tempted to lie about could be examined. Relationships, substance use, symptom severity, and sexual behavior emerged as the four largest groups of content in regards to material that participants either lied about or were tempted to lie about in psychotherapy. It appears that, for participants in the present study, information that individuals were *tempted* to lie about was similar in nature to the material that participants in the Lying group *did* lie about. Again, these results are similar to the findings of individuals who have studied withholding information and similar concepts in psychotherapy (e.g., Hill et al., 1993; Norton, Feldman, & Tafoya, 1974; Pope & Tabachnick, 1994; Yalom, 1970).

What Prevented Lying When Tempted

Participants in the Tempted group were asked to describe what had prevented them from lying to their therapists when they were tempted to do so (see Appendix W). The predominant theme that emerged in their responses to this question concerned a belief that lying would result in unhelpful consequences. Participants observed, for example, that they considered lying as an option but decided it might damage the quality of the therapeutic relationship, prevent them from making progress or getting the help that they needed, or cause them to feel guilty. The fear that therapy would somehow be compromised as a result of lying was frequently noted by individuals in this group. One participant noted, for example, that "It was what I was really seeking therapy for, so even though it was scary, I thought I'd be wasting my time if I didn't tell the counselor." Another noted "I reminded myself that the therapist could help me better if she knew the

whole story." A related theme of values and personal standards was cited by several individuals as preventing lying when tempted to do so. For example, one participant stated that a "need to be truthful" prevented him/her from lying, while another cited "personal standards."

Some participants in the present study did not lie when they were tempted to do so because the information they were tempted to lie about was never discussed in therapy. One participant noted "I had decided not to disclose information about the romantic/sexual piece of the relationship I was in, and that I would lie if directly confronted or challenged by my therapist. I was not/have not been so challenged." Another individual noted that s/he had been able to avoid lying by avoiding the topic s/he was tempted to lie about. For these individuals, lying did not occur because particular topics were never brought up in therapy.

Two participants in the Tempted group cited therapist traits as helping them avoid lying. One reported that "trust and the therapeutic alliance" had prevented him/her from lying, and the other described a sense that the therapist was genuinely interested in him/her, had well-developed rapport in the relationship, and "the fact that he didn't give me too many opportunities to actually speak in the therapy session."

Therapist/Therapeutic Relationship Characteristics that Influenced Truth-Telling

Participants in the Tempted group were asked to indicate what (if any) qualities of the therapist and/or the therapeutic relationship had influenced them to tell the truth in a situation in which they were tempted to lie. Most of the responses to this item made reference to positive therapist/therapeutic relationship qualities (see Appendix U). For example, one participant noted that his/her therapist was "patient and non-judgmental

and caring," which "gave me confidence that the information would not be used inappropriately." Thus, although therapist and therapeutic relationship factors were not frequently cited when participants were asked what had prevented them from lying when tempted in general (see "What Prevented Lying when Tempted," above), most participants noted that some therapist/relationship characteristics had impacted their avoidance of lying when they were asked this specific question.

The most frequently noted quality of the therapist and/or therapeutic relationship described by participants as influencing truth-telling in a situation in which they were tempted to lie concerned trust. Several participants reported that they felt their therapists and/or therapeutic relationships could be trusted, which helped them be honest when they were tempted to lie. For example, one participant noted "Basically, I trusted her." and another indicated that "…trust in the relationship that had been established" helped her/him be honest in a situation in which they were tempted to lie. Therapist qualities such as being nonjudgmental, caring, and supportive were cited as influencing truth telling, and "well-established rapport" was also noted by multiple participants as a positive quality of the relationship that facilitated truth-telling. Participants also indicated that qualities such as openness, honesty, generosity, warmth, empathy, a sense that the therapist had "genuine interest," in them, and feelings of safety as factors that influenced truth-telling.

Several participants in the Tempted group noted that negative therapist/ therapeutic relationship characteristics had influenced their initial temptation to lie. For example, one noted "I wish I had lied. The therapist was demeaning and not helpful to

my true problems," and another noted that "the therapist's characteristics influenced me to want to lie."

Participants' perceptions of therapist/therapeutic relationship characteristics that facilitated truth-telling are somewhat encouraging: they suggest that, at least on some occasions, therapists have some influence in helping their clients be honest and, hopefully, get the help that they need by discussing important (yet sensitive and/or painful) topics. When therapists work with their clients to develop rapport and create safe, supportive environments, it seems that clients may be more likely to be truthful when they are tempted to be dishonest. In some cases, it seems, good rapport and trusting relationships may serve as a buffer to help prevent dishonesty.

Responses to Optional Question

After completing the LPS, TSS, ARM, and SDS-17, participants were given the opportunity to offer feedback. An item at the end of all other surveys instructed "Please feel free to add any additional thoughts you have which might help us better understand lying in psychotherapy."

Although the final item in the LPS was optional, many participants responded (see Appendix Y). Responses varied widely in nature, and included individuals wishing the researcher "good luck," providing critical feedback on the nature of the surveys, and sharing opinions and information on lying in psychotherapy. Responses that included critical feedback and/or participants' own thoughts and experiences with lying in psychotherapy are described throughout this chapter.

Limitations

Although limitations of the present study have been discussed throughout this chapter, additional limitations merit attention. One noteworthy limitation concerns response rate: only 7.3% of individuals who were invited to participate in the present study responded to the survey. This response rate was lower than those obtained by other researchers, such as Fricker, Galesic, Mourangeau, & Yan, (2005) and Kaplowitz, Hadlock, & Levine (2004). These authors utilized web-based survey methodology and obtained response rates of 20% and 50%, respectively, in their studies.

In addition to the poor response rate, the high dropout rate in the present study served as a limitation. Of the 191 participants who began to take the surveys, 53 (27.7%) stopped taking the survey after answering only the first four questions. While it is unknown what caused respondents to discontinue taking the survey, it is also unknown how these individuals may have differed from the individuals who completed all four surveys. It is possible that the individuals who dropped out differed in some significant way from those who finished, which may have caused potentially valuable information to be lost. It is also possible that individuals who decided to participate differed in significant ways from individuals on the APAGS listserv who chose not to participate.

The present study utilized self-report instruments (four surveys), and suffers from the same limitations of similar self-report instruments, including social desirability and distorted perceptions resulting from the passage of time (including forgetting). Although a social desirability scale (the SDS-17, Stoeber, 2001; see Appendix I) was included to help control for social desirability effects, that scale is an obvious measure of social desirability, and may not have picked up on participants' true levels of social

desirability. On a related note, participants in the present study were asked to talk about a subject—lying—that is, in general, condemned in society. They were also asked to talk about personal topics, such as their experiences in psychotherapy, which are sensitive and highly personal matters. All of these factors make it possible that social desirability effects may have influenced the present results. As described earlier in this chapter (see "Lying and Social Desirability" subsection) less obvious measures of social desirability may be used in future studies in order to more accurately examine the relationship between this characteristic and lying in psychotherapy.

One of the major limitations of the present study involves the retrospective nature of survey questions. Most of the participants (98 of 109, or 89.9%) indicated that they were describing a therapeutic relationship that had occurred in the past. Although individuals were not asked how much time had elapsed between the time their therapy had terminated and the time they took the study, it is possible that some participants were describing therapy that occurred many years ago. One participant commented to this effect, stating "Because I am 55 years old and went to therapy the first time at age 23 I could not remember details from that long ago." Clearly, the information being presented could have been distorted by forgetting and/or other maturation effects. As a result, it is recommended that future studies attempt to minimize problems related to forgetting and distorted memories by utilizing samples of individuals who have recently completed therapy.

Another factor related to distorted memories and/or forgetting involves the instructions given to participants as they took the TSS and ARM. Individuals who had lied to their therapists before and those who had been tempted to lie were asked to

respond to items on the TSS and ARM in terms of how they felt about their therapists and therapeutic relationships *just prior to the time they lied or were tempted to*. Asking them to do this presupposed that (1) the individuals remembered how they were feeling before lying or being tempted to lie and (2) the outcome of therapy would not have biased participants' abilities to be accurate about how they had been feeling prior to lying or being tempted to lie. In reality, it is possible that individuals' responses to the ARM and TSS were influenced by forgetting, whether or not they lied, and/or treatment outcome. It is possible, for example, that participants may have presumed that because they lied or had poor treatment outcomes, this was indicative that they did not have a good relationship with their therapist. One participant commented on her/his difficulty in being unbiased about how s/he felt prior to lying, noting "the relationship ended on a really bad note and thus may affect my objectivity!" It should therefore be noted that responses on the TSS and ARM may not have accurately reflected how individuals felt just prior to the time they lied or were tempted to lie, which might limit our ability to use these instruments to predict lying/not lying to therapists.

The differential instructions given to participants (based on whether they indicated that had previously lied, had not lied but had been tempted, or had never lied and never been tempted to lie) on the ARM posed another problem for the current study. Individuals who had lied or been tempted to lie were asked to reflect on how they felt *just prior* to the time they lied or were tempted to lie to their therapists, while individuals who had never lied and never been tempted to lie were asked to describe how they felt about their therapists and therapy experiences *in general*. Asking participants to answer items in these surveys differentially (at different points in the course of their therapy)

may have affected the validity of the results. Future studies should use the same standard of comparison (e.g., ask participants to reflect upon the same stage of the therapeutic relationship) in order to increase validity.

An additional limitation in regards to the surveys utilized in the present concerns the order in which the surveys were presented. All participants first responded to the Lying in Psychotherapy Survey, followed by the Therapist Satisfaction Scale, the Agnew Relationship Measure, and the Social Desirability Scale-17. It is possible that this order biased participants' responses. Answering questions about lying in psychotherapy, for example, may have negatively biased participants' responses to the TSS and ARM. Spending time and energy reflecting on lying in psychotherapy may have negatively impacted participants' perceptions of their therapists and therapeutic relationships, particularly for those participants who indicated that they did not get the help they received as a result of having lied in therapy. Future studies exploring lying and related phenomena in psychotherapy will do well to randomize the order of surveys in order to decrease the likelihood of order effects impacting results.

A major limitation of the present study is related to the participants who provided information on lying in psychotherapy: graduate students in psychology and related fields who were members of the APAGS listerv. All of the individuals in the present sample possessed an undergraduate degree (presumably, many possessed Master's or other post-graduate degrees as well), and all were seeking a post-graduate degree in psychology or a related field. Most of the participants were white women, and the average age was 31 years old. It is therefore obvious that the present sample was not representative of the general population who engages in counseling and psychotherapy,

in terms of age, education, race, gender, and career. This sample likely differs from the general population of individuals who undergo psychotherapy on other important variables, including socio-economic status and level of functioning. As a result, the results of this study may be limited in generalizability.

The present study did not obtain information on demographic characteristics of the therapists that participants lied or did not lie to. Therefore, it was unclear how various therapist characteristics, such as the race, sex, and/or age, were related to whether or not participants lied or did not lie to their therapists. Several participants, however, made comments to the effect that such variables did impact their decisions to lie or not lie. For example, one participant noted "he was the first consistent and healthy male I had in my life…In retrospect, it was not due to any characteristics particular to him, other than his gender…" Another, in response to the optional question that asked participants for feedback on lying in psychotherapy stated "It may also depend on the demographics of the therapist" (see Appendix Y). It is therefore recommended that future studies should obtain information on therapist and client demographic characteristics, in an attempt to see if therapist and client similarities and/or differences on demographic variables are related to lying in psychotherapy. In a similar manner, it may also be useful to gather data on therapeutic approaches utilized by therapists, in order to examine if various theoretical orientations and interventions are related to lying/not lying, as was suggested by several participants in the present study (e.g., "She tended to be more supportive as opposed to psychodynamic.").

The definition of the term "lie" (described to participants in the introduction to the LPS; see Appendix B) may have introduced another limitation in the study. This

definition described lies as "statements (written or spoken)…which you knew at the time were not true." Some participants taking the survey were clearly confused by this definition, and multiple individuals commented on the lack of clarity in the definition in the optional question at the end of the surveys. For example, one individual noted "I wasn't sure if lying included intentionally leaving out info or exaggerating info in order to impress an idea or keep the therapist from discovering something. This was more common for me than giving an outright lie." Thus, future researchers may wish to consider differentiating between exaggerations, "outright lies," and various forms of withholding information.

Implications for Psychologists

Based on the results of the present study and information obtained from the literature on lying in everyday life and lying in psychotherapy specifically, it is evident that it is not uncommon for clients to lie to therapists. Furthermore, clients' decisions to lie can be impacted by their perceptions of therapists and their relationships with their therapists. How can the awareness that lying in psychotherapy is a common occurrence be useful to educators and practitioners of psychotherapy? What should practitioners of psychotherapy do when they believe that clients are lying?

Several authors have commented on the ways that lying in psychotherapy might be approached and dealt with in therapy. Newman and Strauss (2003), for example, recommended collecting information from a variety of sources (e.g., family members, previous clinicians, and clinical records) in order to gather data for more accurate clinical conceptualizations. These authors also suggested interventions for approaching

clients who are suspected of lying, including acknowledging feeling "stuck" or confused when clients' reports are not consistent with the therapists' observations, asking clients to review and restate their goals for therapy, and providing clients a "face-saving" opportunity to resume being truthful. This last method can be accomplished by avoiding shaming the client, and giving the client the opportunity to provide honest information without calling attention to the lie and/or empathizing with and validating the client's difficulty in sharing certain material with the therapist.

Newman and Strauss's additional recommendations for working with clients who are suspected of lying in psychotherapy included staying focused on therapeutic goals and using non-threatening ways to let clients know they are suspected of being dishonest. For example, they suggested that a therapist might say "I have a favor to ask of you. If there's something you would rather not tell me, please tell me so, and I'll respect that and back off. That's much better than having you tell me what you think I want to hear, because that will send me down the wrong path and render me less helpful to you" (p. 249). Approaching clients in such non-threatening ways, the authors suggested, can help them feel more accepted and may even improve the therapeutic alliance. Three final strategies identified by Newman and Strauss include being willing to work things out in order to regain trust with the client, conveying very high expectations of clients (in order to examine if clients are looking for a "free pass through therapy" or are legitimately invested in their treatment), and consulting with colleagues.

While authors such as Newman and Strauss (2003) give useful information on how to address and deal with lying *after* it has occurred in psychotherapy, it may be helpful to address what practitioners can do to help avoid the phenomenon from

occurring in the first place. Although we know that lying is a typical symptom of some psychiatric diagnoses and psychological problems (such as Munchausen syndrome and Cluster B personality disorders), there are instances when lying is not associated with any particular disorder and is more closely related to situational factors, such as therapist and/or therapeutic relationship characteristics. In cases such as this, whether or not a client chooses to lie to a therapist may be more under the practitioners' control than it was previously thought to be.

As described early in this chapter (see the "Hypothesis One" subsection), implications of the findings of the present study include a need for practitioners to be aware of how they are perceived by clients. There are multiple ways that therapists can attempt to learn how they are perceived by clients: they can invite and encourage client feedback during therapy or follow-up sessions, and they can ask clients to fill out surveys (such as the TSS or ARM) anonymously. Live and/or taped supervision may provide therapists the opportunity to receive feedback on how they are perceived from other mental health professionals.

In addition to becoming aware of how they are perceived by clients, it is important that therapists endeavor to create a safe and supportive atmosphere of trust with clients. Consistently and genuinely communicating—through verbal and non-verbal behavior—the notion that we do and will continue to like, accept, and respect our clients despite anything they may say to us might help decrease the possibility that they will lie to therapists in order to avoid the (perceived) possibility of disappointing them.

Normalizing and validating the desire to lie, omit, and/or withhold information from therapists may be another important step towards facilitating honesty in therapy.

Clients need to understand that it is normal (and valid) for them to be tempted to withhold information from us in therapy. In this way, they can realize that desiring to withhold information and/or lie in therapy is a normal part of the therapeutic process that can be worked through. One participant in the present study commented to this effect, stating "If the therapist can set out that sometimes patients omit some things or change things for the therapist, it may normalize it and also make it something they can talk about if it comes up." It may thus be helpful, in the beginning of the therapeutic relationship, to talk with clients about the various ways they can talk to us or express discomfort when they do not feel ready and/or safe to share particular information with us. By doing so, we may teach clients that we respect their boundaries with regard to sensitive information. This may also help clients understand how to approach or communicate with therapists when they are not ready to divulge certain information.

Therapists may need to practice ways that they can non-critically approach clients when they are informed by clients that they are not yet ready to divulge information and/or they (therapists) suspect that clients are not being completely honest in therapy. One participant in the present study noted that s/he felt safer to be honest in therapy after receiving supportive feedback from her/his therapist, noting "I did not lie to my counselor, but I did withhold some details which I felt were too shameful, and I admitted this to her. She encouraged me to tell her those details when I was ready, which I felt was the perfect response" (see Appendix Y). Practitioners who are sensitive, supportive, and non-defensive with clients who may be having difficulty being open and honest in therapy may facilitate honesty and openness in their clients.

An additional consideration that merits attention concerns the notion that lying may not always be bad or harmful for clients, the therapeutic relationship, and/or the therapy outcome. Although society in general condemns lying, and although most practitioners of psychotherapy would agree that being honest with one's self and one's therapist is typically a goal that should be strived for, it is possible that lying is not always a negative or hurtful event, as suggested by several participants in the present study.

One clear implication of the present study for individuals practicing, teaching, and researching counseling and psychotherapy is that the topic of lying in psychotherapy merits further attention in practice and research endeavors. We need to learn more about causes and consequences of lying in psychotherapy in order to develop a deeper understanding of the implications of lying to therapists, and in order to help our clients most effectively.

Conclusions

As suggested by results of the present study and authors such as Gediman and Lieberman (1996) and Miller (1992), it is evident that lying in psychotherapy is not an unusual phenomenon. Although there are likely many instances where client lying in completely beyond the control of the therapist, it appears that clients sometimes lie to therapists as a result of the ways that clients perceive their therapists and their therapeutic alliances. Relationship characteristics, such lack of trust or rapport, and relationships in which clients do not perceive their therapists to have unconditional positive regard for them, can influence clients' decisions to lie to their therapists. One

potential consequence of lying, as described by multiple participants in the present study, is that clients may not get the help they need in therapy. Satisfaction with treatment outcome may also be compromised as a result of lying in psychotherapy.

Individuals who practice counseling and psychotherapy need to be aware of the various personal and relationship characteristics that influence whether or not clients choose to lie to their therapists, so that they can work to create situations that foster a feeling of safety in being honest among their clients. In order to maximize our effectiveness and helpfulness to our clients, it will serve us well to strive to show unconditional positive regard with our clients, and to model and foster openness and honesty in the therapeutic relationship. We need to normalize the temptation to withhold information or provide false information, and convey (through words and actions) the message that clients will be supported no matter what they may say to us in therapy. If we are successful in being open, supportive, and honest with our clients, we may facilitate their ability to be honest with us and get the help they need and deserve in psychotherapy.

REFERENCES

Ackerman, S.J., Benjamin, L.S., Beutler, L.E., Gelso, C.J., Goldfried, M.R., Hill, C., et al. (2001). Empirically supported therapy relationships: Conclusions and recommendations of the Division 29 Task Force. *Psychotherapy, 38,* 495-497.

Adler, J. (1997). Lying, deceiving, or falsely implicating. *The Journal of Philosophy, 94,* 435-452.

Agnew-Davies, R., Stiles, W.B., Hardy, G.E., Barkham, M., & Shapiro, D.A. (1998). Alliance structure as assessed by the Agnew Relationship Measure (ARM). *British Journal of Clinical Psychology, 37,* 155-172.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

Anderson, D.E., Ansfield, M.E., & DePaulo, B.M. (1999). Love's best habit: Deception in the context of relationships. In P. Philippot & R.S. Feldman, (Eds.), *The social context of nonverbal behavior: Studies in emotion and social interaction.* (pp. 372-409). New York: Cambridge University Press.

Ary, D., Jacobs, L., & Razavieh, A. (1996). *Introduction to research in education.* Orlando, FL: Harcourt Brace & Company.

Barnes, J.A. (1994). *A pack of lies.* Cambridge: Cambridge University Press.

Bell, K.L., & DePaulo, B.M. (1996). Liking and lying. *Basic and Applied Social Psychology, 18,* 243-266.

Bilney, C., & D'Ardenne, P. (2001). The truth is rarely pure and never simple: A study of some factors affecting history-sharing in the GUM clinic setting. *Sexual and Relationship Therapy, 16,* 349-364.

Blum, H.P. (1983). The psychoanalytic process and analytic inference: A clinical study of a lie and loss. *International Journal of Psycho-Analysis, 64,* 17-33.

Briggs, S.R., Cheek, J.M., & Buss, A.H. (1980). An analysis of the Self-Monitoring Scale. *Journal of Personality and Social Psychology, 38,* 679-686.

Brody, S. (1995). Lack of evidence for transmission of human immunodeficiency virus through vaginal intercourse. *Archives of Sexual Behavior, 24,* 383-393.

Bok, S. (1978). Lying: Moral choice in public and private life. New York: Pantheon Books.

Borkenau, P., & Ostendorf, F. (1992). Social desirability scales as moderator and suppressor variables. *European Journal of Personality, 3,* 31-45.

Burgoon, M., Callister, M., & Hunsaker, F.G. (1994). Patients who deceive: An empirical investigation of patient-physician communication. *Journal of Language and Social Psychology, 13,* 443-468.

Bussey, K. (1999). Children's categorization and evaluation of different types of lies and truths. *Child Development, 70,* 1338-1347.

Camden, C., Motley, M.T., & Wilson, A. (1984). White lies in interpersonal communication: A taxonomy and preliminary investigation of social motivations. *The Western Journal of Speech Communication, 48,* 309-325.

Conte, H.R., Buckley, P., Picard, S., Karasu, T.B. (1994). Relations between satisfaction with therapists and psychotherapy outcome. *The Journal of Psychotherapy Practice and Research, 3,* 215-221.

Conte, H.R., Plutchik, R., Buckley, P., Spence, D.W., Karasu, T.B. (1989). Outpatients view their psychiatric treatment. *Hospital and Community Psychiatry, 40,* 641-643.

Conte, H.R., Ratto, R., Clutz, K., & Karasu, T.B. (1995). Determinants of outpatients' satisfaction with therapists: Relation to outcome. *Journal of Psychotherapy Practice and Research, 4,* 43-50.

Costa, P.T. Jr., & McRae, R.R. (1992). *Revised NEO Personality Inventory (NEO PI-R) and NEO Five Factor Inventory: Professional Manual*. Odessa, FL: Psychological Assessment Resources.

Crowne, D.P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology, 24,* 349-354.

Davidoff, E. (1942). The treatment of pathological liars. *Nervous Child, 1,* 358-388.

Dearing, R.L., Maddux, J.E., & Tagney, J.P. (2005). Predictors of psychological help seeking in clinical and counseling psychology graduate students. *Professional Psychology: Research and Practice, 36,* 323-329.

DePaulo, B.M, & Bell, K.L. (1996). Truth and investment: Lies are told to those who care. *Journal of Personality and Social Psychology, 71,* 703-716.

DePaulo, B.M., Epstein, J.A., & Wyer, M.M. (1993). Sex differences in lying. In M. Lewis & C. Saarni (Eds.). *Lying and deception in everyday life.* (pp. 126-147), New York: The Guilford Press.

DePaulo, B.M., & Kashy, D.A. (1998). Everyday lies in close and casual relationships. *Journal of Personality and Social Psychology, 74,* 63-79.

DePaulo, B.M., Kashy, D.A., Kirkendol, S.C., Wyer, M.M., & Epstein, J.A. (1996). Lying in everyday life. *Journal of Personality and Social Psychology, 70,* 979-995.

DePaulo, B.M., Wetzel, C., Sternglanz, W., & Wilson, M.W. (2003). Verbal and nonverbal dynamics of privacy, secrecy, and deceit. *Journal of Social Issues, 59,* 391-411.

Deutsch, H. (1982). On the pathological lie (*pseudologia phantastica*). *Journal of the American Academy of Psychoanalysis, 10,* 369-386. (Original work published 1923)

Ekman, P. (1992). *Telling lies: Clues to deceit in the marketplace, politics, and marriage.* New York: WW Norton.

Eysenck, H.J., & Eysenck S.B.G. (1991). *Manual of the Eysenck Personality Scales (EPS Adult).* London: Hodder and Stoughton.

Fenichel, O. (1954). The economics of pseudologia fantastica. In H. Fenichel and D. Rapaport (Eds.), *The collected papers of Otto Fenichel, second series.* (pp. 129-140). New York: Norton.

Fenigstein, A., Scheier, M.F., & Buss, A.H. (1975). Public and private self-consciousness: Assessment and theory. *Journal of Consulting and Clinical Psychology, 43,* 522-527.

Ford, C.V. 1996. *Lies! Lies! Lies! The psychology of deceit.* Washington, DC: American Psychiatric Press, Inc.

Ford, C.V., King, B.H., & Hollender, M.H. (1988). Lies and liars: Psychiatric aspects of prevarication. *American Journal of Psychiatry, 145,* 554-562.

Fricker, S., Galesic, M., Tourangeau, R., & Yan, T. (2005). An experimental comparison of web and telephone surveys. *Public Opinion Quarterly, 69,* 370-392.

Friedl, E. (1962). *Vasilika: A village in modern Greece.* New York: Holt, Rinehart & Winston.

Frued, S. (1913). Two lies told by children. *Collected papers, Vol. 2* (pp. 144-149). New York: Basic Books.

Gediman, H.K., & Lieberman, J.S. (1996). *The many faces of deceit: Omissions, lies, and disguise in psychotherapy.* Northvale, NJ: Jason Aronson Inc.

Gilsenan, M. (1976). Lying, honor, and contradiction. In Kapferer, B. (Ed.), ASA essays in social anthropology: Vol 1. Transaction and meaning: Directions in the anthropology of exchange and symbolic behavior. (pp. 191-219). Philadelphia: Institute for the Study of Human Issues.

Glenn, S.S. (1983). Maladaptive functional relations in client verbal behavior. *The Behavior Analyst, 6,* 47-56.

Goffman, E. (1959). *The presentation of the self in everyday life.* New York: Doubleday.

Grover, S. (1993). Why professionals lie: The impact of professional role on reporting accuracy. *Organization Behavior and Human Decision Processes, 55,* 251-272.

Hample, D. (1980). Purposes and effects of lying. *The Southern Speech Communication Journal, 46,* 33-47.

Hantoot, M.S. (2000). Lying in psychotherapy supervision: Why residents say one thing and do another. *Academic Psychiatry, 24,* 179-187.

Hill, C.E., Thompson, B.J., Cogar, M.C., & Denman, D.W. (1993). Beneath the surface of long-term therapy: Therapist and client report of their own and each other's covert processes. *Journal of Counseling Psychology, 40,* 278-287.

Holzman, L.A., Searight, H.R., & Hughes, H.M. (1996). Clinical psychology graduate students and personal psychotherapy: Results of an exploratory survey. *Professional Psychology: Research and Practice, 27,* 98-101.

Horvath, A.O., & Greenberg, L.S. (1986). The development of the Working Alliance Inventory. In L.S. Greenberg & W.M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 529-556). New York: Guilford Press.

Horvath, A.O., & Greenberg, L.S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36,* 223-233.

Horvath, A.O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 61,* 561-573.

Huck, S. C. (2000). *Reading statistics and research* (3rd ed.). New York: Addison Wesley Longman, Inc.

Kaplowitz, M.D., Hadlock, T.D., & Levine, R. (2004). A comparison of web and mail survey response rates. *Public Opinion Quarterly, 68,* 94-101.

Karpman, B. (1953). Lying. In E. Podolsky (Ed.), *Encyclopedia of aberrations: A psychiatric handbook* (pp. 288-300). New York: Philosophical Library.

Kashy, D.A., & DePaulo, B.M. (1996). Who lies? *Journal of Personality and Social Psychology, 70,* 1037-1051.

Kelly, A.E. (1998). Client's secret-keeping in outpatient therapy. *Journal of Counseling Psychology, 45,* 50-57.

Kelly, A.E. (2000). Helping construct desirable identities: A self-presentational view of psychotherapy. *Psychological Bulletin, 126,* 475-494.

Kivlighan, D.M., & Shaughnessy, P. (2000). Patterns of working alliance development: A typology of working alliance ratings. *Journal of Counseling Psychology, 47,* 362-371.

Knox, D., Schacht, C., Holt, J., & Turner, J. (1993). Sexual lies among university students. *College Student Journal, 27,* 269-272.

Lambert, M.J., & Barley, D.E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy, 38,* 357-361.

Larsen, D.L., Attkisson, C., Hargreaves, W., & Nguyen, T.D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning, 2,* 197-207.

Lippard, P.V. (1988). 'Ask me no questions, I'll tell you no lies': Situational exigencies for interpersonal deception. *Western Journal of Speech Communication, 52,* 91-103.

Marcos, L.R. (1972). Lying: A particular defense met in psychoanalytic therapy. *American Journal of Psychoanalysis, 32,* 195-202.

Marmar, C.R., Weiss, D.S., & Gaston, L. (1989). Toward the validation of the California Therapeutic Alliance Rating System. *Psychological Assessment, 1,* 46-52.

Metts, S. (1989). An exploratory investigation of deception in close relationships. *Journal of Social and Personal Relationships, 6,* 159-179.

Millar, K.U., & Tesser, A. (1988). Deceptive behavior in social relationships: A consequence of violated expectations. *The Journal of Psychology, 122,* 263-273.

Miller, G.R. (1983). Telling it like it isn't and not telling it like it is: Some thoughts on deceptive communication. In J.I. Sisco (Ed.), *The Jensen lectures: Contemporary communication studies* (pp. 91-116). Tampa, FL: USF Press.

Miller, G.R., Mongeau, P.A., & Sleight, C. (1986). Fudging with friends and lying with lovers: Deceptive communication in interpersonal relationships. *Journal of Social and Personal Relationships, 3,* 495-512.

Miller, M.J. (1992). The Pinocchio syndrome: Lying and its impact on the counseling process. *Counseling & Values, 37*, 25-31.

Newman, C.F., & Strauss, J.L. (2003). When clients are untruthful: Implications for the therapeutic alliance, case conceptualization, and intervention. *Journal of Cognitive Psychotherapy: An International Quarterly, 17,* 241-252.

Norton, R., Feldman, C., & Tafoya, D. (1974). Risk parameters across types of secrets. *Journal of Counseling Psychology, 21,* 450-454.

Nyberg, D. (1993). *The varnished truth: Truth telling and deceiving in ordinary life.* Chicago: University of Chicago Press.

Orlinsky, D.E., Grawe, K., & Parks, B.K. (1994). Process and outcome in psychotherapy –Noch einmal. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 257-310). New York: Wiley.

O'Shaughnessy, E. (1990). Can a liar be psychoanalyzed? *International Journal of Psycho-Analysis, 71,* 187-196.

Pampel, F.C. (2000). Logistic regression: A primer. *Sage University Papers Series on Quantitative Applications in the Social Sciences, 07-132*. Thousand Oaks, CA: Sage.

Patterson, F., & Linden, E. (1981). *The education of Koko.* New York: Holt, Rinehart, & Winston.

Paulhus, D.L. (1984). Two-component models of socially desirable responding. *Journal of Personality and Social Psychology, 46,* 598-609.

Paulhus, D.L. (1986). Self-deception and impression management in test responses. In Angleitner & J. S. Wiggins (Eds.), *Personality assessment via questionnaires* (pp. 143-165). Berlin: Springer-Verlag.

Paulhus, D.L. (1994). *Balanced Inventory of Desirable Responding: Reference Manual For BIDR version 6.* Unpublished manuscript, University of British Columbia, Vancouver, Canada. (As cited in Stöber, 2001)

Pennebaker, J.W., Colder, M., & Sharp, L.K. (1990). Accelerating the coping process. *Journal of Personality and Social Psychology, 58,* 528-537.

Pennebaker, J.W., Hughes, C.F., & O'Heeron, R.C. (1987). The psychophysiology of confession: Linking inhibitory and psychosomatic processes. *Journal of Personality and Social Psychology, 52,* 781-793.

Pope, K.S., & Tabachnick, B.G. (1994). Therapists as patients: A national survey of psychologists' experiences, problems, and beliefs. *Professional Psychology: Research and Practice, 25,* 247-258.

Random House. (1987). *Random House dictionary* (2nd ed.). New York: Random House.

Rankin, H. (1990). Validity of self-reports in clinical settings. *Behavioral Assessment, 12,* 107-116.

Regan, A.M., & Hill, C.E. (1992). Investigation of what clients and counselors do not say in brief therapy. *Journal of Counseling Psychology, 39,* 168-174.

Rennie, D. (1985, June). *The inner experience of psychotherapy.* (Paper presented at the annual meeting of the Society for Psychotherapy Research, Evanston, IL). (As cited in Regan & Hill, 1992)

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Counseling Psychology, 21*, 95-103.

Saarni, C. (1982). Social and affective functions of nonverbal behavior: Developmental concerns. In R.S. Feldman (Ed.), *Development of nonverbal behavior in children.* (pp. 123-147). New York : Springer-Verlag.

Sabourin, S., Bourgeois, L., Gendreau, P., & Moval, M. (1989). Self-deception, impression management, and consumer satisfaction with mental health treatment. *Psychological Assessment, 1,* 126-129.

Sackeim, H.A., & Gur, R.C. (1978). Self-deception, self-confrontation, and consciousness. In G.E. Schwartz & D. Shapiro (Eds.,. *Consciousness and self-regulation: Advances in Research*, *Vol. 2* (pp. 139-197). New York: Plenum.

Saxe, L. (1991). Lying: Thoughts of an applied social psychologist. *American Psychologist, 46,* 409-415.

Schlenker, B.R. (1980). *Impression management: The self-concept, social identity, and interpersonal relations.* Belmont, CA: Wadsworth, Inc.

Serban, G. (2001). *Lying: Man's second nature.* Westport, CT: Praeger.

Shippee, G. (1977). Perceived deception in everyday social relationships: A preliminary statement. *Psychology—A Quarterly Journal, 14,* 57-62.

Silva, M. (2005, May 27). Change in APA Policy Regarding Posting Surveys to Listservs Hosted by APA. Message posted to Student Affiliate Group of Division 17 electronic mailing list, message not archived.

Snyder, M. (1974). The self-monitoring of expressive behavior. *Journal of Personality and Social Psychology, 30,* 526-537.

Solomon, R.C. (1993). What a tangled web: Deception and self-deception in philosophy. In M. Lewis & C. Saarni (Eds.), *Lying and deception in everyday life* (pp. 30-58). New York: Guilford Press.

Stiles, W.B, Agnew-Davies, R., Barkham, M., Culverwell, A., Goldfried, M.R., Halstead, J., et al. (2002). Convergent validity of the Agnew Relationship Measure and the Working Alliance Inventory. *Psychological Assessment, 14,* 209-220.

Stöber, J. (2001). The Social Desirability Scale-17 (SDS-17): Convergent validity, discriminant validity, and relationship with age. *European Journal of Psychological Assessment, 17,* 222-232.

Strupp, H.H., Fox, R.E., & Lessler, K. (1969). *Patients view their psychotherapy.* Baltimore: Johns Hopkins University Press.

Tedeschi, J.T., Schlenker, B.R., & Bonoma, T.V. (1971). Cognitive dissonance: Private ratiocination or public spectacle? *American Psychologist, 26,* 685-695.

Turner, R.E., Edgley, C., & Olmstead, G. (1975). Information control in conversation: Honesty is not always the best policy. *Kansas Journal of Sociology, 11,* 69-89.

Vrij, A. (2000). *Detecting lies and deceit: The psychology of lying and the implications for professional practice*. West Sussex, England: John Wiley & Sons Ltd.

Vrij, A., Floyd, M., & Ennis, E. (2003). Telling lies to strangers or close friends: Its relationship with attachment style. *Advances in Psychology Research, 20,* 61-73.

Weinshel, E.M. (1979). Some observations on not telling the truth. *Journal of the American Psychoanalysis Association, 27,* 503-531.

Wile, I.S. (1942). Lying as a biological and social phenomenon. *Nervous Child, 1,* 293-313.

Winnicott, D.W. (1964). *The child, the family and the outside world.* Harmondsorth, England: Penguin.

Wolf, J.M. (1988). Psychiatric aspects of lying. *American Journal of Psychiatry, 145,* 1611.

Wright, T.L., Ingraham, L. J, Chemtob, H.J., & Perez-Arce, P. (1985). Satisfaction and things not said: Clinical tools for group therapists. *Small Group Behavior, 16,* 565-572.

Wyer, M. (1989). *Everyday lying in close and casual relationships.* Unpublished doctoral dissertation, University of Virginia.

Yalom, I.D. (1970). *The theory and practice of group psychotherapy.* New York: Basic Books.

Zagon, I.K., & Jackson, H.J. (1994). Construct validity of a psychopathology measure. *Journal of Personality and Individual Differences, 17,* 125-135.

APPENDIX A.

INFORMED CONSENT E-MAIL SENT TO APAGS LISTSERV

Dear APAGS Member:

Hello! You are invited to participate in a dissertation research study that examines clients' experiences in psychotherapy, with particular emphasis on factors influencing whether or not clients lie to therapists in counseling and psychotherapy. I am conducting this study under the supervision of my faculty advisor, Dr. Randolph Pipes. You have been selected as a possible participant because you are a graduate student in psychology or a related field. You are eligible to participate in this study if you have been a client in counseling or psychotherapy since your 18th birthday. You must be age 19 or over to participate if you live in Alabama or Nebraska.

If you decide to participate in the study, please click on the link below. By clicking on the link, you are stating that you are over 18 years of age (or over 19 in the states of Alabama and Nebraska), have been or currently are in therapy, and are voluntarily participating in this study. The link will take you to a secure website where you will be asked to respond to survey items, including questions about yourself and your experiences in therapy, such as whether or not you have ever lied to a therapist, questions about your therapist, and questions about your relationship with your therapist.

Results of pilot testing indicated that respondents took between 15-30 minutes to complete all questions, with an average of 23 minutes. Your responses to survey items will be anonymous. Please be aware that the site that is hosting my survey does not capture the e-mail addresses of participants. You can withdraw from participating at any time without penalty or prejudice. Any information obtained in connection with this study will remain anonymous. I am offering six $50 random drawings for participants. If you choose to register for the random $50 drawings there will be no way for myself or anyone else to link your e-mail addresses to your survey responses. Please be aware that if you provide your information there will be no way to withdraw your data after participation, as there will be no way to identify individual information. Information collected through your participation will be used for purposes of completing my doctoral dissertation, and may be published in a professional journal. Any information or direct quotes used as illustrative examples in the course of reporting this research will not include your identifiable information.

If you have any questions I invite you to ask them now (see my contact information below). If you have questions later, I or my faculty advisor, Dr. Randolph Pipes (pipesrb@auburn.edu), will be happy to answer them.

For more information regarding your rights as a research participant you may contact the Office of Human Subjects Research by phone or e-mail. The people to contact there are Executive Director E.N. "Chip" Burson (334) 844-5966 (bursoen@auburn.edu) or IRB chair Dr. Peter Grandjean at (334) 844-1462 (grandpw@auburn.edu).

Having read the above information, you are deciding whether to participate in this research project. If you decide to participate, the data you provide will serve as your agreement to do so. Thank you so much for your time!

https://www.psychdata.com/surveys.asp?SID=7615

Sincerely,

Leslie Peck
Department of Counseling and Counseling Psychology
Auburn University
peckles@auburn.edu
(808) 956-9011

APPENDIX B.

LYING IN PSYCHOTHERAPY SURVEY: INTRODUCTION AND QUESTIONS 1-4

Lying in Psychotherapy Survey

The following survey contains questions about your experiences in therapy, including questions about lying (or not lying) to your therapist. In this survey, the term "lie" refers to *statements (written or spoken), told to a therapist, which you knew at the time were not true.* The total time to complete all questions should be approximately 25-30 minutes.

As you respond to my survey, please be aware that, although lying is often condemned by society, I do not condemn nor condone lying. I am merely interested in gathering some information on lying in psychotherapy. We know that lying is a common occurrence in daily social interactions, but have very little information on lying in therapy. As a result, I am conducting this exploratory study in order to fill in some gaps in our knowledge of this phenomenon. If you are not sure about an answer, please give your best guess. All answers will be anonymous.

If you would like to sign-up to win one of the 6 $50 drawings I am offering, please follow the prompts at the end of the survey. After submitting your survey responses, you will be sent to a secure website where you will be asked to enter your e-mail address. Please be aware that at no time will I or anyone else be able to link your e-mail address with your survey responses. After I have collected all survey responses, I will randomly select 6 e-mails to receive the $50 drawings. I will then notify you by e-mail if I have selected your e-mail address. All identifying information will be kept confidential. Thank you so much for your time!

Demographic and Background Information:

1) Age: ___

2) Gender:

- ¢ Female
- ¢ Male

3) Ethnicity:

- ¢ African American/Black

- ¢ Asian/Pacific Islander
- ¢ Caucasian
- ¢ Hispanic/Latino/a
- ¢ Native American/American Indian
- ¢ Other (Please Specify) _____

4) Since your 18th birthday, OTHER THAN DURING AN INTAKE SESSION, have you ever lied to a therapist during a therapy session?

- ¢ Yes
- ¢ No
- ¢ Can't remember

APPENDIX C.

LYING IN PSYCHOTHERAPY SURVEY: QUESTIONS FOR PARTICIPANTS WHO HAVE LIED TO A THERAPIST (Q 5-22)

Information on Lying in Psychotherapy

5) How many therapists have you seen since your 18th birthday? ___

6) Of the therapists you have seen since your 18th birthday, to how many did you tell a lie? ___

Many of us have seen multiple therapists in our adulthood, and may have lied more than once to one or more of them**. As you answer the remaining survey questions, please think of what you consider to be the *most significant* lie you ever told a therapist and describe that lie**. **Also refer to the therapist to whom you told that lie, and the relationship you had with that particular therapist**. Although the following questions use the past tense, you may discuss a therapeutic relationship in which you are currently involved.

7) What was/were your presenting complaints in the therapeutic relationship that you are describing?

8) Please describe the content of the lie you told your therapist. In other words, what did lie about?

9) To the best of your knowledge, at the time you lied to your therapist, what did you conceive was your motivation for doing so?

10) What, if any, THERAPIST CHARACTERISTICS and/or QUALITIES OF THE RELATIONSHIP you had with your therapist influenced your decision to lie?

11) In approximately what session number of how many sessions did you FIRST tell the lie you have been discussing? Please answer in the following format: _____ of ____ sessions.

12) In your opinion, was the material you lied about relevant to the problem for which you were seeking treatment?

- ¢ Not at all relevant
- ¢ Not very relevant
- ¢ Somewhat relevant
- ¢ Relevant
- ¢ Highly relevant

13) How much consideration did you give prior to telling the lie you are describing?

- ¢ None, the lie was completely spontaneous
- ¢ I made the decision to lie during the session in which it was told
- ¢ I decided to lie prior to the session in which it was told
- ¢ Can't remember

14) When you told the lie, was it prompted by a comment or question from the therapist?

- ¢ Prompted by a direct question which called for factual information
- ¢ Prompted by an indirect question or comment
- ¢ Completely voluntary/not at all prompted
- ¢ Can't remember

Effects/Consequences of Lying in Therapy

15) Do you feel that the lie or lies you told your therapist affected the therapeutic RELATIONSHIP?

- ¢ Yes
- ¢ No

- ¢ Can't remember

16) If you answered "yes" to the previous question ("Do you believe the lie or lies you told your therapist affected the therapeutic relationship?"), please describe how the lie or lies you told affected the therapeutic relationship.

17) Do you feel that the lie or lies you told your therapist affected the therapeutic OUTCOME?
- ¢ Yes
- ¢ No
- ¢ Not sure-therapy is ongoing

18) If you answered "yes" to the previous question ("Do you believe the lie or lies you told your therapist affected the therapeutic outcome?"), please describe how you believe the lie or lies you told affected the therapeutic outcome.

19) In the course of your therapy, did your lie ever come to be revealed to your therapist?
- ¢ Yes
- ¢ No

20) If you answered "yes," to the previous question, how did your lie come ot be revealed to your therapist?
- ¢ I voluntarily admitted I had lied
- ¢ I admitted the lie in response to a therapist comment, question, or confrontation
- ¢ A third party revealed that I had lied
- ¢ Not applicable
- ¢ Other (Please specify)

21) People go into therapy for a variety of reasons. For some, it is completely voluntary, while for others, it is mandated by outside sources. To what degree would you say the therapy you are describing involved coercion from others?

- ¢ Therapy was mandated or involved strong coercion
- ¢ Therapy involved significant pressure from others
- ¢ Therapy involved some pressure from others
- ¢ Therapy involved little or no pressure from others

22) Which of the following best describes your satisfaction with treatment outcome for the therapy you are describing in this survey?

- ¢ Very unsatisfied
- ¢ Not satisfied
- ¢ Fairly satisfied
- ¢ Satisfied
- ¢ Very satisfied
- ¢ Not sure-therapy is ongoing

APPENDIX D.

LYING IN PSYCHOTHERAPY SURVEY: QUESTIONS FOR ALL RESPONDENTS WHO NEVER LIED (Q 23—24)

23) How many therapists have you seen since your 18th birthday?

24) Although you have never previously lied to a therapist, have you ever been tempted to do so?

- ¢ Yes
- ¢ No
- ¢ Can't remember

APPENDIX E.

LYING IN PSYCHOTHERAPY SURVEY: QUESTIONS FOR RESPONDENTS WHO NEVER LIED BUT WERE TEMPTED (Q 25-32)

In your experiences as a client in therapy, you may have been tempted to lie to one or more therapists for a variety of reasons. **Although many of us have seen multiple therapists in our adulthood, please think of *the therapist to whom you were most tempted to lie* and specifically refer to that therapist and your relationship with that therapist for the remaining questions**. Although the following questions use the past tense, you may discuss a therapeutic relationship in which you are currently involved.

25) What was/were your presenting complaint(s) in the therapeutic relationship that you are describing?

26) What were you tempted to lie about?

27) Please describe what prevented you from lying when you were tempted to tell a lie.

28) What, if any, THERAPIST CHARACTERISTICS and/or QUALITIES OF YOUR RELATIONSHIP WITH YOUR THERAPIST influenced your decision to tell the truth in a situation in which you were tempted to lie?

29) What, if any, therapist characteristics influenced your decision to tell the truth in a situation in which you were tempted to lie? Therapist characteristics might include

any number of personal factors (for example, the age or religious values of the therapist). Such characteristics may also include personality factors (for example, warmth or aloofness) or style of interacting with you (for example, being friendly or punitive).

30) In approximately what session number of how many sessions did you first become tempted to lie? Please answer in the following format: ___ of ____ sessions.

31) People go into therapy for a variety of reasons. For some, it is completely voluntary, while for others, it is mandated by outside sources. To what degree would you say the therapy you are describing involved coercion from others?

- ¢ Therapy was mandated or involved strong coercion
- ¢ Therapy involved significant pressure from others
- ¢ Therapy involved some pressure from others
- ¢ Therapy involved little or no pressure from others

32) Which of the following best describes your satisfaction with treatment outcome for the therapy you are describing in this survey?

- ¢ Very unsatisfied
- ¢ Not satisfied
- ¢ Fairly satisfied
- ¢ Satisfied
- ¢ Very satisfied
- ¢ Not sure-therapy is ongoing

APPENDIX F.

LYING IN PSYCHOTHERAPY SURVEY: QUESTIONS FOR NO-LIE/NO-TEMPT PARTICIPANTS (Q 33-36)

Psychotherapy Information

Many of us have seen multiple therapists in our adulthood. **As you answer the following questions, please think of one therapist with whom you were involved and specifically refer to that therapist and your relationship with that therapist for the remaining questions**. Although the following questions use the past tense, you may discuss a therapeutic relationship in which you are currently involved.

33) Approximately how many sessions did you have with the therapist to whom you are referring? Please indicate the number of sessions you have had if the therapy is ongoing. _____

34) What was/were your presenting complaint(s) in the therapeutic relationship that you are describing?

35) People go into therapy for a variety of reasons. For some, it is completely voluntary, while for others, it is mandated by outside sources. To what degree would you say the therapy you are describing involved coercion from others?
- ¢ Therapy was mandated or involved strong coercion
- ¢ Therapy involved significant pressure from others
- ¢ Therapy involved some pressure from others
- ¢ Therapy involved little or no pressure from others

36) Which of the following best describes your satisfaction with treatment outcome for the therapy you are describing in this survey?
- ¢ Very unsatisfied
- ¢ Not satisfied
- ¢ Fairly satisfied
- ¢ Satisfied
- ¢ Very satisfied
- ¢ Not sure-therapy is ongoing

APPENDIX G.

THE THERAPIST SATISFACTION SCALE

The Therapist Satisfaction Scale
(adapted from Conte, Buckley, Picard, and Karasu, 1994)

When answering the following statements, please refer to the therapist you have been describing throughout this survey.

If you have lied to a therapist before, please indicate for each statement below how you felt about your therapist ***just prior to the time you lied to your therapist***.

If you have never lied to a therapist but were tempted, please indicate for each statement below how you felt about your therapist ***just prior to the time you were tempted to lie to your therapist***.

If you have never lied to a therapist and were never tempted, please indicate for each statement below how you felt about your therapist in general.

1) I felt that my therapist was likeable
¢ Not at all ¢ A little ¢ A lot

2) I felt that my therapist understood me
¢ Not at all ¢ A little ¢ A lot

3) I felt that me therapist liked me
¢ Not at all ¢ A little ¢ A lot

I felt that my therapist could be trusted
¢ Not at all ¢ A little ¢ A lot

5) I felt that my therapist was encouraging
¢ Not at all ¢ A little ¢ A lot

6) I felt that my therapist respected me
¢ Not at all ¢ A little ¢ A lot

7) I felt that my therapist accepted me
¢ Not at all ¢ A little ¢ A lot

8) I felt that my therapist gave me good advice
¢ Not at all ¢ A little ¢ A lot

9) I felt that my therapist helped me understand myself
¢ Not at all ¢ A little ¢ A lot

10) I felt that my therapist gave me his/her full attention
¢ Not at all ¢ A little ¢ A lot

11) I felt that my therapist was physically attractive
¢ Not at all ¢ A little ¢ A lot

12) I felt that my therapist knew what he/she was doing
¢ Not at all ¢ A little ¢ A lot

13) I felt that my therapist could be fooled
¢ Not at all ¢ A little ¢ A lot

14) I felt that my therapist was stubborn
¢ Not at all ¢ A little ¢ A lot

15) I felt that my therapist argued with me
¢ Not at all ¢ A little ¢ A lot

16) I felt that my therapist made me nervous
¢ Not at all ¢ A little ¢ A lot

17) I felt that my therapist was too quiet
¢ Not at all ¢ A little ¢ A lot

18) I felt that my therapist avoided certain topics
¢ Not at all ¢ A little ¢ A lot

APPENDIX H.

THE AGNEW RELATIONSHIP MEASURE (ARM)

The Agnew Relationship Measure
(adapted from Agnew-Davies, Barkham, & Shapiro, 1998)

When answering the following statements, please refer to the therapist you have been describing throughout this survey. If you are not sure about an answer, please give your best guess.

If you *have* lied to a therapist before, please describe how each statement below reflects how you felt ***just prior to the time you lied to your therapist***.

If you *have never lied to a therapist but were tempted*, please describe how each statement below reflects how you felt ***just prior to the time you were tempted to lie to your therapist***.

If you *have never lied to a therapist and were never tempted*, please describe how each statement below reflects how you felt about your therapist in general.

1) I felt free to express the things that worried me.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

2) I felt friendly towards my therapist.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

3) I was worried about embarrassing myself in front of my therapist.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

4) I kept some important things to myself and did not share them with my therapist.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

5) I had confidence in my therapist and his/her techniques.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

6) I felt optimistic about my progress.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

7) I felt I could openly express my thoughts and feelings to my therapist.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

8) I felt critical or disappointed in my therapist.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

9) I could discuss personal matters I was ordinarily ashamed or afraid to reveal.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

10) My therapist's professional skills were impressive.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

11) My therapist accepted me no matter what I said or did.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

12) My therapist tried to influence me in ways that were not beneficial to me.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

13) My therapist found it hard to understand me.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

14) My therapist was warm and friendly with me.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

15) My therapist did not give me the advice I would have liked.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

16) My therapist was supportive.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

17) My therapist followed his/her own plans and ignored my views of how to proceed.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

18) My therapist was confident in him/herself and his/her techniques.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

19) My therapist seemed bored or impatient with me.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

20) My therapist and I were willing to work hard together.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

21) My therapist and I agreed about how to work together.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

22) My therapist and I had difficulty working as a partnership.

¢	¢	¢	¢	¢	¢	¢
Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree

APPENDIX I.

THE SOCIAL DESIRABILITY SCALE – 17

The Social Desirability Scale-17 (SDS-17)
Stöber, 2001

Below you will find a list of statements. Please read each statement carefully and decide if that statement describes you or not. If it describes you, check the word "true"; if not, check the word "false."

	TRUE	**FALSE**
1) I sometimes litter.	¢	¢
2) I always admit my mistakes openly and face the potential negative consequences.	¢	¢
3) In traffic I am always polite and considerate of others.	¢	¢
4) I have tried illegal drugs (for example, marijuana, cocaine, etc.)	¢	¢
5) I always accept others' opinions, even when they don't agree with my own.	¢	¢
6) I take out my bad moods on others now and then.	¢	¢
7) There has been an occasion when I took advantage of someone else.	¢	¢
8) In conversations I always listen attentively and let others finish their sentences.	¢	¢
9) never hesitate to help someone in case of emergency.	¢	¢
10) When I have made a promise, I keep it –no ifs, ands, or buts.	¢	¢
11) I occasionally speak badly of others behind their back.	¢	¢
12) I would never live off other people.	¢	¢

13) I always stay friendly and courteous with other people, even when I am stressed out. ¢ ¢

14) During arguments I always stay objective and matter-of-fact. ¢ ¢

15) There has been at least one occasion when I failed to return an item that I borrowed. ¢ ¢

16) I always eat a healthy diet. ¢ ¢

17) Sometimes I only help because I expect something in return. ¢ ¢

APPENDIX J.

OPTIONAL PART OF LYING IN PSYCHOTHERAPY SURVEY

(COMPLETED AFTER RESPONDING TO SDS-17)

Please enter your e-mail address below if you are interested in registering for one of the six random $50 drawings.

OPTIONAL: Please feel free to add any additional thoughts you have which might help us better understand lying in psychotherapy.

APPENDIX K.

PRESENTING PROBLEMS TABLE

Presenting Problems/Concerns	Lying	Tempted	No Lie/ No Tempt	Total
Depression or general unhappiness	23	6	12	41
Anxiety (general)	14	5	6	25
Relationships/interpersonal conflict (general)	5	3	7	15
Adjustment or transition issues/problems	2	4	4	10
Career, work, school, or studies	4	4	2	10
Family	1		7	8
Trauma, PTSD, PTSD symptoms	5	1	1	7
Self-esteem, self-confidence, self-concept		1	5	6
Marriage or divorce	1		4	5
Stress	1	2	2	5
Grief, loss, bereavement	2	1	2	5
Breakup (non-marital), loss of relationship	2		2	4
Personal growth	2		1	3
Obsessive thoughts and/or compulsive behavior	1		2	3
Self-understanding, self-exploration			3	3
Focus on participant's parents (mother, father, or both)		1	2	3
Eating disorder	2	1		3
Awareness or management of feelings	1		1	2
Self-injury (not part of P and T's list)	2			2

Mood disorder/bipolar	2			2
Panic attacks	2			2
Intrusive thoughts	2			2
Social anxiety	1		1	2
Suicidal ideation/suicidality	2			2
Bizarre/unusual experiences (derealization, hallucinations, etc.)	2			2
Participant's parenting role or duties		1	1	2
Sexual orientation/sexual identity		1	1	2
Childhood sexual abuse	1		1	2
Seeking help for another's problem		2		2
Therapy mandated		1	1	2
Miscellaneous	8	7	7	22

APPENDIX L.

PRESENTING PROBLEMS (PARTICIPANTS' WRITTEN RESPONSES)

What was/were your presenting complaints in the therapeutic relationship that you are describing? (LPS questions 7,25, & 33):

Lying group:

1. unwanted flashbacks to an experience, intrusive thoughts, anxiety about the experience recurring, depression
2. anxiety
3. anxiety
4. PTSD, depression
5. depression and anxiety
6. attachment difficulty, anxiety, depression, and self-injury
7. relationship problems/depression
8. obsessive thoughts and fears of self-mutilating behavior, as well as severe recurrent depression with a recent vegetative state
9. anxiety/tension
10. major depression and posttraumatic stress symptoms
11. nothing, it was personal growth (Jungian)
12. childhood sexual abuse and resulting depression, anxiety
13. prolonged sadness and exhaustion
14. grief, adjustment disorder, recent loss of a relationship
15. romantic relationship difficulties

16. eating disorders, depression

17. lifelong history of episodes of depression, anxiety, and derealization; inability to move forward in my doctoral program (internship)

18. depression, relationship issues, identity crisis

19. depression, anxiety, trauma

20. major depressive disorder, severe, without psychotic features

21. adjustment difficulties due to school

22. My aunt had recently died from Leukemia and I had just broken up with my fiancé who cheated on me.

23. depression, suicidal ideation

24. panic attacks/depression

25. depression and anxiety about graduate school and what the future may hold for me as a professional psychologist

26. history of child abuse in family of origin

27. eating disorder/mood disorder

28. panic attacks and anxiety since I began my graduate career

29. depression

30. social anxiety, feelings of alienation, difficulty expressing emotions, and intrusive thoughts from past events

31. problems with in-laws or significant relationships at the time

32. I was being treated for bipolar disorder

33. I was experiencing considerable anxiety as I dealt with the demands of graduate school and the fallout from a painful divorce. In addition, I wanted to explore the roots of shame and feelings of inadequacy that have plagued me for most of my life.

34. depression, suicidality, self-injury

35. depression, anxiety, personality disorder

36. depression, anxiety, and auditory hallucinations

37. PTSD, depression, anxiety, mood swings

38. anxiety/depression. Lack of assertiveness

39. personal growth

40. dealing w/ a negative relationship

Tempted group:

1. The therapist was also counseling my boyfriend at the time, and I felt I needed to hide negative feelings I had about my boyfriend, his client.

2. stress

3. depression

4. depression

5. partner's anger management

6. If I have/had a complaint it would be that I found it difficult to trust my therapist. I know this is/was due to problems within myself and not my therapist

7. anxiety

8. difficulty re-adjusting to college after having been abroad for one year; bulimia

9. depression and anxiety

10. depression and relationship issues

11. coping skills

12. was sent to the therapist against my will, as I was a minor, and my parents believed I had some issues to resolve, and I was upset about the situation so I thought I might overstate anything to make them think something was really wrong

13. I can't think of really specific situations. I just remember being very uncomfortable speaking about things I was ashamed of such as sexual issues or times I did not treat my children well. This happened with all my therapists.

14. coping with becoming a therapist, diagnosed with Adjustment disorder with mixed mood

15. stress

16. trauma

17. coping with the death of my mother

18. behavioral problems with my 4-year-old son. The therapist concluded that I needed more parenting skills

19. professionalism

20. I was talking about relationships with people specifically my mother

21. general support for adjustment to grad school, depression management

22. adjustment issues

23. anxiety, self-esteem, sexual orientation issues

24. lack of therapists trust. Therapist and I had personality problems

25. school issues

26. relationship issues

27. anxiety and fears

28. depression

29. relationship problems

<u>No Lie/No Tempt group:</u>

1. physical symptoms (chest pain, difficulty breathing) family issues

2. adjustment following break-up

3. PTSD

4. depression

5. marriage counseling

6. anxiety and compulsive skin-picking

7. my complaints were not about the therapeutic relationship, as this question suggests. I sought therapy for help with issues in my personal life and coming to terms with my sexual identity.

8. depression

9. school requirement but also to address family issues

10. acculturation, perfectionism, bereavement

11. I had no complaint about the therapeutic relationship

12. further exploration of who I am and to find connections between how I behave and my parents influence

13. relationship issues

14. generalized anxiety disorder, depressive symptoms

15. anxiety, unresolved issues with family of origin, stress, adjustment to being new mom

16. issues surrounding a divorce

17. depression, resolving family history issues, improving positive self-concept, opening up to feelings, self-actualization, etc.

18. relationship problems, depression

19. grief over unexpected passing of my mom, then a relationship breakup where cheating and deceit by my exboyfriend took place

20. interpersonal conflicts

21. depression

22. childhood sexual abuse

23. personal growth work

24. depression, transition issues, self-esteem problems

25. problems in family, shyness having no confidence in myself

26. generalized anxiety, social anxiety, wanting to understand myself better

27. depression, anxiety, OCD, self-esteem

28. no complaints-discussing future job options

29. relationship struggles—essentially needed help making a decision to end one, which I did, ultimately

30. presenting complaint: feeling dependent on romantic relationships, and feeling estranged from my father. In general, I have been using therapy as a self-exlploration method to help me as a therapist.

31. relationship problems with my partner and my own depression

32. needing assistance while leaving my husband

33. stress related to graduate school and relationship issues

34. depression, difficulty adjusting

35. dealing with issues related to my family of origin

36. depression, low self-esteem, family conflict

37. depression, marital problems

38. anxiety

39. interpersonal difficulties

APPENDIX M.

CONTENT OF LIES TOLD TO THERAPISTS

Content of Lie	Total
Relationships	7
Substance Use/abuse/dependence	6
Symptoms/symptom severity (over-under-exaggerating symptoms)	5
Feelings/thoughts (general)	4
Sexual behavior	4
Abuse related	3
Medication related	3
Self-injury	3
Completion of homework/assignment	2
Eating behaviors/weight	2
Feelings or thoughts about the therapist	2
Referral Concern	2
Safety Issues	2
Suicide-related	2
Trauma (history of)	2
Abortion	1
Codependency	1
Coping	1
Details of an experience/event (general)	1
Finances	1
Self-care	1

APPENDIX N.

CONTENT OF LIES TOLD (PARTICIPANTS' WRITTEN RESPONSES)

Please describe the content of the lie you told your therapist. In other words, what did you lie about? (LPS question 8):

1. I made up an experience that I could bear to talk about...similar in nature to the one that actually happened.

2. how a particular relationship ended

3. feelings, thoughts about the therapist

4. I minimized or falsified dangerous situations I put myself in at the time (drinking/driving, use of drugs, unhealthy/abusive relationship).

5. issues of codependency

6. little things continuously that were mostly based on severity of symptoms or feelings. There was not one particular thing. An example would be: Therapist: "Sounds very hurtful" Client: "No, I didn't care." When actually I did. I had difficulty expressing emotions for the first few years of therapy. I minimized things.

7. told her i was taking my antidepressant medication when i was not

8. Whether or not I had actually engaged in self-mutilating behavor or not.

9. I downplayed the extent to which I drink and its consequences. Not a complete lie, but a deliberate attempt to minimize my actions

10. I have lied about self-care issues, such as how often I'm exercising or meditating.

11. benign (i believe, as I did not feel like further "exploring" it at the time). -sex with swingers.

12. how much the abuse bothered me (I minimized it)

13. My actual referral concern. A close friend strongly encouraged me to seek therapy for a specific concern. However, during the therapy sessions I lied about my real concern and we, as a result, focused the majority of the sessions on minor problems I was having.

14. i didn't lie as much as downplay emotions and thoughts about situations

15. I lied and told her that I wasn't pursuing a romantic relationship outside my primary romantic relationship. Eventually when I did tell her, I then again lied and told her we ended the relationship when we didn't.

16. I repeatedly engaged in self-injurious behavior, from starvation to purging to suicide attempts, and I lied about safety issues to all my therapists.

17. I denied having/would not admit to having certain feelings about my therapist, e.g., that she was quite important to me, that I cared very much what she thought of me, that I worried a great deal about what she thought of how my personal issues would affect my ability to work as a professional therapist , wishing that we had met under other circumstances--that we could be colleagues, perhaps friends (but not lovers) as opposed to therapist-client

18. Regarding my relationship that I was in then, my level of commitment to my ex-boyfriend and how I was contributing to the breakdown of the relationship.

19. I had run up a therapy bill with my therapist when I was in financial constraints, then lied about my financial situation when it most likely that I could have paid off the bill somewhat sooner.

20. Reported taking meds regularly when I wasn't

21. I said that I did not have a history of trauma when I did. She was jumping to conclusions and pushing me on the topic (she was right) but I felt violated and lied.

22. My general condition. (I was very depressed, but said I was handling it.) As well as what I was doing to handle it and all the details surrounding my ex fiance.

23. I lied about whether or not I smoked marijuana (I said I didn't when it had been a major part of my college and post-college life).

24. Amount of alcohol consumption, things I didn’t want the insurance company to have access to.

25. drug use

26. my involvement with friends with substance abuse problems

27. weight, completion of homework

28. my drinking habits. i minimized my drinking because i was worried she would judge me for being a psychology graduate student who drinks; i also minimized my anxiety because i was scared she would think less of me because i am a psychology student. ultimately, i felt the need and pressure to present an image of being more "put together" than i was due to the nature of the field in which i am studying and practicing.

29. I lied about the nature of the relationship I had with my roommate at the time, in particular, I portrayed the relationship as platonic, while we were, in fact, dating.

30. I told him that my intrusive thoughts were from a different experience than they actually were from, because I did not want to admit what really happened. The event that I said was the cause was a real event, but I exaggerated it; the actualy triggering event was something I was ashamed of. Both were similar in that they both related to sexual trauma; the incident that I claimed was the cause was something that I did not believe was my fault (sexual assault) while the true triggering event had been more or less in my control: I had participated in sexual activity with others when I did not want to in order to please someone else and for psychological validation, repeatedly, and it finally reached a point where it was extremely upsetting. I also did not tell my therapist the real reason because I did not want him to believe that my significant other was forcing me to do these things; in fact my significant other was under the impression that I was enjoying myself when I was not. So, basically, I repeatedly traumatized myself, and did not feel that my therapist would understand. I later told him the truth, and he was very empathic and understanding, but at the time I did not want to take the chance of not being taken seriously.

31. Details regarding embarrassing past activities such as sexual behaviors, etc.

32. I told this therapist (who was a psychiatrist) on multiple occasions that I had been taking my mood stabilizers when in fact I had gone off them for many months. So this lie continued on a long term basis.

33. I lied about the fact that I had an abortion--told her I miscarried. I liked this therapist and felt like we could be friends under different circumstances--I didn't want her to think poorly of me.

34. Whether or not I had self-injured, whether or not I had the means with which to kill myself

35. usually lied about what I was feeling or how I was doing--either a "flight into health" or telling the therapist what I though he/she wanted to hear

36. Just about everything! I lied about not sleeping, which I really wasn't getting much of...However, instead of telling my therapist I slept 5 hours I would say I hadn't slept at all or I slept only an hour or two. Also, I lied about the extent of my symptoms. I tended to exaggerate all symptoms just to make myself appear sicker than I actually was. Or maybe I was as sick as I wanted to be...

37. I told the therapist that I was there because of my relationship with my ex-husband and the adjustment to graduate school stresses. I failed to mention that as a child I was sexually, mentally and physically abused while I lived within a cult. I had disclosed this to several previous therapists. Even though the current therapist asked and tried to probe that area, I lied to avoid the discussion.

38. My therapist had wanted me to take action with my professors at school and lodge a complaint. I didn't want to do it, understanding the ramifications it could have for me, and instead said that it had been otherwise resolved when it hadn't.

39. I was struggling with a breakup and i told me therapist that I hadn't seen my ex when in fact I'd had dinner with him and spent time with him.

40. That I was no longer having sex with the person I had recently broken up with.

APPENDIX O.

MOTIVATION FOR LYING

To the best of your knowledge, at the time you lied to your therapist, what did you conceive was your motivation for doing so? (LPS question 9):

1. The original experience that I went to therapy for was too painful to actually talk about. It was much easier to talk about the made up experience instead.

2. ashamed of telling the truth about how the relationship ended

3. fear of rejection if the truth were revealed

4. I was aware of (a) not wanting him to worry and (b) not wanting him to disapprove of my behavior. In retrospect, I think I was using the behaviors I was hiding to also hide material that was important to the therapy.

5. not wanting to look like i needed to control things

6. Not letting my therapist get close to me and not allowing myself to feel the comfort of her empathy. I also did not want her to know how well she was getting to know me, so I would often tell her she was wrong about her hypotheses that were actually correct.

7. i knew i should be taking it but had reasons that i was not and i did not want to explain those reasons to my therapists

8. My motivation for doing so was that she had drafted a no-harm contract stating that if I had self-harmed, and I had not tried to contact her or help first, our therapuetic relationship would end.

9. embarassment/social desirability

10. I mostly did not want to disappoint her.

11. not wanting to explore it further at that time. we had other more important work in my opinion

12. embarrassment and shame

13. lack of trust, avoidance of the real issue

14. i didn't want to have to talk about the subject any further or deeper... it was too uncomfortable at that point in time.

15. She would pressure me to end the relationship and I didn't want to.

16. Avoiding commitment!

17. preserving a positive image of me in my therapist's mind, didn't want her to think less of me, avoid humiliation of admitting I wanted something that I could never have (another kind of relationship)

18. Wanted to look good. Wanted someone to be on my side.

19. I didn't want her to raise her fees once I paid off the full balance.

20. I wanted to be a good client but didn't like the side effects of the meds

21. I felt violated; as though she didn't respect my boundaries.

22. I didn’t trust her or feel that she really cared.

23. Fear of being judged.

24. I thought well of my therapist, and did not want to disappiont her.

25. Didn't want any drug use on my record in case it was ever recovered and used in my professional career...i.e. embarrassment and shame

26. I think I was unsure why I was lying at the time.

27. Not ready to admit that my eating was out of control, therefore did not want her to be concerned or to question me further regarding my weight

28. the career path i chose... the fact that she was a psychologist and i am studying psychology, i felt pressure to present my self as being more "stable" than i felt at the time

29. I was embarrassed and ashamed of my choice to date a roommate, which I felt was not a healthy decision on my part (living together made it more difficult to maintain strong, healthy boundaries in the beginning stages of this relationship).

30. Shame and feelings that I would not be understood or taken seriously

31. to avoid embarassment or judgement from others

32. I did not want him to know I had been a "bad client" and gone off my medication, especially since I was a student in psychology and should know better. I also felt it was a futile effort to discuss this choice since I knew he disagreed. I knew he would just try to give me a different medication if I disliked that one and I was tired of going on different medications when they all made me feel numb. It seemed our two viewpoints were irreconcilable through no fault of eitehr one of us (that is his profession, and the research does show that bipolar clients need to stay on their meds).

33. As I stated in the last answer, I didn't want her to think poorly of me; I only wanted to share experiences that weren't of my choosing--if I was the helpless victim, then it wasn't my fault, but if I deliberately chose to do wrong, then I deserved to feel shame (went my reasoning).

34. fear of hospitalization. fear of disappointing the therapist

35. wanting to please the therapist or make myself look better

36. sympathy, attention

37. I was concerned about confidentiality. I was also concerned about discussing the issue with a male therapist. I had not had very good luck discussing it with female therapists. I did not believe that it would be any better talking to a male.

38. I felt that she wasn't considering important implications, and that my having raised that before with her wasn't heard. I guess I felt that I knew best in this situation. But I also lied because I guess I wanted her to view me as having handled things, and to respect me.

39. Pride.

40. I personally felt that it was not in my best interest to continue to have sex with this person so I didn’t want to admit it to anyone else.

APPENDIX P.

THERAPIST/THERAPEUTIC RELATIONSHIP CHARACTERISTICS FOR

PARTICIPANTS WHO LIED

What, if any, therapist characteristics and/or qualities of the therapeutic relationship you had with your therapist influenced your decision to lie? (LPS question 10):

1) I didn't know them very well, not well enough to voluntarily cry in front of them

2) She was not as soothing as I would have liked. She tended to be more supportive as opposed to psychodynamic

3) a dynamic of equality and mutual respect. an alliance that I did not want to injure in any way

4) None, really -- except a genuine concern for me.

5) I'm not sure it was a completely conscious decision; it was more of an underestimation of my issues regarding codependency. it was early in the therapeutic relationship and i wanted to make a good impression

6) None. She is the best psychologist ever. I am very honest with her now. I am glad she was patient. If anything, I lied b/c I liked her so much and did not want to lose her. But, I had attachment difficulties and I did not want her to know how attached I was becoming.

7) none that I can think of.

8) The fact that she saw it as a black and white issue----ie, Cut, and no relationship.

9) Lack of trust, owing to the fact that it was the first session and was possibly exacerbated by her demeanor, which I felt was cold and did not enduce a feeling of comfort

10) I really liked this therapist and felt very connected to her. I valued her opinion. Interestingly, these same factors contributed to me finally telling her when I was lying and apologizing for it.

11) Nope, he was great.

12) didn't know them well enough to come directly to the truth

13) I felt rapport was never totally established. The therapist seemed to assume that trust had been established before I felt that it was

14) I was afraid she might be judging me.

15) Directly telling me what I should/should not do, her being an authority figure

16) [Response left blank]

17) My therapist is fairly analytic and personally non-disclosing/reserved--so I never really knew what she was thinking about me/how she was judging/evaluating me, and in my mind (being rather depressed, self-denigrating, etc) I assumed that meant it was negative (in the absence of any feedback to the contrary). This also made it seem like she was a paragon, compared to me, a struggling student, mere human with flaws, who made mistakes, etc. Also, she seems very aware of professional ethics, fairly rigid (like a "classical analyst") about things like possible boundary violations, dual relationships.

18) The relationship was important to me, and did not want her to disapprove.

19) I liked that she was willing to continue seeing me even as I was unable to pay her consistently.

20) High level of trust and therapist's positive perceptions of me - I didn't want to be a 'bad' client.

21) She was smug and talked about herself in session all the time. She would tell me how great she was about one thing or another, and was completely unethical (told me another client's name/would leave charts out/talked about how she was treating other clients and how wonderfully it was working)

22) She was VERY confrontive from the first session and I felt she was trying to push decisions on me (to sign myself out of school).

23) I wasn't quite sure what therapy was all about. I didn't trust this therapist. She seemed too eager to give advice and too quick to positively refrain my negative experiences. Of course, this was an EAP referral so it was also "brief therapy," which I knew little of at the time.

24) Caring about what the therapist thought. Wanting to please.

25) Don't know that therapist characteristics had anything to do with it

26) Working towards terminating therapy, and did not want to bring up new issues.

27) I really wanted to present as better than I was because I really liked her and respected her opinion. Therefore the thought of her thinking of me as sick was unbearable. However, as therapy progressed I was able to be honest with her and lying decreased.

28) A major factor was the fact that she graduated from the same doctorate program in which I am enrolled; I also felt scrutinized right off the bat even though she was asking typical intake questions). I felt like there was a specific answer to every question, and the answer had to be correct (I realize this is more of my "stuff" than anything about her or anything she did/said). I guess it wasn't anything about her that was the problem. It was difficult sitting in the room, knowing what she would ask next or what she may be thinking, due to my own training

29) I believe it was my own desire to please my therapist, or a desire not to disappoint him, as he was the first consistent and healthy male I had in my life (a surrogate father or "object"). In retrospect, it was not due to any characteristics particular to him, other than his gender and role as my therapist, but was due to my own need to please a father figure. I had seen this therapist on and off for a number of years before this lie was told.

30) I wanted him to respect me.

31) too goody good two shoes or too condescending

32) I 'spose I liked him enough to lie. That is, I didn't want to worry or upset him. At the same time, I think our relationship lacked the proper equality. If he had been better at conveying unconditional positive regard, I would have felt comfortable disclosing my decision. Instead I felt he would judge me.

33) We were of similar age and personality. She is the type of therapist that I would like to eventually be--I think I wanted to identify with her and I wanted her to identify with me.

34) [Response left blank]

35) I think the lying was pretty much an effect of my personality issues

36) caring and understanding

37) He was of the opposite gender, I had not been seeing him every long and there were more important items that I felt needed to be discussed.

38) She was judgmental at times, and let her opinions be known. We didn't have a very good connection, but I guess enough of one where I felt it necessary to lie to preserve something.

39) I believe that my therapist sees me positively and I wanted her (and me) to think that I was doing a good job sticking to my resolve.

40) None--it was simply having to say it out loud to another person that I didn't want to.

APPENDIX Q.

HOW LIES AFFECTED THERAPEUTIC RELATIONSHIP

Describe how the lie or lies you told affected the therapeutic relationship. (LPS question 16):

1. Only on my part because I knew there was something I was privy to in the relationship that she did not know. *(This response corresponds to those of Lying participant # 2)*

2. To be fair, I happen to think everything said (or not) affects the relationship! BUt in this case, when I later "came clean" there was a greater sense of trust and respect on my part. In that way, I suppose I was testing him... *(This response corresponds to those of Lying participant # 4)*

3. I didn't feel entirely comfortable with it so I would have to surmise it affected the therapeutic relationship. *(This response corresponds to those of Lying participant # 7)*

4. It proved that I did not trust her. *(This response corresponds to those of Lying participant # 8)*

5. but I actually think it improved the relationship in the long run, because I ended up telling her and we talked about the relationship and what was going on that prompted me to lie. *(This response corresponds to those of Lying participant # 10)*

6. I felt dishonest, which is exactly the opposite of whats needed in what i was seeking (growth and personal knowledge). *(This response corresponds to those of Lying participant # 11)*

7. It created a fictitious relationship for the remainder of our sessions. *(This response corresponds to those of Lying participant # 13)*

8. I didn't trust her, and I believe she lost trust in me after she found out I had been lying. *(This response corresponds to those of Lying participant # 15)*

9. I felt I could not be completely honest about those kinds of things, which left me feeling alone with them; this also confused my therapist about how I really felt about her and our relationship, and frustrated her. *(This response corresponds to those of Lying participant # 17)*

10. It made the relationship in certain respects dishonest. I felt guilty and like I was taking advantage of my therapist. It also caused me to be more cautious when I spoke about the topic of which the lie was about. *(This response corresponds to those of Lying participant # 19)*

11. I lost more trust in her. *(This response corresponds to those of Lying participant # 21)*

12. I think I was with-holding so much about myself because I felt ashamed and feared being judged. I was also in denial about the impact marijuana was having on my life. *(This response corresponds to those of Lying participant # 23)*

13. From the moment in which I told the lie I no longer felt I could be myself; it was as if there was an automative barrier between her and I, and I could no longer be honest; so the relationship remained superficial throughout therapy and it became a waste of time. *(This response corresponds to those of Lying participant # 28)*

14. It became weaker. Because I could "get away" with this lie, I felt less respect for him and I felt the falsity between us trivialized the relationship. When I eventually confessed, I doubt he trusted me as much in the future (I sure wouldn't). Overall-- decreased trust and authenticity. *(This response corresponds to those of Lying participant # 32)*

15. I was careful to refrain from lying again--I paid extra attention to my motivation to improve in therapy and in this way the relationship actually improved, I think. *(This response corresponds to those of Lying participant # 33)*

16. Telling a lie and then later having to "come clean" results in a trust violation between patient and therapist. the therapist, rightfully, has reasons to not trust what is being said by the client. *(This response corresponds to those of Lying participant # 34)*

17. I think that it caused frustration for both the therapist and myself. Because he know that I was hiding something and I wanted to be honest but was afraid. *(This response corresponds to those of Lying participant # 37)*

18. It solidified for me that it wasn't going to be a very open and accepting relationship. *(This response corresponds to those of Lying participant # 38)*

19. I felt badly because I had been dishonest. I never lied again, but I didn't like that I had done that. So it affected the relationship because I was ashamed of myself. *(This response corresponds to those of Lying participant # 40)*

APPENDIX R.

HOW LIES AFFECTED THERAPEUTIC OUTCOME

Describe how you believe the lie or lies you told affected the therapeutic outcome. (LPS question 18):

1. The therapy would have probably been more effective if I had been able to tell the truth about the original experience. *(This response corresponds to those of Lying participant # 1)*

2. therapy would most likely have been facilitated by my taking the medication *(This response corresponds to those of Lying participant # 7)*

3. Again, the direct reason for referral was never addressed or attended to. *(This response corresponds to those of Lying participant # 13)*

4. I was not dealing with the real issue, which was having two relationships at once. *(This response corresponds to those of Lying participant # 15)*

5. It took a lot longer for my problems to be solved/ for me to be able to progress in the therapy. *(This response corresponds to those of Lying participant # 18)*

6. Delayed progress of therapy, thus delaying remittance of symptoms during that particular episode *(This response corresponds to those of Lying participant # 20)*

7. I would not talk about what some of my main issues were with my adjustment related to my traumatic past, and I stopped going. *(This response corresponds to those of Lying participant # 21)*

8. I didn't receive the help I needed, however I don't believe I could have ever received help from her due to my lack of trust. *(This response corresponds to those of Lying participant # 22)*

9. I never formed a bond with this therapist and only met with her for 2 sessions. We had scheduled a third which I forgot about. When I called to apologize for forgetting she expressed her anger at me and I didn't think to reschedule. I remained depressed and smoking marijuana for about 2 more years until I finally

quit on my own and eventually started another round of therapy. *(This response corresponds to those of Lying participant # 23)*

10. If the therapist had known the extent of previous and current drug use, he might have geared his interventions toward the drug use initially, which might have improved outcome. *(This response corresponds to those of Lying participant # 25)*

11. I completed the sessions i was required to complete (by my program) and i dropped out immediately. although i have considered going back, i don't feel that true honesty can ever be established (unless, of course, i admit the truth) *(This response corresponds to those of Lying participant # 28)*

12. prevented me from dealing with certain issues that are still problematic *(This response corresponds to those of Lying participant # 31)*

13. I believe my lie created more distance which unfortunately reinforced my notions of being isolated in my illness... and acted like a self-fulfilling prophesy in aggravating the oppositional feelings I had toward psychiatry and therapy in general. It worked against helping me accept my condition and accept help. *(This response corresponds to those of Lying participant # 32)*

14. I examined my motives for lying and resolved to tell the truth thereafter. I deliberately began to tell her everything I was ashamed of and began to resolve some longstanding issues. *(This response corresponds to those of Lying participant # 33)*

15. In some ways it may have actually made the therapeutic alliance and the therapy work stronger - having to overcome those trust issues and working on the relationship may have actually been beneficial in my case *(This response corresponds to those of Lying participant # 34)*

16. I realized that I'd eventually leave and try to get more work done with someone else. Things like this continued to pile up and I did leave. *(This response corresponds to those of Lying participant # 38)*

APPENDIX S.

HOW LIES WERE REVEALED TO THERAPISTS

If you answered "yes" to the previous question ("Did your lie ever come to be revealed to your therapist?"), how did your lie come to be revealed to your therapist? (LPS question 20):

1. We eventually worked through the issue where I was able to admit when I was actually self-injuring, and the relationship did not immediately terminate (*this response corresponds to those of Lying participant # 8*)

2. As the therapy progressed, I came clear to her (*this response corresponds to those of Lying participant # 18*)

3. As my trust in her grew, it became less necessary to lie, besides it was apparent *(this response corresponds to those of Lying participant # 27)*

APPENDIX T.

CONTENT OF INFORMATION PARTICIPANTS WERE TEMPTED TO LIE ABOUT

Content	Total
Family/home	4
Sexual behavior	3
Completion of homework/assignment	2
Details of an experience/event (general)	2
Information about a third party (not abuse-related)	2
Relationships	2
Substance Use/abuse/dependence	2
Symptoms/symptom severity (over-under-exaggerating symptoms)	2
Abuse related	1
Eating behaviors/weight	1
Finances	1
Missing an appointment	1
Parenting practices	1
Quality of life	1
Self-injury	1
Sexual orientation	1
Trauma	1
Blank/inappropriate response/did not answer	5

APPENDIX U.

INFORMATION PARTICIPANTS WERE TEMPTED TO LIE ABOUT

(WRITTEN RESPONSES)

What were you tempted to lie about? (LPS question 26):

1. yes
2. why a therapeutic assignment was not completed
3. I didn't want to disclose that my boyfriend was beating me.
4. financial resources
5. his drug use
6. I wanted to lie about my life being better than it actually was. I didn't want him to know how aweful my life was.
7. familial relationships
8. my bulimic behaviors
9. My past relationships (I had sex with a boy that I wasn't dating when I was drunk and lost my virginity). Also, my home life. I went to a very upscale university but come from a very poor background.
10. My involvement in a particular event. I may not have lied, but I might have left out relevant information.
11. missing an appointment...I thought about making up an excuse rather than simply admitting that I just didn't feel like going to the session that day
12. anything and everything
13. [response left blank]

14. I was more tempted to omit information rather than lie. Since he didn't ask about other areas, I didn't divulge it.

15. extent of stress

16. details about the trauma

17. I saw how worked up my therapist got in regards to the different roles my family members were playing, I was tempted to make it better by telling her what she wanted to hear.

18. Have I ever spanked him. Also, when she would give me specific things to try throughout the week and I could not/would not follow through, I was tempted to lie and say that I had done everything that was asked of me.

19. sexual promiscuity

20. I was tempted to leave out portions of my experience because I didn't want to cry and appear weak in front of my therapist.

21. A sexual relationship in which I was involved.

22. my relationship with family

23. Information about my sexual orientation and a relationship I was currently in. More specifically my reasons for being in the relationship and fears about it ending.

24. drug intake/alcohol consumption

25. symptom severity

26. my partner’s extramarital interests

27. I can’t remember

28. My drug use. I was tempted to lie because I lived in a small town and I was aware that this therapist had broken my confidentiality before.

29. self-harming behavior

APPENDIX V.

CONTENT OF LIES TOLD *AND* INFORMATION PARTICIPANTS WERE TEMPTED TO LIE ABOUT

Content of Lie	Liars	Tempted	Total
Relationships	7	2	9
Substance Use/abuse/dependence	6	2	8
Symptoms/symptom severity (over-under-exaggerating symptoms)	5	2	7
Sexual behavior	4	3	7
Abuse related	3	1	4
Completion of homework/assignment	2	2	4
Family/home	--	4	4
Feelings/thoughts (general)	4	--	4
Self-injury	3	1	4
Details of an experience/event (general)	1	2	3
Eating behaviors/weight	2	1	3
Medication related	3	--	3
Trauma	2	1	3
Feelings or thoughts about the therapist	2	--	2
Finances	1	1	2
Information about a third party (not abuse-related)	--	2	2
Referral Concern	2	--	2
Safety Issues	2	--	2
Suicide-related	2	--	2
Abortion	1	--	1
Codependency	1	--	1
Coping	1	--	1
Missing an appointment	--	1	1
Parenting practices	--	1	1
Quality of life	--	1	1
Self-care	1	--	1
Sexual orientation	--	1	1
Blank/inappropriate response/did not answer	--	5	5

APPENDIX W.

WHAT PREVENTED PARTICIPANTS FROM LYING WHEN TEMPTED

Please describe what prevented you from lying when you were tempted to tell a lie. (LPS question 27):

1) I talked about other things/problems other than my boyfriend.

2) Decided it wasn't worth it.

3) I knew that lying wouldn't help me feel better.

4) I thought it would damage the quality of our relationship

5) It never came up.

6) I wanted to lie, but, I keep feeling like I was cheating myself again. I wanted to establish healthy responses.

7) conscience

8) It was what I was really seeking therapy for, so even though it was scary, I thought I'd be wasting my time if I didn't tell the counselor.

9) I knew that if I lied then maybe it wouldn't work as well because they wouldn't have all the information to use.

10) Lying would not help the therapeutic process.

11) felt too guilty about lying to him and thought he would see right through it anyway and then I would look stupid

12) The therapist expressed a genuine interest in me and was able to establish rapport with me very quickly. That and the fact he didn't give me too many opportunities to actually speak in the therapy session.

13) [response left blank]

14) N/A

15) I knew I was in this for myself.

16) I felt unsafe - so instead of lying I talked with my therapist about feeling unsafe and wanting to lie.

17) My own standards. I felt more comfortable with the truth than my therapist appeared to be. I wanted to set clear boundaries with her.

18) I truly wanted my son's behavior to change and if I had lied, I would not receive the help that I needed in order to make the changes. It paid off tremendously!

19) trust and therapeutic alliance

20) I reminded myself that the therapist could help me more if she knew the whole story.

21) I had decided not to disclose information about the romantic/sexual piece of the relationship I was in, and that I would lie if directly confronted or challenged by my therapist. I was not/have not been so challenged.

22) wanted to present myself better than what I thought I was

23) I realized that if I told a lie it would undermine the progress that I had made and would prevent any further progress from occuring.

24) Thought lying would not accomplish the purpose of therapy working for myself.

25) need to be truthful

26) The realization that my therapist could best help me if she knew all the details about my situation...

27) I didn't want lying to start, because then my help from her would have been less solid.

28) My therapist never asked me questions about my drug use, so I just never volunteered the information.

29) I wanted to build a therapeutic relationship and I thought lying would harm it.

APPENDIX X.

THERAPIST/THERAPEUTIC RELATIONSHIP CHARACTERISTICS THAT INFLUENCED TRUTH-TELLING

What, if any, therapist characteristics and/or qualities of your relationship with your therapist influenced your decision to tell the truth in a situation in which you were tempted to lie? (LPS question 28):

1. I avoided conversations which may lead to lying.
2. well established rapport, felt therapist was attuned to my difficulties
3. nonjudgmental
4. She has been very honest and generous with me regarding adjusting the sliding scale to accommodate my financial situation.
5. She was patient and non-judgmental and caring. It gave me confidence that the information would not be used inappropriately
6. My therapist is an honorable man who made me feel safe in the therapeutic situation, even when if felt internally unsafe.
7. nothing
8. She called me to see how I was doing after she came back from a vacation. That and other behaviors helped me feel cared for.
9. None - the therapist 's characteristics influenced me to want to lie.
10. I knew he would be disappointed in me if I lied.
11. trust of the relationship; warmth of the relationship; his own honesty with me
12. his established rapport, genuine interest in my well being
13. [response left blank]

14. N/A

15. demeanor, how trustworthy and non judgemental she seemed.

16. My therapist was open and willing to work with me. She would tell me what to expect, was predictable, and would follow through on promises or procedures. Basically, I trusted her.

17. In this case it was my own boundaries that influenced the truth telling.

18. The therapist was not judgmental and was understanding when I told her that I found something (a homework assignment) difficult to do. She was firm, but warm and showed empathy toward my situation.

19. genuine interest and trust in the relationship that had been established

20. Her previous support and helpfulness. Her kindness and caring.

21. N/A, see above

22. felt that she was not really getting what I was trying to say

23. My therapist was non-judgmental and supportive enough that I was able to trust him with information about myself that I felt was negative or unflattering.

24. I wish I had lied. The therapist was demeaning and not helpful to my true problems.

25. yes, she seems trusting

26. She was extremely empathic, and worked from a person-centered approach. I got the feeling that she genuinely cared about me, and I didn't want to do anything that would make her like me less or influence the way we worked together.

27. She is pretty supportive of me and how I feel.

28. The only thing I've ever lied about in therapy (prior to age 18) was my drug use. I only lie if I don't trust my therapist. I had told my 2nd therapist that I used drugs and gave her permission to speak to my psychiatirst. However, I specifically asked her not to tell the psychiatrist that I smoked pot. This was because I lived in a small town and the psychiatrist knew my family well. However, the therapist did give this information to the psychiatrist. So, things I look for in a therapist are their ability to keep information confidential, whether or not they overreact to

something that I report, and their ideas about whether drug use should be turned in to the authorities.

29. The relationship had already developed rapport and I was challenging myself to be open for self-growth.

APPENDIX Y.

RESPONSES TO OPTIONAL QUESTION

OPTIONAL: Please feel free to add any additional thoughts you have which might help us better understand lying in psychotherapy.

1. I think a great deal depends on how much you are willing to share. I say this because although I have never lied to my therapist, there are many things I just haven't told her. Not so much because I don't trust her, but because I have a difficult time trusting most people, especially with this type of information.

2. I was tempted to lie because I was worried that the drug use would end up on our records somewhere and prevent us from pursuing future goals.

3. I think that if someone volunteers to go to psychotherapy, it is to their advantage not to lie because they are obviously there to help themselves, however, when there are mandates set forth, then maybe the individual will be more apt to lie...something to think about.

4. it would have been easier to complete had the survey not relied on one specific lie. Unless there is one big lie, it is hard to remember a specific one. Mine were consistent for about a year on a session-to-session basis and all involved denying some feeling I was actually having or saying that I did not like my therapist when I really did, etc. So, It was hard to think of one specific lie.

5. From personal experience i would say that when a therapist is set on their own views and beliefs about you as a client, it is more likely that I will purposefully withhold pertenant information.

6. It's important to note that I really didn't stick around long and so some of the questions about the therapeutic relationship were difficult to respond to (since it was not long enough to establish a strong alliance/relationship)

7. read "lying on the couch" by yalom. intersting book.

8. lying is often omission and not direct deceit. sometimes it is a lack of readiness to tell the whole truth or a glossing over, or believing that someone has an

impression of you which is positive but erroneous and not bothering to correct that impression. perhaps something feels true at the time because it is consistent with our personal story and that story gets edited and not true anymore.

9. I never lied in therapy because I always thought that I would be lying to myself - Moreover, I was very motivated to treatment and wanted it to work and wanted changes. I felt I had no choice but be honest...

10. My siutation involved couples counseling, which made a few of the questions difficult, but overall, I'm really interested in reading what you find in a journal someday! Good luck!

11. good luck

12. I have friends who have said they withhold info or color the truth because they're ashamed and don't want their therapists to see the "real them" but I personally cannot recall ever lying or feeling the need to lie in therapy.

13. My responses depended on which therapist I selected. I chose my most recent one, with whom I have had a positive experience. If I had used my former therapist, my responses would have drastically differed, however, my responses about lying would be the same.

14. This survey was very hard to complete because I really couldn't remember lying or having a strong urge to lie in therapy. Also, the social desirability scale is very obvious and probably not going to be very sensitive, especially for people in psychology.

15. I think some people don't lie, they just may not tell everything to keep from being embarrassed or judged.

16. The section of your survey where you are testing for truthfulness contained a question that was very confusing: I always/never live off anyone else or words to that effect. I didn't understand the question. In my clinical experience, clients always lie about something; the key is whether the issue of of clinical importance and what the underlying motivation is.

17. Interesting study!

18. I had previously seen the therapist I was thinking of during this survey to continue my work on being raped and she made me feel guilty for having been raped and still feeling strong emotions around it less than a year later. Due to this when I was referred to her for my difficulties I was very reluctant.

19. I occasionally avoid sharing certain things that I'm ashamed or embarassed about. I have found that I have only started doing that since seeing clients myself. I have not lied because I feel like lying defeats the purpose of therapy, if I'm lying I'm not doing my work.

20. It is extremely hard to remember how I felt just before such an incident, especially since I don't experience the times as "incidences," but more as a general feeling (i.e., of shame about whatever it is I would lie about). Also, I think more often than not lying in therapy will be a transference issue, which is very hard to address in terms of therapist characteristics, etc., as the transference exists unique to each individual and often regardless of therapist qualities.

21. I was open and honest with my last therapist, however I did not tell her some things I was afriad to reveal, but they were not related. However, we made better progress.

22. Most of my responses to open-ended questions did not apply to my therapist in terms of her characteristics or my experience in therapy in relation to my lying to her; rather, my lying was more of the pressure i felt due to my anxiety over being a psychology student in therapy (which i believe was the intention of my program in requiring this experience for graduation). My therapeutic experience was not voluntary, nor was I ready for the experience, which, I believe, explains my reluctance to be completely open and honest with her. As a result, I lied to "save face."

23. My personality characteristics - wanting respect and feeling shame about what I perceived as personal weaknesses and failings - were known to my therapist, and could have indicated areas where I might lie or withhold information. Now, I still occasionally withhold information that I am ashamed of (even though he is accepting and empathic) in instances where I find myself simply UNABLE to admit something even though I want to, but I will never (intentionally) lie to him. I have become unable to, as our relationship has strengthened. A major reason for this is that he models decency, integrity, and honesty, while maintaining excellent boundaries. That, plus developing the atmosphere of trust, acceptance, and confidentiality, inspires greater openness and honesty - also, at this point in treatment (three years, with him), ANYTHING might be relevant, and so I really can't withhold if I am to keep my best interests in mind and keep treatment progressing, and I ceertainly can't lie. But the therapeutic relationship is the cause of this. Without it, I would probably just be going around in circles and not getting anywhere, which was the case with the other three therapists: I did not trust them, so I wanted to present myself in the best possible light. Another very significant area related to lying and withholding information which I did not refer to when describing this incident, because it was not relevant, but which occurred with the other three previous therapists (which is why I am not with them anymore!) is a tendency for some (either very biased, or not very competent)

clinicians to pathologize all or most statements. That, understandably, leads to a reluctance to share anything that might make a person feel more misunderstood; in which case, "lying" may be the only way to accurately convey, to a person with such a bias, the "truth" about what is going on. For example, I once had a therapist who considered all anger to be indicative of borderline pathology (apparently). As confirmed by several professionals, I do not have, nor have I ever had, borderline personality disorder, but this practitioner felt that anger was diagnostic of this disorder. She also had an extremely dim view, which she did not hesitate to express, of anything she viewed as "borderline" - so, consequently, I NEVER displayed anger to this clinician, even when it would have been appropriate. I would say I was not angry when I was, and so forth - and learning to express emotion was one of the reasons I entered treatment in the first place, so obviously this was very counterproductive to a good therapeutic outcome. Stigma, which many patients have experienced while traversing the mental health system, is a powerful reason not to tell the truth. As a student therapist I have also encountered this: patients do not want to be mistreated, misdiagnosed, misunderstood, stigmatized, discriminated against, involuntarily committed when not necessary, and so forth - and so they are not honest about facts that have earned them such treatment in the past. (I am not including denying suicidality in a patient who is acutely suicidal - that is an entirely different situation). I believe in general lying and withholding decreases as the trust increases and as the relationship becomes stronger, but it can take a lot of work. And, when it does occur, it can be a very valuable insight into a patient's personality - context, content, circumstances, etc. of the lie can function as a "projective test" to an alert clinician.

24. great survey! i'm glad someone is studying this. in most clients, i think lying occurs as a symptom of a poor therapeutic relationship, primarily when a person feels they will be judged by the therapist and/or when they feel the divulgence will take them down a futile or frightening road in therapy. that's my 2 cents.

25. It seems that your construct for lying is in terms of providing false information. It seems to me, that leaving out relevant information that potentially alters the story being told in therapy is also a form of lying--and the one that is most related to my responses to your questionnaire.

26. I found some difficulty in completeing this survey as I have seen multiple therapists and I wasn't sure if I should consider my answers by sticking strictly to the therapist I am currently seeing or if I should have picked a therapist that I have seen in the past. I sort of found myself having a lot of different answers based on which therapist I was considering. I tried to stick to one particular therapist throughout, but this was difficult. Plus, the relationship ended on a really bad note and thus may affect my objectivity!

27. in terms of the survey, I noticed there was no n/a, or doesn't apply, to some of the therapist items-- for example--the nature of the therapy with my therapist-- she never would have advised me, so it is hard to assess what I thought of her advice (good/bad/agreed with/disagreed with) just based on her orientation. You might think about that, depending on how some of the data looks.... In the same light, it might be interesting to know orientation-- my therapist was psychodynamic, so I talked, she listened and guided a little, but it may be for that reason I felt little pressure to lie. Had I been with someone more directive, with their own agenda, perhaps it would have felt different? Very interesting stuff!

28. I think my lying in therapy was directly the result of my issues and didn't really reflect anything the therapists had done. I no longer feel the need to lie to my current therapist becasue I have stayed in the process long enough to resolve the underlying issues that prompted my "defensive" lying.

29. One of the best parts of therapy is the opportunity to be more honest than I ever would be by myself. I treasure that. On the other hand: while I've never lied outright, I have manipulated my therapist in order to avoid crying or otherwise expressing painful emotions--after a long time of working together, I know how I can get her to go into lecture mode, and I have done so semi-consciously at times.

30. Interesting questions. Regarding telling lies to my therapist--as I was answering questions, I realized that many times I told likes or exaggerated truths as a means of testing my therapist's commitment to me and my therapy. Best of luck in your academic endeavors.

31. I have lied for many different reasons. Since I have been in and out of therapy for almost 15 years. Some reasons that I have lied in therapy are shame, fear of disapproval, desire to not relive the look of horror on the therapists face when you tell them the things that you have lived through, the fact that they constantly probe that same area. No matter how much you look at something it is still there.

32. I only had 3 sessions w/ my therapist and haven't formed a strong therapeutic relationship w/ him. Personally, if I don't have a strong relationship w/ someone, I usually do not care much about how that person thinks of me, and therefore, do not feel the need to lie to that person.

33. Good Luck!

34. I might choose not to reveal certain information that I think my therapist would disapprove of (or would complicate the therapeutic issues), but I would not lie outright. I might just skip over potentially relevant information if not asked directly about it.

35. I would suggest giving other names, perhaps even euphemisms for lying such as embellishments. I had a hard time recalling whether I told a lie or not to any of my therapists. I tend to be quite open in therapy and sincerely couldn't think of a lie I told. However, I may have "played a story up" but couldn't think of a specific time of that either. I tried to answer the survey as best I could. Good luck. I would like the $50 in the form of a personal check ;)

36. You might have asked the question in a way that included the peron's conscious "intent" to lie or not. I think that is important and might affect your research outcomes.

37. I truly believe that lying in psychotherapy is caused because of lack of trust between patient and therapist. If lying occurs or is thought about, I strongly suggest the patient seeks another therapist. I would like to sees the results, if you would kindly send them to me. I would greatly appreciate it.

38. I think it is true that there can be different motivations for lying. I think that a lot of times, the client is aware of the reasons for lying, but not necessarily how it may affect the therapeutic relationship or doesn't think about what it means about the relationship. If the therapist can set out that sometimes patients omit some things or change things for the therapist, it may normalize it and also make it something they can talk about if it comes up.

39. The items that asked about therapist advice giving were suprising to me. I do not go to a therapist for advice and feel that if my therapist were to give me advice she would be crossing a professional boundary. As a student in a PsyD program, advice giving was one of the first things we were trained NOT to do as therapists!

40. I was tempted to lie to my therapist about a personal problem that was difficult for me to talk about. I did not lie to my therapist because I did not want to jeopardize our therapeutic relationship. The negative views that I now hold regarding the thearpist are mostly because of how they handled the personal information that I ended up not lying about. It was a big decision for me not to lie about it and because of what resulted I wish I had lied about it.

41. It may also depend on the demographics of the therapist

42. As a person, I am not inclined to lie on a regular basis. As a client, I would be more inclined to lie to my therapist early in the therapeutic relationship. I feel that it is more difficult to lie to others once you feel that you know them. Good luck on your dissertation

43. I wasn't sure if lying included intentionally leaving out info or exaggerating info in order to impress an idea or keep the therapist from discovering something. This was more common for me than giving an outright lie.

44. I believe that lying in psychotherapy is a defense mechanism and paramountly proves that the client does not trust the therapist, and has issues with trust in general.

45. Because of the severity of the issues I was working on, I was actually lying to myself. With each successive therapist I became more comfortable with the truth and it became easier to speak. Side note: You did not ask about gender differences. I lied the most about sexual abuse to my male therapists. Just a thought; content and gender are probably covariates.

46. Sometimes it's not a matter of lying per se -- but avoiding difficult topics. If the therapist does not probe in those areas, you may avoid them altogether even if they are very important. Even though I told my therapist what these "hot topics" were and that I would probably avoid them, she rarely brought them up...

47. When I was lying to my therapist, I was also fooling myself in a way. At the time, I only thought of my lie as a natural, "white lie" to present myself in slightly favorable light, when in fact it was a total misrepresentation. I wonder if it may be interesting to look at that aspect- to look into the self deception and lying to others in the course of therapy.

48. you might consider differentiating between lying by ommission, e.g., witholding information, denying feelings or wishes vs "outright" lying--telling a direct lie, e.g. denying you had drunk alcohol before a session when in fact you had. good luck--your results should be interesting

49. Because I am 55 years old and went to therapy the first time at age 23 I could not remember details from that long ago. I was not tempted to lie to my most recent therapist.

50. might differentiate between lies of comission and lies of omission

51. I personally did not lie directly in therapy. Rather I omitted divulging information that was not specifically asked about.

52. I think this is an important topic and am glad you are looking at it.

53. I feel that when a person chooses to enter into the psychotherapeutic relationship, it is not in her/his best interest to lie about anything. I did not lie to my counselor, but I did withhold some details which I felt were too shameful, and I admitted

this to her. She encouraged me to tell her those details when I was ready, which I felt was the perfect response.

54. This survey was an interesting experience for me. I think my instance of lying was due to an interaction between my own shame and need to be seen as perfect, and working with an EAP therapist who was rushing things due to time constraints (only 3 sessions covered by my employer). I never formed a trusting relationship with her, and 3 sessions did not seem adequate enough time for me to trust her.

55. I felt that the final survey in this battery was a lie or integrity test as it used many always and never formatted items. I assumed that this was to discover individuals who might be "faking good".

56. What's your definition of lying? Would it include avoiding certain topics, or not telling full truths?

57. I never lied but there were a few things that I never brought up.