THERAPISTS' BELIEFS AND ATTITUDES TOWARDS CLIENT DECEPTION

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To the Dean of the Graduate School:

I am submitting herewith a dissertation written by Drew A. Curtis entitled "Therapists' Beliefs and Attitudes Towards Client Deception." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Counseling Psychology.

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We have read this dissertation and recommend its acceptance:

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Accepted:

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DEDICATION

God for His loving grace and mercy.

To my wonderful, loving, and supportive family: Rachel, Lydia, and Isaiah.

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ABSTRACT

DREW A. CURTIS

THERAPISTS' BELIEFS AND ATTITUDES TOWARDS CLIENT DECEPTION

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The current study investigated therapists' beliefs about indicators of deception and attitudes towards client deception. Participants were recruited from various APA accredited internship sites. Participants completed a Demographics Questionnaire, the Detection of Deception Questionnaire, and the Therapist Attitudes Towards Deception Scale. The questionnaires were used to assess therapists' beliefs and attitudes towards client deception. The results indicated that therapists possess many inaccurate beliefs about indicators of deception. Therapists held the most accurate beliefs about paraverbal indicators of deception compared to nonverbal and verbal indicators. Therapists also held a number of negative attitudes towards client deception. There was not a statistically significant relationship between therapists' attitudes and their worldviews. Further implications of therapists' beliefs and attitudes towards deception are discussed.

TABLE OF CONTENTS

Page

LIST OF TABLES

CHAPTER I

INTRODUCTION

Everyone lies! This phrase is often quoted by the popular, arrogant, and highly intellectual television character, Dr. Gregory House (Mitchell & Singer, 2004). An initial response in reading the phrase may elicit dissonance or unease. Claiming that everyone lies may lead to a realization that you lie or others lie to you. People often judge typical interactions with others as honest and truthful (Bond & DePaulo, 2006) and most social interactions consist of more truthful statements than deceptive ones (Vrij, 2000). Thus, hearing that everyone lies elicits strong reactions because it is contrary to how people perceive the world (Vrij, 2008). Believing that most people are honest and most social interactions involve telling the truth may lead people to become susceptible prey of deceitful people. People may also believe that most interactions are honest because they do not want to entertain the possibility that they were victims of deceit (Ekman, 1996; Vrij, 2000, 2008). Ignorance of the truth may be preferred to dealing with the consequences of a truth. Yet, deception plays a crucial role within social dynamics. When asked to consider how often a person lies, people indicate that they probably lie on average, about two times a day (DePaulo & Bell, 1996; DePaulo & Kashy, 1998; Kashy & DePaulo, 1996, Vrij, 2000) to a variety of people, including significant others, spouses, and even therapists (DePaulo, 2009; Kottler & Carlson, 2011). Overall, most people are often successful with their deceit.

Origins and Definitions of Deception

Throughout time and culture, deception has been recorded and people have tried to make sense of deceit. The origins of deception, for followers of the Bible, traces back to the book of *Genesis,* when the serpent lied to Eve (Genesis 3:1, English Standard Version). The book of *Genesis* illustrates the introduction of deceit and views it as sinful and leading to the fall of humankind. On the other hand, in Greek mythology, Hermes earned his status among the gods by deceiving Apollo and through telling Zeus what he wanted to hear (Graves, 1955). Stories involving Hermes as a deceiver or trickster demonstrated how the use of deception can be used for personal gains. Alternatively, the Hindu god, Krishna, deceives in order to bring about a higher moral purpose (Leeming, 1990). Even children's fables have been known to impart morals regarding topics such as deceit. For example, the moral of Aesop's *The Boy Who Cried Wolf* is simply that one should not lie (Aesop, 1793). Deceit is a concept that has been seen throughout time and a variety of definitions have been proposed by various theorists and researchers.

Communication is laden with many dynamics and reaching a consensus of honest communication can be difficult at the least. Thus, defining lying or deceptive behavior comes with the difficult task of accurately honing in on the components of a lie. Various definitions of dishonesty, lies, and deceit have been proposed and modified to achieve an accurate explanation of deception.

Burgoon and Buller (1994) defined deception as "a deliberate act perpetrated by a sender to engender in a receiver beliefs contrary to what the sender believes is true to put

the receiver at a disadvantage" (pp. 155-156). The proposed definition encompasses the interpersonal dynamics between a sender and receiver of a message. Also, the definition addresses the intentionality of deception. Some communication that is misleading unintentionally would not be considered deceptive. For example, a person who provided another with faulty directions due to a lapse in memory would not be considered a liar. The definition of deception addresses subjective versus objective truth by stating that the message is contrary to what the sender believes is true. Thus, deception is based on the intent of the sender, in that the sender is intentionally trying to convey a falsehood based on what the sender believes to be false. A drawback of the proposed definition is that it claimed that deception would place the receiver at a disadvantage. Some lies are told for the sake of others (DePaulo, Kashy, Kirkendol, Wyer, & Epstein, 1996) or to protect the receiver's feelings (Ekman, 2009). Another limitation of the definition is that it does not discuss forewarning of the sender. Some people may warn others about their intentions, which would not be considered deception. Actors convey false impressions and statements to an audience but the audience is forewarned that they will be deceived about these events.

Another definition offered by Ekman (2009) identified deception as "one person intends to mislead another, doing so deliberately, without prior notification of this purpose, and without having been explicitly asked to do so by the target" (p. 28). The definition speaks to the deliberate nature of deception and also the hidden intent to mislead the target. Although Ekman's definition of deception encompasses most of the

components of deceit, it does not include the outcome of the lie, as argued by Vrij (2000, 2008).

Consequently, Vrij (2000, 2008) comprehensively discussed various definitions of deception, weaknesses within each definition, and proposed an alternative definition. He defined deception as "a successful or unsuccessful deliberate attempt, without forewarning, to create in another a belief which the communicator considers to be untrue" (Vrij, 2008, p. 15). This definition speaks to the deliberate nature of deceit, hidden intentions from the target of deceit, and the variability of consequences from attempts (i.e., successful or not). Vrij's (2000) definition is active in nature as it specifically addresses human deception rather than passive encompassing deception of non-human species. Because of the comprehensive nature of this definition, it has been widely used in recent research (e.g., Granhag & Strömwall, 2004; Hart, Filmore, & Griffith, 2009). As a result, the current study will utilize Vrij's definition of deception in order to account for the various aforementioned components that formulate a lie. Furthermore, this term will be used interchangeably with lies, which is a practice found among other authors (e.g., DePaulo et al., 2003; Hart et al., 2009; Hartwig & Bond, 2011; Vrij, 2000).

The Shades of a Lie

Having a working definition allows a strong foundation for what qualifies as deception but there are still many communicative nuances that fit the definition's framework. Many lies can and are told on a daily basis (DePaulo et al., 1996; DePaulo &

Kashy, 1998), and those lies take a variety of forms: outright lies, exaggerations, and subtle lies (DePaulo et al.; Vrij, 2000).

Outright lies are purposeful and explicit lies (DePaulo et al., 1996; Vrij, 2000). An outright lie is a falsehood that is intended to be completely different from or as far removed from the truth as possible. For example, telling a teacher that you were not talking during class when, in fact you were, would be an outright lie. Furthermore, such lies do not necessarily need to have evidence against the truth. For example, a teenager who smokes cigarettes and has never smelled of smoke around his parents could lie to his parents by telling them that he does not smoke. Overall, most lies told, about 67% for college students and 59% for community members, are outright lies (DePaulo et al., 1996).

Another type of lie, an exaggeration, is seen as overstating the facts or creating an impression beyond the truth (DePaulo et al., 1996; DePaulo & Kashy, 1998). About 14% of college students and 9% of community members reported telling exaggerations (DePaulo et al., 1996). As opposed to the outright lie, some truth may exist with an exaggeration. For example, a person may exaggerate their feelings of sympathy for another person's pain.

The third type of a lie is a subtle lie. Subtle lies are described as omitting relevant details and telling literal truths with the intent to mislead another person (DePaulo et al., 1996; DePaulo & Kashy, 1998). These types of lies may be sometimes referred to as lies of omission. About 8% of college students and 23% of community members reported

telling subtle lies (DePaulo et al., 1996). A form of subtle lies may be found in an example of infidelity where a person is asked by a significant other if he or she is cheating. The deceiver replies that he or she loves his or her significant other. The deceiver told a literal truth about loving his or her significant other and was able to avoid directly answering the question about cheating. Thus, the deceiver intentionally omitted information about infidelity.

Deception in Therapy

One of the more popular examples of deception in psychotherapy involved the staff from 12 hospitals who were unknowingly being deceived by eight pseudopatients, feigning symptoms of hearing voices (Rosenhan, 1973). The experimenter utilized psuedopatient deception to gain information about the reliability of mental health professionals as well as examine the effects that labels may have on individuals within psychiatric facilities. Though the primary purpose of Rosenhan's study was not in examining deception or its detection, it brings forth the issue that clients may enter therapy and lie. Clients enter therapy and decide what they want to reveal. In the process of sharing information, clients may deceive through purposefully omitting information, altering details of a narrative, or even outright falsifying statements.

Because much of the deception literature suggests that people lie within everyday situations (DePaulo et al., 1996), then it is reasonable to consider that deception may be involved within therapy. Given that therapists have been shown to have higher rates of accuracy in detecting deception (Ekman, O'Sullivan, & Frank, 1999), then it is important

to look at the beliefs and confidence that therapist hold in detecting deception. Currently, there has been little research investigating deception as a variable of interest in therapy.

Therapy Defined

Similarly to deception, many contributors have sought to define therapy. There are about as many definitions of therapy as there are of psychotherapy theories. Many theorists define therapy in terms related to their theories, worldviews, experiences, and philosophies. Thus, defining therapy can be a daunting task. Prochaska and Norcross (2010) claimed, "no single definition of psychotherapy has won universal acceptance" (p.3). However, some authors have sought to evaluate multiple theories of psychotherapy and define these therapies by their common thread or by a definition that can be broadly applicable and accepted among a majority of these various theories. In Corsini and Wedding's (2005) writings on various psychotherapies, they propose a definition for therapy. Due to the difficulty of the task to establish an all-encompassing definition, the authors cautioned that the definition may not be completely inclusive. However, the current study will define therapy in terms of Corsini and Wedding's definition. The authors defined therapy as:

> Psychotherapy is a formal process of interaction between two parties, each party usually consisting of one person but with the possibility that there may be two or more people in each party, for the purpose of amelioration of distress in one of the two parties relative to any or all of the following areas of disability or malfunction: cognitive function (disorders of thinking), affective functions

(suffering or emotional discomforts), or behavioral functions (inadequacy of behavior), with the therapist having some theory of personality's origins, development, maintenance, and change along with some method of treatment logically related to the theory and professional and legal approval to act as a therapist. (p. 1)

This working definition is strong because it addresses the nature of therapy involving a relationship between at least two parties. Furthermore, the purpose of therapy is geared towards helping the client with the distress. The proposed definition accounts for the purpose of therapy to relieve or eliminate the client's distress.

Some authors report that there are distinctions between therapy and counseling (Corsini &Wedding, 2005). The primary difference noted involves the length of therapy. Counseling has been understood as being shorter in length, one to five sessions, and psychotherapy has been traditionally viewed as long-term, up to many years of therapy (Corsini & Wedding, 2005). For the purposes of the current study therapy, psychotherapy, and counseling will be used interchangeably.

A therapist will be defined as any person who practices therapy. For the purposes of this study, therapists will include persons practicing therapy with a license and non-licensed graduate students who practice under the rights of their institutional program. Terms that may be used interchangeably with therapist will be counselor, practitioner, mental health provider, and psychotherapist.

Overview of Study

Given the increasing number of articles and writings that are examining deception within an array of scholarly disciplines (e.g., Burgoon, & Buller, 1994), forensic settings (e.g., Vrij, Granhag, & Mann, 2010), across cultures (Global Deception Research Team, 2006), and the general public (e.g., DePaulo, 2009) it is imperative to extend upon the current research base. Understanding that deceit occurs within a variety of social contexts, and given that the therapeutic context involves frequent exchanges in communication between client and therapist, it is important to examine deception within therapy. To date, limited research has investigated deception within the therapeutic context (e.g., Briggs, 1992, Langer, 2010; Sitton & Griffin, 1981).

There are numerous reasons to explore deception within therapy. First, the literature on deception and therapy is limited. Second, it is important to investigate deception in therapy because therapy is a relationship, and the research (e.g., DePaulo & Kashy, 1998) has demonstrated that people lie within the context of relationships. Third, therapists are usually not trained to explicitly deal with deception in therapy; therefore, research implications could enhance training models. Fourth, therapists may hold accurate beliefs about indicators deception and place a confidence in their abilities to detect deceit. Lastly, therapists may have attitudes towards deception and its detection within therapy, which may impact therapeutic effectiveness.

The current study has added to the current literature base by investigating therapists' accuracy and attitudes towards deception in therapy. Through this research, a

greater understanding of how deception impacts the therapeutic relationship has been attained and provides direction on how to address the concept in this context.

CHAPTER II

LITERATURE REVIEW

The fields of social psychology, forensic psychology, and communications have been the forerunners in researching deception. The bulk of deception studies have examined its detection. Recently, attention to the importance of deception detection has increased (see Vrij, 2008). The application of deception and detection literature can reap benefits for forensic contexts, social relationships, dating relationships, workplace interviews and relationships, or even everyday interactions.

In this chapter, the reasons that people lie are discussed. Next, the experiences of liars, theories of understanding lies, individual differences, social and cultural influences of lies are examined. Thirdly, exploring methods used to detect deception and the accuracy and beliefs about deception are addressed. Next, deception within the therapeutic situation is reviewed, and finally, the purpose of the study and relevance to the field of Counseling Psychology are presented.

Reasons People Lie

Motivations for lying fall into three dimensions: (a) the oriented direction of benefit or whether it benefits the deceiver or target of deception, (b) gaining advantage or avoiding loss, and (c) for materialistic or psychological reasons (Vrij, 2008). The categories for these motivations are dimensional and not mutually exclusive. Thus, a lie

could be told to gain a selfish advantage concerning materialistic rewards. The following section examines these three motivations for lying.

Self-Oriented and Other-Oriented Lies

About 50% of lies told are self-oriented lies (DePaulo, et al., 1996). Self-oriented lies are told to protect liars from physical, emotional, and/or psychological harm or to provide lairs with some advantage (DePaulo et al., 1996). For example, in a self-oriented lie a person may tell others that he or she likes something, such as football, when he or she despises it, in order to avoid social rejection and gain acceptance.

In addition to telling lies to benefit the self, people are also motivated to tell lies in order to benefit others or make others appear better. These are other-oriented lies. Approximately 25% of lies told are other-oriented lies (DePaulo et al., 1996). Other-oriented lies are told to protect other people from physical, emotional, or psychological harm or to provide others with some advantage. People are often motivated to tell other-oriented lies to people they like (Bell & DePaulo, 1996). For example, a person may be more likely to lie to a significant other about liking a meal that was cooked by him or her than to tell a restaurant chef that the meal was horribly cooked.

Another noted motivation for lying is a combination of self-oriented and other-oriented lies. About 25% of lies serve a self-interest and the interest of others (DePaulo et al., 1996). Vrij (2000) referred to these types of lies as social lies. Social lies exist to promote and maintain social relationships. These lies differ from self- or other-oriented lies because they are primarily motivated to preserve social relationships rather than just

one person. Self-oriented lies serve the best interest of the deceiver and other-oriented lies are told for the benefits of others. Vrij argued that honesty all the time would lead to awkward social interactions and people may be seen as unnecessarily rude. Being honest by telling a boss that he or she is not really liked and one is only pretending in order to gain a promotion would likely be seen as rude, inappropriate, or just foolish. As a consequence, one would also be adversely affected in her or his job.

Lying Based on Emotions

People may lie in response to an emotion, to conceal an emotion, or to foster an emotion. For example, fear can often be a motivator to lie (Ekman, 2009). The truth can hurt. Telling the truth can sometimes hurt the receiver, which may result in negative consequences for the truth-teller. For example, telling a friend that you dislike his or her interpersonal communication style with your other friends may hurt your friend. In turn, your friend may cease the friendship or avoid social gatherings with you. Thus, the fear of the potential consequences motivates people to lie versus tell the truth (Ekman, 2009). Furthermore, the fear of getting caught for any transgression can motivate telling lies (Ekman, 2009). For example, a person who is having an affair may lie in response to a fear of being caught.

Alternatively, lies can be told to conceal emotional expression (Ekman, 2009). People frequently enter social situations in which they lie rather than offer their true emotions. Lying to conceal emotions may be influenced by gender role socialization or by social norms. On the one hand, the acceptability of displaying particular emotions is

influenced by societal gender roles. For example, women in the United States of America are more likely to suppress anger expression and display other emotions (Cox, Stabb, & Hulgus, 2000). For example, a woman who felt anger as a result of a traffic incident may tell co-workers, when asked, that her day is going well. Telling the truth would reveal the woman's true feeling, anger. Due to anger not being an acceptable emotion to display for women, the woman may lie to her coworkers in order to conceal the emotion. Lying to conceal emotions may also be influenced by social norms. Situational variables influence individuals to adapt their behavior to the situation (Deutsch & Gerard, 1955). When placed in a public situation people may change their opinions or behaviors to mimic group members (Argyle, 1957). People may conceal thoughts or emotions from group members in favor of responding similarly with the group even when group members provide incorrect or inaccurate responses (Asch, 1955).

Telling lies can also be a means to create or perpetuate a positive emotion. For example, some people tell lies in order to feel happiness. Lying to a date about your vested interest in that person may enhance the rest of the date night. Lying can also result in good feelings for the deceiver. Successfully deceiving another person may lead to what Ekman (2009) referred to as duping delight. Duping delight is a positive feeling in response to successfully lying to another person. If a lie is successful, then the deceiver may feel a sense of accomplishment from telling the lie and duping another. The positive feeling is a result of not getting caught by the person who was duped. Though there does

not need to be an audience to witness the lie being told, the greatest intensity of duping delight is felt when an audience is present.

Lying as a Learned Response

From an early age, children develop the ability to be deceptive (Sodian, 1991). Learning to tell lies gets reinforced through operant conditioning (Skinner, 1938). Principles of reinforcement and punishment affect the likelihood of behaviors to occur in the future (Skinner, 1938). For example, a 3-year-old boy takes his sister's toy which leads to her crying. Parents soon hear the sister's cries and attempt to interrogate the children. The boy is asked what he did to his sister and he answers them by stating he took the toy. The young boy is then reprimanded. As a result, the child learns that honesty leads to a negative consequence. Consequently, the next time the young child is interrogated for taking something that was not his, he seeks to avoid punishment by lying. The punishment is this time evaded by not receiving an aversive consequence for his actions. Though children may directly learn to lie by avoiding punishment or through reinforcement, they also learn to lie through social learning (Bandura, Ross, & Ross, 1961).

Learning to lie at an early age may be strengthened through reinforcement and carried into adulthood (Skinner, 1938). Society may reinforce lying through social norms. People avoid telling a truth in order to avoid being ostracized or punished by other members of a group if the behavior conflicts with normative social influence (Asch,

1955). Conversely, lying in order to maintain social norms could be reinforced through praise or social acceptance (Asch, 1955). For example, telling a host of a formal dinner party that you do not enjoy the company and food may result in a rude response or being asked to leave.

Experiences When Lying

Liars may experience three processes when lying: (a) emotional, (b) content complexity, and (c) behavioral control (Vrij, 2000, 2008). People may experience various emotions when they are lying that range from guilt to excitement. Lying to a significant other about infidelity may bring about guilty feelings if the liar is remorseful or emotionally close to his or her partner. Telling lies can also create fear within someone, in that you may be afraid of getting caught. On the other hand, excitement can also be felt if the liar is getting away with telling the lie (Ekman, 2009).

Telling lies can also be cognitively complex through exhausting cognitive resources (Vrij, 2008). Fabricating a story that requires creating many specific details that are woven together to form a coherent narrative can require cognitive resources. Furthermore, consistently recalling and retelling details of a false narrative may be more cognitively taxing. It requires fewer cognitive resources to rely on one's truthful recollection than to falsely create a story. Thus, falsifying more specific details of an event requires more cognitive resources. A person who wishes to avoid awkwardness from denying a lunch date with a fellow co-worker may deceive through fabricating alternative plans. However, questions asked around the details of the co-worker's plans

may yield a challenge in which the co-worker is put on the spot to create a coherent narrative. Saying that one is not available to attend lunch may be less challenging than coming up with specific details about the restaurant, place, or type of food.

Finally, people who lie may also experience a need to control their behavior (Vrij, 2008). When telling lies, people will try to act in a normative fashion, by suppressing behaviors (Burgoon & Buller, 1994; Vrij, 2000). Facial features and reactions are examples of behaviors that people may try to control and may not be seen as normative but as more rigid or planned (Ekman, 2009). For example, believing that gaze aversion is a behavior that liars show, people who are motivated to successfully lie may suppress gaze aversion and stare rigidly and unnaturally.

Individual Differences

In telling lies people may differ on frequency, motivation, and comfort. These individual differences within deception have been ascribed to various deceptive personality types. Vrij (2000) labeled four personality types that deal with deception in unique ways: manipulators, actors, sociable people, and adaptors. Manipulators are people who often tell self-oriented lies and are persistent in deception. In addition, these individuals are also manipulative, hedonistic, egocentric, show lack of remorse, and have a general preference for lying. Interpersonally, they lie when advantageous and are aware of the consequences that may occur from their deceit. Furthermore, manipulators are often liked by others more (Kashy & DePaulo, 1996). Being liked by others may serve as reinforcement for manipulators to increase lying behaviors.

On the other hand, actors are viewed as skilled regulators of their verbal and nonverbal behaviors (Vrij, 2000). Essentially, these personality types maintain emotional control in communication. Actors are also seen as being persistent in telling lies, experiencing little discomfort in doing so, and have less difficulty in telling lies. The term actor is used to portray these individuals as people who exercise a great deal of control in emotion and nonverbal behaviors. These individuals have a great ability to role-play in numerous social situations.

The third personality type discussed is termed sociable people. These individuals are often attracted to social situations, extraverted, and are motivated to lie to maintain a social conversation. Sociable people lie at higher rates than non-sociable people (Kashy & DePaulo 1996; Vrij, 2000). Sociable people may be motivated to lie in order to be favored by others, promote social interactions, and to avoid conflict within social situations.

The final personality type described by Vrij (2000) is adaptors. These individuals are seen as socially anxious people who are highly motivated to make a positive impression. Adaptors may adjust to social situations by lying, in order to make good impressions. Unlike the sociable person, adaptors may be motivated to lie to avoid the social awkwardness that sometimes occurs with honesty (Vrij, 2000).

Social and Cultural Influences

Personality captures particular characteristics of people who lie and the various attitudes and comfort they have in lying; however, social and cultural influences also

contribute to deception. Vrij (2000) claimed that, "how often people lie depends on the situation" (p. 8). Though people tell an average of two lies per day, deception occurs in various situations and some situations elicit more deception than others. Due to the influence of social norms on perceived deceptive cues, deviance from the norms would be seen suspiciously or more likely deceptive (Bond et al. 1992). People who do not follow social convention or may be unaware of societal norms may fall prey to being seen as more suspicious (Bond et al., 1992).

In some situations it may be more difficult to tell a lie due to the cognitive challenge (Vrij, 2000). Lying about something in which one has little to no knowledge can be very cognitively complex and may lead to refraining from lying all together. Furthermore, people may not be motivated to lie. If a group of men are talking about cars and you have no interest in cars or the group of men, then you may not be motivated to lie within that social interaction.

Other social situations may influence people's willingness to lie. For example, 83% of students reported that they are more willing to lie to get a job than they are to lie to close friends (Robinson, Shepherd, & Heywood, 1998). Overall, it is perceived as more wrong to lie to friends than to potential employers. Dating is another social context that is perceived as a permissible context for deceit. A majority of people, 90%, report willingness to tell at least one lie on a date and are more willing to lie when a prospective date was rated higher in facial physical attractiveness (Rowatt, Cunningham, & Druen, 1998, 1999).

Similarly, men and women may tell lies based on situational factors. In comparing gender, there were no differences found in the frequency of lying between men and women (DePaulo et al., 1996). However, men and women tend to tell different lies. Some of this research parallels with the research on conformity, in which there are no significant differences between men and women among conformity rates but differences exist when the task they are presented with is relatively unfamiliar to them (Eagly & Carli, 1981). Men tell more self-oriented lies and women tend to tell more other-oriented lies (DePaulo et al., 1996). Women may offer more compliments to others and avoid saying things that may hurt others' feelings.

Cultural differences are ever present with the United States of America (McAuliffe, 2008) and understanding these differences has slowly progressed within the field of psychology (Hall, 1997). Lies are also witnessed across cultures. In defining deception, some examples of deceit found within cultural groups were noted. In investigating American, Jordanian, and Indian cultures, lies were told and detected within these cultures (Bond & Atoum, 2000; Bond, Omar, Mahmoud, & Bonser, 1990). A study of 58 countries revealed that people in each of those countries held beliefs about liars (Global Deception Research Team, 2006). The common belief held across these cultures was that liars avert their gaze. However, research on indicators of deception does not support this belief (Vrij, 2008).

Differences in ethnic origins can complicate deception detection (Vrij, 2000). Research has shown that Black individuals are viewed with more suspicion by Dutch

Caucasian police officers, which is attributed to the differences between behaviors displayed by respective cultural groups. Thus, defying social norms or violating the majority behavioral-expectancy may lead to suspicion from the majority culture and result in being perceived as deceptive. Vrij discussed how eye contact in Western cultures is seen as polite, but may be rude in other cultures. Consequently, he further notes that African-Americans may avert their gaze from White authority figures and this may be judged as a sign of deception.

Detecting Deception

Detecting deception has become increasingly popular. The television show titled *Lie to Me*, a series based on a professional lie detector, began airing in January 2009 and has successfully reached its third season (Lie to Me, 2010). The show's main character features a psychologist, Dr. Cal Lightman, who is based on a leading researcher in deception detection. Much of deception research is tailored to investigating how to detect deception (e.g., Bond & DePaulo, 2006). Thus, it is important to discuss research and findings related to detection deception.

When it comes to being able to detect deception, Vrij (2000) claimed that "There is nothing like Pinocchio's nose" (p. 24). Basically, there is no typical lying behavior. Liars do not tell lies followed by their nose growing, which would make it much easier to detect them. Contrary to popular myth, deception does not follow one set of behaviors, which is what makes detecting deception a complex task. Nonetheless, there are some indicators of deception which include nonverbal and verbal behaviors.

Nonverbal Behavior Indicators of Deception

Deception often does not present people with opportunities to verify truth. When there is no information to verify truth, people may rely on nonverbal behaviors to detect deception (Vrij, 2000). Nonverbal behavior can be understood as "behavior that reveals a person's feelings without words" (Brehm, Kassin, & Fein, 2005, p.100). Smiling, head nods, and hand movements are all examples of nonverbal behaviors. Nonverbal behaviors are often referred to in detecting deception; however, there is no typical nonverbal behavior that definitively indicates deception.

There are four reasons addressed as difficulties in controlling nonverbal behavior (Vrij, 2000). The first reason is that there are strong associations between nonverbal behavior and emotions (Vrij, 2000). Associations are made from early years of development and are expressed through physiological reactions (Ekman, 2009). Facial responses to emotion have been referred to as microexpressions (Ekman, 2009). Secondly, people are generally more attentive to words than nonverbal behavior (Vrij, 2000). Thus, the lack of attention to nonverbal behavior makes it more difficult to control these behaviors. Reading and writing skills are typically emphasized in school more than understanding nonverbal behaviors. Thirdly, words are often viewed as more important than behavior in social interactions (Vrij, 2000). If nonverbal behaviors are not viewed as important as verbal content, then verbal content will be more salient and require more attention and energy. It is usually trained professionals who are attentive to nonverbal communication. Psychologists, graduate counseling students, orators, and others who

specialize in some form of communication may be ones who are aware of nonverbal behaviors. Therapists are often trained to attend to nonverbal behaviors when learning basic interviewing skills (Ivey & Ivey, 2003). Finally, people may be able to silence themselves from words but muting nonverbal is near impossible for people (Vrij, 2000). People still react with nonverbal behavior even if content is suppressed. Reacting with nonverbal behaviors can provide information about cues to deception.

Nonverbal behavioral indicators of deception include eye contact, eye blinks, head movements, hand and finger movements, arm movements, leg and foot movements, smiles, postural shifts, shrugs, and gestures (Hart, Hudson, Fillmore, & Griffith, 2006; Vrij, 2008). Prior research has revealed a decrease in hand and finger movements, arm movements, leg and foot movements when people tell lies (Hart et al., 2006; Vrij, 2008). See Table 1 for a list of nonverbal indicators of deception (Hart et al., 2006; Vrij, 2008).

Table 1

Nonverbal Indicators of Deception

Deception Variable	Prior Research
Eye contact	No change
Eye blinks	No change
Head movements	No change
Hand and finger movements	Decrease
Arm movements	Decrease
Leg and foot movements	Decrease
Smiles	No change
Postural shifts	No change
Shrugs	No change
Gestures	No change

Note: The current table was adapted from Hart and colleagues (2006).

Verbal and Paraverbal Indicators of Deception

Researchers suggest that there is no typical verbal deceptive behavior (e.g., DePaulo et al., 2003; Vrij, 2008). However, as with nonverbal behavioral indicators, there are some verbal indicators of deception (Akehurst, Köhnken, Vrij, & Bull 1996; DePaulo et al., 2003; Vrij, 2008). Verbal indicators that are more likely to occur with deception which includes more negative statements, more implausible answers, shorter responses, fewer self-references, and more indirect replies (Vrij, 2000).

Paraverbal indicators of deception are "vocal cues that accompany speech behavior" (Sporer & Schwandt, 2006, p. 422). Paraverbal indicators include voice pitch, response latencies, filled and unfilled pauses, message duration, speech errors, and repetitions (Akehurst et al.; Hart, Fillmore, & Griffith, 2010). These cues have been discovered as indicators of deception (Hart et al., 2010; Sporer & Schwandt, 2006).

The two paraverbal cues that share consistency in research as indicators which increase with deception are pitch and response latency. See Table 2 for a list of verbal and paraverbal indicators of deception and findings related whether the behavior increases, decreases, or does not change (Akehurst et al., 1996; Hart et al., 2010; Vrij, 2008).

Table 2

Verbal and Paraverbal Indicators of Deception

Deception Variable	Prior Research
Speech interruptions	No change
Pauses	No change
Latency to respond	Increase
Hectic speech	No change
Pitch	Increase
Answer length	No change
Short simple sentences	Increase
Plausible descriptions	Decrease
Logical consistency	Decrease
Detailed description	Decrease
Unusual detail	No change
Unnecessary detail	No change
Description of feelings	No change
Describe what someone had said	Decrease
Description of interactions	No change
Spontaneous corrections	Decrease
Claim lack of memory	Decrease
Story contradictions	No change

Note: The current table was adapted from Hart and colleagues (2006).

Accuracy

When it comes to detecting deception, Vrij (2000) reported that, "Generally, people are rather good at lying, but not very good at detecting lies" (p.2). In fact, a study that analyzed 206 deception detection studies found that people are only slightly better than chance (54%) in accurately detecting deception (Bond & DePaulo, 2006). People also more correctly identify truths (61%) than correctly identifying lies (47%). Reflecting back to the statement that everyone lies may cause one to wonder what makes people not good at detecting lies if it seems a part of human nature.

Professional lie detectors. The most popular professional lie detector consists of being connected to wires that report to a machine, known as a polygraph (Vrij, 2000, 2008). The polygraph is an instrument that has been used to detect deception by measuring physiological responses (Vrij, 2000). The polygraph records palmar sweat, blood pressure, and respiration. The intended function of the polygraph was to record sympathetic nervous system arousal. Sympathetic nervous system arousal may be attributed to lying because many think that people who lie get anxious or nervous (Ekman, 2009). People have often referred to the polygraph machine as a lie-detector but the name is misleading because the polygraph measures physiological arousal rather than directly measuring deceit (Vrij, 2000).

Since the polygraph, other recent developments have been constructed to measure the veracity of claims (Vrij, 2008). Some of these specialized tools have been used to analyze speech content and brain activity. Overall, the majority of these various approaches have yielded higher than chance probabilities at detecting deception. Some authors suggest exercising some caution in interpreting the results of these detection tools. Some of the field studies of the polygraphs yield the highest accuracy but may contain sampling bias and difficulties with establishing the ground truth or achieving high accuracy in identifying truth-tellers (Vrij, 2008).

Accuracy of detection. Mixed research indicated that professional people were good at detecting deception. Bond and DePaulo's (2006) meta-analysis suggested that people are only slightly better than chance at detecting deception. Vrij (2008) reported

the accuracy rates of laypersons and professionals and found that they were not much higher than chance. Laypersons maintain an accuracy rate of 63% of truth detection and 48% lie detection. Professionals' accuracy ratings were 56% for truth detection and 56% for lie detection (Bond & DePaulo, 2006; Vrij, 2000).

Ekman and colleagues (1999) discussed that the most studies of deception are conducted in laboratories, having low external validity and not representing high-stakes lying situations. The accuracy ratings reported by Vrij (2008) of laypersons and professions were both laboratory studies. Two studies discovered that secret service agents and federal agents are among the few who can detect deception with a high degree of accuracy (Ekman & O'Sullivan, 1991; Ekman et al., 1999).

Vrij (2000) provides several reasons for why people may not be good at detecting deception. He reported that people are not educated about how to catch liars. Rather than discovering the truth about deception, people may rely on heuristics to detect deception, such as the faulty belief that liars avert their eye gaze. People may also vary in their motivation to detect deception. For example, some people may be motivated to not detect deception because the truth would not serve them well. As a result, people who are not motivated to detect deception may subscribe to the phrase of ignorance is bliss. Detecting deception can be difficult at times because some people are good liars (Vrij, 2008; Vrij et al., 2010).

Beliefs

Another reason that people may not be good lie detectors is due to possessing inaccurate beliefs about lying behaviors (Forrest, Feldman, & Tyler, 2004). Though there is no typical behavior that people display when lying, people may hold inaccurate beliefs about nonverbal, verbal, or paraverbal indicators of deception. For example, looking away or looking to the left has often been seen as an indication of lying (Global Deception Research Team, 2006). Folklore, traditional wisdom, and faulty police literature contribute to maintaining inaccurate beliefs about cues to deception (Vrij, 2000). Vrij reported that most people believe that an increase in gaze aversion and smiling are indicators of deception. These two indicators are not found to occur significantly with deception, although many have this belief.

A global study investigated beliefs about deception from 58 countries (Global Deception Research Team, 2006). Various researchers in the different countries across the world provided participants with an open-ended and closed-ended survey to measure the various beliefs that people have regarding cues to deception. The study discovered that the most significantly held beliefs related to deception were gaze behaviors. Thus, faulty beliefs about deception may be a reason as to why people perform poorly in detecting deception.

People who hold more accurate beliefs about cues to deception were better lie detectors (Forrest et al., 2004). Judges of deception were deemed most accurate in detecting deception when they held highly accurate beliefs about cues to deception and

those beliefs were activated. Thus, suspicion or holding accurate beliefs about cues to deception alone are not enough to produce accurate judges of deception (Forrest et al., 2004). The combination of suspicion and accurate beliefs about indicators of deception yields accurate deception detectors.

Discovery of various cues to behaviors has allowed researchers to apply these findings to explore beliefs about cues to deception by comparing reported beliefs about deceptive behaviors with actual indicators of deceptive behavior. A study investigated beliefs that managers held about nonverbal cues to deception (Hart et al., 2006). The study was intended to identify if managers held accurate beliefs about nonverbal indicators of deception. The researchers hypothesized that due to managers having deception detection as one of their job duties, they would be more skilled at detecting deception and hold more accurate beliefs about deception compared to non-managers. The study recruited 120 non-manager and 120 manager participants. Both groups were given a questionnaire that asked participants to rate their beliefs about 10 nonverbal behaviors: (a) eye contact, (b) eye blinks, (c) head movements, (d) hand and finger movements, (e.) arm movements, (f) leg and foot movements, (g) smiles, (h) postural shifts, (i) shrugs, and (j) gestures. Participants were to rate whether they believed these nonverbal indicators to increase, decrease, or show no change. After rating nonverbal indicators, participants were asked to indicate their confidence in detecting deception. Results from the study revealed that mangers and non-managers did not differ significantly in their beliefs about deceptive cues. Mangers held inaccurate beliefs for all

indicators except smiling. Managers accurately identified that smiling does not change as an indicator in deception.

Another study by Hart and colleagues (2010) examined beliefs about verbal and verbal cues. The study examined managers' beliefs compared to non-mangers' beliefs. The study asked participants to rate 18 variables: (a) speech interruptions, (b) pauses, (c) latency to respond, (d) hectic pitch, (e) speech, (f) answer length, (g) short simple sentences, (h) plausible descriptions, (i) logical consistency, (j) detailed description, (k) unusual detail, (l) unnecessary detail, (m) description of feelings, (n) reporting what another had said, (o) describing interactions with others, (p) spontaneous corrections, (q) reporting a lack of memory for information, and (r) story contradictions. Participants rated whether each of the 18 variables increased, decreased, or remained the same during deception. Findings indicated that managers and non-managers did not differ significantly in their beliefs about deceptive cues. Managers and non-managers held inaccurate beliefs about 15 out of 18 of the variables. The three beliefs that were accurate with previous research findings were latency to respond, pitch, and logical consistency. Participants accurately believed that latency to respond and pitch increased during deception, and logical consistency decreases.

Deceit and Therapy

Deception research has increased over the past decade, yet little research has examined deceit within the context of therapy. Much of the literature pertaining to therapy and deception has almost exclusively addressed its detection by investigating

psychologists (e.g., Briggs, 1992, Ekman et al., 1999). Other literature has referenced deception detection within psychological assessments (e.g., Greene, 2000; Groth-Marnat, 2009). Outside of detection some authors have attempted to shed light on their experiences of being duped by clients (Kottler & Carlson, 2011), discussed motivations for lies through theoretical lenses (Miller, 1992), and examined counselor's attention to beliefs about deception (Briggs, 1992).

Accuracy of Therapists

Even though most people perform no better than chance at detecting deception (Bond & DePaulo, 2006), much of the detection literature has sought to identify specially trained individuals who can use their skills to accurately identify deception (Ekman & O'Sullivan, 1991; Ekman et al., 1999). Psychologists and therapists have received minimal attention towards detection abilities. As a result, it is uncertain how well a therapist can detect deception. Understanding human behavior and how it aligns with verbal content is a task that most, if not all, therapists undertake, whether it is the sole focus of a theory or merely a means to build rapport (Ivey & Ivey, 2003). Briggs (1992) claimed that therapist accuracy in detecting deception would be a good skill for therapists to have in her or his repertoire. Being able to accurately detect deception would allow a therapist to discuss the deceit with the client. Therapist and client could address the nature and function of a client's lies. Though psychologists are not formally trained in deception detection they are trained in attending to human behavior and discrepancies in behavior (Ivey & Ivey, 2003).

A study that examined psychologists' accuracy in detecting deception found that psychologists performed better than chance (Ekman et al., 1999). The study enlisted 107 practicing clinical psychologists who were interested in deception, 209 clinical psychologists with no special interest in deception, and 125 academic psychologists. All groups were shown 1 minute video samples of 10 different males who discussed their opinions about controversial social issues. Out of the 10 males shown, half told the truth and the other half told lies. Findings from the study revealed that clinical psychologists who had an interest in deception demonstrated a statistically significant difference in detecting deception (M = 67.5%) compared to clinical psychologists with no interest in deception and academic psychologists. Furthermore, clinical psychologists, who held no special interest in deception, demonstrated a statistically significant difference in detection accuracy (M = 62.1%) compared to the academic psychologists (M = 57.7%).

Ekman and colleagues (1999) noted that psychologists might be more accurate in detecting deception, because it may be that elements in counseling , such as understanding and attending to nonverbal behaviors, that might help therapists hone in on the potential discrepancies, or lies, in therapy. In most training programs, therapists practice awareness of, and bringing attention to, the discrepancies between nonverbal behaviors, content, and reported emotions. For example, while laughing, a client may state that he or she is mad about his or her partner ending the relationship. A therapist might note that the client has reported anger but is laughing and then draws attention to

this discrepancy. Similarly, while crying, a client may also lie to a therapist and state that she or he is not bothered by a loss in his or her life.

Another study (Briggs, 1992) also investigated counselors' accuracy in detecting deception. In this study, counselors' accuracy in assessing the veracity of clients' statements were investigated in a counseling situation. The study randomly assigned 40 participants to 20 vocational counselors. Unknown to the counselors, half of the participants were informed to be honest to the counselors and the other half were instructed to lie to the counselors. Each counselor interviewed two participants, one participant who lied and one who was honest. The participant assignment was counterbalanced, in which ten counselors interviewed the truthful client first and lying client second and vice versa. Each interview lasted for 15 minutes. Counselors were to assess each client's level of career development/maturity. Following each interview the counselors were asked to complete the Counselor Assessment Questionnaire (CAQ) and Inventory of Verbal and Nonverbal Behavior. The CAQ was used as the dependent measure to score counselor's assessments of honest and deceptive clients. The study revealed that counselors were able to detect the deceptive and honest clients with 85% accuracy. Honest clients were correctly identified with 90% accuracy and deceptive clients were identified with 80% accuracy.

Briggs (1992) suggested that these findings might have been due to utilizing a realistic research design. The naturalistic setting of vocational interviews for vocational counselors mimics real counseling situations more than showing counselors various

videos of people and asking them to detect the liars. Therapists may have also performed better than chance with detecting deception because they are trained to observe human behaviors and discrepancies (Ivey & Ivey, 2003).

Detection in Assessments

One of the most commonly used therapeutic tools for clinical assessment, diagnosis, and treatment is the Diagnostic and Statistical Manual of Mental Disorders, revised fourth edition (American Psychiatric Association [*DSM-IV-TR*], 2000). Deception is noted as a part of two disorders within the *DSM-IV-TR*. The first, Antisocial Personality Disorder (301.7), requires a minimum of three out of seven criteria to warrant diagnosis, one of which is deceitfulness. Secondly, Malingering (V65.2) is another clinical condition that is based on lying and motivation by external incentives. For example, clients with the malingering diagnosis may lie about false symptoms in order to avoid work or to obtain some financial gains.

Psychometrics is another assessment area that has documented interest in deception (e.g., Greene, 2000; Guenther & Otto, 2010). Many of the instruments are geared towards providing the most reliable and valid profile of a client to aid in the evaluation process. Some assessments utilize deception detection strategies and items to help assess the validity of a given measure through evaluating the propensity of the client to respond to items in a particular manner with the intent to mislead the examiner (e.g. Greene, 2000). The Minnesota Multiphasic Personality Inventory-II (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 2001) is set up to detect deception through scales that

seek to determine if a client is attempting to lie, respond in a socially desirable manner, or fake psychopathology (Greene, 2000). Increases or spikes on these particular scales can create an invalid test or uninterpretable test. The Millon Clinical Multiphasic Inventory-III (Millon, Davis, Millon, & Grossman, 2009) also has scales that indicate if clients are trying to be socially desirable, omit information, or exaggerate negative aspects (Groth-Marnat, 2009).

Therapists Who were Duped

A recent book, *Duped,* presents a compilation of various tales of client deceit, the consequences of the deceit, and the therapist's evaluation of the situation (Kottler & Carlson, 2011). Many therapists have reported a variety of experiences in which they were duped by their clients. Therapists report having been duped by clients with a range of intentions from purposefully falsifying an entire therapeutic relationship (Grzegorek, 2011) to omitting information about dying from a terminal illness (Rochlen, 2011).

The collection of various stories of client deception provides insight into the wide range of client deceit, including the various motivations of the client to lie to the reactions of the therapist once the deception is discovered. Client lies ranged from outright lies to lies of omission and included self-oriented and other-oriented motivations. On the other hand, there were two dimensions of therapist reactions to client deceit: initial and reflective reactions. Many therapists reported initial reactions of negative emotional responses, such as embarrassment, anger, shame, and surprise, after the discovery of the client's deceit. However, upon reflection, many therapists reported that their experiences

contributed to their learning and growth and experienced more tolerant or positive responses (Kottler & Carlson, 2011).

In summary, Kottler and Carlson (2011) proposed 6 clinical implications for lying within therapy: (a) lies have a meaning in the relationship and therapists should allow the meaning to surface, (b) lying is often about impression management, (c) be open in discussing the meaning of truth with clients, colleagues, and self, (d) therapists and supervisors perpetuate a myth that clients are honest (truth bias), (e) the client is in charge of discussing lies and therapists are not detectives or interrogators, and (f) therapists should accept lying as a part of therapy. The inferences made by Kottler and Carlson (2011) appeared to offer an explanation of the function of deception in therapy and suggest a role for therapist in dealing with deception. Pertaining to the function of deception in therapy, the authors inferred that deception is a normative part of therapy, lies are told for impression management and are meaningful in therapy. In discussing the role of the therapist in client deception, the authors implied that therapists should assume a passive role in dealing with client deception and pursue an active role in discussing suspicion and client deceit with supervisors and colleagues. A passive role is understood to mean that therapists should not seek to detect deception as their primary goal. The authors suggested that therapists should discuss a lie if the client mentions lying as a concern or if it surfaces among other discussions and should not intentionally seek to discover client lies. The authors suggested that supervision and consultations should be

the context for explicitly and intentionally discussing client lies. Within these contexts a therapist is able to discuss the function and reasons for client lies.

Reasons for Client Deceit

People may be motivated to lie for various reasons. Some of the motivations discovered for everyday lies (DePaulo et al., 1996) can also be applied to therapeutic situations. For example, clients may tell self-oriented lies to avoid expressing an emotion. Thus, a client may be grieving the loss of a loved one and tell the therapist that he or she is doing well with the loss in order to avoid expressing sadness. Clients may also tell other-oriented lies to protect the therapist. For example, a client, when asked to evaluate therapy and the therapist, may lie by stating that she or he has had profound insight and changes when there has been no difference. Clients may tell these types of lies to protect the therapist's feelings (Ekman, 2009) or to prevent the therapist from thinking that he or she failed (Stevens, 2011).

Client deceit and theoretical orientation. Understanding client deception may be viewed differently based upon a therapist's theoretical framework. A psychotherapeutic theory is often the foundation of how a therapist may view his or her clients. Miller (1992) suggested that client lies could be understood through psychotherapy perspectives and proposed three perspectives for understanding deceit: Freudian/psychoanalytic, person-centered, and behavioral.

From the psychoanalytic perspective, lying may be a means to protect oneself from unconscious motives or to protect another person from wish fulfillment (Miller,

1992). A lie from this perspective allows the client to fulfill a wish occurring in fantasy but not in reality. For example, lying by denying your feelings for another person, when the other person asks you if you are romantically interested, would allow you to maintain your fantasy of really liking the person while also protecting your image in reality. Protection of self and others fits with self-oriented and other-oriented lies that people often tell (DePaulo et al., 1996). A client could protect him or herself by avoiding potential embarrassment if rejected and protect others by avoiding potential awkwardness if the other person was not romantically interested.

From the person-centered approach, lying is centered in protecting self-worth (Miller, 1992). Self-worth has been reported to be one of the four needs of meaning for individuals, which allows people to feel valued (Baumeister, 1991). Thus, clients seek to preserve their sense of worth and will lie to do so (Miller). For example, a client may state that he or she makes more money than she or he actually does in order to feel a great sense of worth.

Finally, lies discussed from a behavioral perspective may be seen as learned, modeled, shaped, and immediately reinforced (Miller, 1992). Telling the truth may sometimes elicit aversive consequences. For example, a client who reveals that he or she was intimately involved with someone of the same sex may feel shamed by the therapist. The therapist's remarks that elicit shame in the client would be an aversive consequence. Thus, the client's discussion of sexual orientation has been punished and the likelihood of discussing sexual orientation in the future has decreased.

Deceit and the Therapeutic Relationship

Therapy consists of a relationship between a therapist and client in which the client often presents with an issue or distress and the therapist attempts to provide intervention, or help (Orlinsky, Ronnestad, & Willutzki, 2004). At its core, therapy involves a relationship or bond between at least two people, the therapist and the client. The therapeutic relationship is often reported as a primary factor in therapeutic outcome for the client (Lambert & Ogles, 2004). A positive relationship is a supportive one, which precedes other factors for improvement found in psychotherapy and it is often viewed as necessary for change.

Another interpersonal facet of the therapeutic relationship is the product of the contributions of both the therapist and client is referred to as the therapeutic bond (Orlinsky et al., 2004). People who do not work well together or do not contribute to the relational bond will not be productive. The therapeutic bond has been found to be a significant aspect of process and outcome research (Orlinsky et al., 2004). The therapeutic bond could be threatened and therapy could be affected with the introduction of client deceit.

Consequences of Deception in Therapy

Telling lies in therapy could have negative consequences for the client and therapist. People may be motivated to lie out of fear of losing a relationship, to avoid the harmful consequences of telling the truth, or to reap the most benefits for one's self. Some lies within relationships may seem to preserve the relationship; however, most

serious lies are told to close relationship partners (DePaulo, Ansfield, Kirkendol, & Boden, 2004) and can have consequential effects on relationships. Specifically, lies that are told in conjunction with a transgression are less forgivable and diminish the capacity to fully recover trust (Schweitzer, Hershey, Bradlow, 2006). Client lies may be more financially or psychologically costly (DePaulo et al, 2003), hinder or cease treatment outcome, extend or suspend therapy, and negatively affect the relationship (e.g., Sagarin, Rhoads, & Cialdini, 1998). Though client lies affect both parties, the consequences differ for client and therapist.

Dangers for clients in telling lies. Beyond the therapeutic relationship, "the patient's contribution to psychotherapy outcome is vastly greater than that of either the particular treatment method or the therapy relationship" (Norcross & Lambert, 2011, p. 4). As deception has been defined as an intentional attempt to create a false belief (Vrij, 2008), it appears that its use in therapy would not contribute to outcome but rather suspend it.

The majority of clients enter into therapy with intentions of receiving help from the therapist. If a client's intentions were withheld from a therapist, then a therapist may not be able to fully aid the client in relieving distress. Ekman (2009) discussed a psychiatric patient who lied to therapists in order to receive a weekend pass out of the facility. The client successfully fooled the staff into believing that she was well enough for a weekend pass though she had desperately wanted to kill herself. She revealed the nature of her lie before receiving the weekend pass. The danger in the client's lie was that

it could have prevented her from receiving mental health services and resulted in the end of her life.

Some lies may hold a stronger consequence for the client depending on the therapeutic situation. For example, discovering a client's lie about substance abuse (Stevens, 2011) may have more negative consequences for a client than from discovering that a client has lied for the purposes of an insurance settlement (Burns, 2011). On the one hand, the client within a mandated treatment context may face additional fines, legal fees, accrue more therapy sessions, possibly be arrested, and/or have to terminate therapy. A client's omission about the use of substance abuse could even be detrimental by ending in death (Stevens, 2011). On the other hand, a client who lies to insurance claims for financial gains would benefit from the consequences, if successful in her or his deceit (Burns, 2011).

Sometimes lies are told in order to create or manage impressions (DePaulo et al., 2003). Clients may enter therapy with preconceived expectations of how they are to act as a client, or they may create an image of who they want to be (Orlinsky et al., 2004). Telling lies within therapy in order to create and consistently manage an impression can be very psychologically taxing (DePaulo et al., 2003). DePaulo and colleagues claimed, "Deliberate attempts to manage impressions, including impressions of credibility, are attempts at self-regulation, and self-regulation consumes mental resources" (p.5). The dangers of lying may entail using up cognitive resources for the purpose of consistently conveying a narrative, rather than focusing on the treatment at hand. Thus, clients who lie

in therapy create a cognitive load rather than dedicating those resources for other therapeutic gains (i.e., presenting concern; DePaulo et al.,2003).

Dangers for therapists in being duped. Therapy involves a relationship, in which deception can have negative consequences (Miller, Perlman, & Brehm., 2007). A consequence of client lies, for therapists, is the emotional reactions that therapists may have in response to lies (Kottler & Calrson, 2011). Therapists do not want to be duped and may react to discovered deception with a variety of emotions, such as surprise, anger, embarrassment, and/or shame (Kottler & Carlson, 2011). These emotional reactions may be at the expense of the therapeutic relationship and the client's goals for therapy.

A client who creates a completely false presentation of concerns and personal details may elicit emotions of anger or embarrassment, such as the case discussed by Grzegorek (2011). A 20 year-old university student sought counseling services primarily motivated to create all false information in order to see if he could successfully deceive a therapist. He was successful. The therapist believed the client throughout all of the sessions. She did not have evidence suggesting otherwise. During the last session the client revealed his true motivations and reported that he lied about everything. When the therapist asked the client to share his motivations for lying he reported that he likes to have fun with people and wants to see if he can make them do things and was purely motivated by duping delight. In short, he wanted to see if he could successfully deceive someone who is an apparent expert on human behavior. However, for the therapist the consequence was less positive. She reported feeling "used, violated, and angry…like a

chump" (p.36). Subsequently, the therapist began questioning her ability as a therapist. She reported that the case made her less trusting of other clients.

However, not all client lies are directed at the therapist or exclusively motivated to trick the therapist for duping delight (Kottler & Calrson, 2011). The majority of client lies do not likely resemble the previous case. In many cases, client deception may involve other topics or relationships. For example, a client who lies about a yearly salary to a therapist is not intentionally seeking to sabotage the relationship. The client may be motivated to create an impression of wealth, or to gain acceptance from the therapist. Nonetheless, discovering client lies can still affect therapists. In discovering client lies therapists may be less likely to trust the client (Schweitzer et al, 2006), be more suspicious in therapy (e.g., Grzegorek, 2011), have a reduced desire to counsel, and/or be less satisfied with client outcome (e.g., Stevens, 2011).

All of the reported cases of client deceit in Kottler and Carlson's (2011) book were discovered instances of deception. However, there are many times that therapists are not privy to their client's lies. Many therapists may subscribe to the notion that out of sight is out of mind and undetected deception is unimportant. However, it is not the case that undetected deception preserves a relationship. Sagarin and colleagues (1998) discovered that undetected deception can damage a therapeutic relationship. The researchers constructed a study based on the premise that a liar perceives the target of a lie as less honest based on the liar's deception, which they refer to as deceiver's distrust. The experimenters tested their premise based on three psychological processes: (a) a false

consensus effect, (b) ego-protective mechanism, and (c) belief in a just world. The authors discovered that deceiver's distrust did exist and participants in their study perceived targets of lies as dishonest. The mechanism that best supported this effect was the ego-protection motivated version of the false consensus. Essentially, the liar normalizes his or her behavior by believing that others lie too. Thus, undetected lies in therapy may lead the client to distrust the therapist based on deceiver's distrust. Viewing a therapist as dishonest and untrustworthy may negatively affect the relationship (Sagarin et al., 1998). Undetected deception and client perceptions stemming from distrust are factors that are not things that therapists can control.

Therapists' Training in Deception

Therapists are trained in a variety of areas but none include training as an interrogator or deception detection expert (Stedman, 2006). Therapists may discuss perceived lies in terms of discrepancies (Ivey & Ivey, 2003). Even if therapists explicitly discuss clients' lies, the primary purpose of therapy and therapists is not to detect deception but to relieve the client's distress (Corsini & Wedding, 2005), which may be the reason that they are able to be more accurate in detecting deception.

A study investigated indirect versus direct lie detection and its effects on accurately detecting deception (Hart et al., 2009). The researchers recruited 104 participants who were randomly assigned to one of two groups: (a) the direct lie detection group or (b) the indirect lie detection group. Both groups observed a video of 20 people who responded to interview questions. On the video, 10 of the interviewees told lies and

the other 10 told the truth. Each group was provided with different instructions. The direct lie detection group was to determine whether the individuals shown in the video were lying or telling the truth. Participants in the indirect lie detection group were instructed to determine whether the individuals shown in the video displayed a change in behavior, body language, or speech changes. Findings indicated that participants in the indirect lie detection group were significantly more accurate in identifying lies compared to participants in the direct lie detection group. The findings also revealed that the indirect lie detection group performed better than chance in detecting lies. Lastly, the results found that participants in the indirect lie detection group were more confident in their decisions while judging lies. Thus, a part of therapists' accuracy in detecting deception may be related to therapists being indirect lie detectors. Therapists are not formally trained as interrogators but their behavioral observations skills may align with being indirect detectors. Simply, therapists are not explicitly instructed to seek client lies before each session or implement deception detection methods as a primary goal of therapy.

In handling client deception, the topic is rarely discussed (Reed, 1996). Miller (1992) reported that all counselors "can recall a situation in which we either felt a client was not telling the truth [and] counselors-in-training often ask advice on how to deal with a client who was speaking dishonestly" (p. 25). Reed noted that "in psychiatric and psychotherapeutic literature, the idea of clients lying is not one that is commonly voiced, and many therapeutic positions seem to discourage discussion of the issue" (p. 249).

Mental health professionals reported that discussing deception was taboo (Reed, 1996) or that its discussion is a way of admitting incompetence (Kottler & Carlson, 2011).

Given that client lies may have consequences, such as perceiving the target as untrusting (Sagarin et al., 1998) and damaging trust within relationships (Möllering, 2009), and many therapists seek knowledge in handling deceptive clients (Miller, 1992), it seems important train therapists about how to handle deception. Nonetheless, there is a dearth of literature and training in client deception. The literature has provided three reasons that deception in therapy is not typically addressed: (a) fear of incompetence (Kottler & Carlson, 2011), (b) a truth bias towards clients (O'Sullivan, 2003), and (c) the perceived therapist role (Barnett, 2011).

Fear of Incompetence

Kottler and Carlson (2011) reported that while writing their book *Duped* many therapists were reluctant to share stories. The authors suggested that these therapists might have been afraid to be discovered as a fraud and/or afraid of admitting incompetence and being reported to a licensing board. The fear that therapists may have in admitting to being duped may stem from the perception that therapists are masters of human behavior (Kottler & Carlson, 2011). Therapists interact with a variety of clients and attend to client discrepancies. Thus, admitting that a client was able to lie in therapy might be admitting incompetence in an inability to decode human behavior.

Therapists' Truth Bias

Interactions with others typically involve communicating more truthful statements than false statements (Bond & DePaulo, 2006). Communication may be difficult if the majority of messages were falsehoods. Believing statements to be true does not become a problem until a lie is communicated. A reason that people are poor at detecting deception is due to a tendency to believe most statements as true, creating a truth bias (O'Sullivan, 2003; Vrij 2008). A meta-analysis revealed that people judge more messages to be honest than deceptive due to most interactions being truthful (Bond & DePaulo, 2006). As a result, therapists may believe that most of their clients are truthful, even after being duped (Grzegorek, 2011). Myths about client honesty may be perpetuated by therapists (Kottler & Carlson, 2011). The myth that clients do not lie may be referred to as therapists' truth bias. There are a few reasons that therapists may be inclined to believe that clients would be more likely to tell the truth than lie. Kottler and Carlson claimed that "therapists make it easy for their clients to lie" (p. 272). Therapists often enter therapy with the mindset to establish a trusting relationship and in doing so they may believe all of what a client has to say as being truth.

The initial intent of confidentiality was to implement a safe trusting environment for clients to be open and truthful (Pope & Vasquez, 2007). Therapists often discuss confidentiality as a means for clients to share most things without incurring negative penalties or being reported to an official. The entire purpose of confidentiality is to encourage client honesty. Clients are allowed to share personal information with the

safeguard of knowing that their information will not be distributed or made known to others, within certain legal limits that are noted as part of the informed consent.

Lastly, psychotherapy involves financial costs (Kazdin, 2004; Krupnick & Pincus, 1992). Lying about presenting concerns may avoid the central concern, unless that concern is lying. Each session dedicated to avoiding, falsifying, or omitting things in therapy may be financially costly. Therefore, therapists may believe that a client would be wasting resources if he or she were to lie in therapy.

Therapist Role

The role of a therapist typically involves providing assessments, diagnosis, and treatment through psychotherapy (American Psychological Association; APA, 1999). Therapists are not professional lie detectors or interrogators. "Taking the attitude or approach of an interrogator and believing nothing until I receive absolute proof would likely be inimical to the establishment and maintenance of a positive therapeutic alliance" (Barnett, 2011, p. 125). Therapists often ask clients many questions but the intent and delivery of those questions seem to be key in building rapport. Playing the role of interrogator could be perceived as untrusting and prevent the establishment of rapport, setting the stage for a poor therapeutic relationship.

As a result, in some instances it may be more beneficial to believe clients and be duped than to interrogate and challenge the client. Langer (2010) claimed that "sometimes believing the patient is more important than knowing whether the patient's story is true" (p. 16). Believing the story of a client who has been sexually abused may be

more important and helpful than seeking to detect the veracity of the client's narrative. Often, sexually abused clients may have other people in their lives who questioned the events and the existence of the assault. Clients who report being sexually assaulted are often interrogated by police officers and report negative experiences with how the police handled the situation (Felson & Pare, 2008). In short, these situations are examples through which a therapist might not approach a client to reveal deceit (Langer, 2010).

On the other hand, therapists do ask many open-ended questions and prompt for truthful information (Ivey & Ivey, 2003). Truthful information means the most accurate representation and purposeful intent to convey such information. Therapists seek an honest representation of client histories, feelings, thoughts, and behaviors per the client's experience. When clients disclose information, therapists may hold beliefs about client behaviors that relate to the veracity of their statements.

Therapist Beliefs and Confidence

Much of the literature that has examined beliefs about cues to deception has included laypeople, university students, police officers, customs officers, managers, judges, migration board personnel, teachers, prosecutors, prisoners, prison officers, and social workers (see Vrij, 2008). Given that people often develop beliefs about how liars behave and use those beliefs when detecting deception, it may be important to investigate therapists' beliefs about deception (Forrest et al., 2004; Vrij, 2008). Therapists interact with people frequently and though they may not be actively interrogating their clients, they may be seeking client truths and falsehoods. Examining the beliefs that therapists

hold about cues to deception may shed light on therapists' accuracy in detecting deception and reveal the accuracy of deceptive cues used by therapists (Forrest et al., 2004).

There is currently no known work that has explored therapists' beliefs about cues to deception. The literature that closely associated with therapists' beliefs about cues to deception was a dissertation that investigated counselor assessments of truthful and honest clients (Briggs, 1992). The author explored the different verbal and nonverbal cues to which counselors attend when assessing deceptive clients. The nature of the design was exploratory and no hypotheses were made. The author recruited 132 doctoral counselor interns from 40 counseling centers and asked participants to complete the Inventory of Verbal and Nonverbal Behaviors. The inventory was created by the author and consisted of 25 verbal and nonverbal cues. The author did not know if these cues were related to deception. The inventory asked participants to respond to how much attention is dedicated to each cue. Responses for attention to cues were rated on a 4-point Likert-type rating scale (never to always). Participants were instructed that they were to indicate the degree to which they would attend to each behavior if they were interviewing a deceptive client. The author entered the data into an exploratory factor analysis with the intent of reducing the numerous amounts of possible cues into few factors. Four factors were discovered and accounted for 64% of the variability: (a) stationary cues of a client's face and body, (b) movements of a client's limbs, (c) the quality/style of a client's communications, and (d) the content/expression of a client's communications.

The findings from the study contributed to the literature of deception in therapy. Specifically, the findings reflected that therapists do report attending to certain cues when suspicious of client deceit (Briggs, 1992). The limitation of the study was that accurate cues to deception were not known or available when the research was conducted. Therefore, the study could not substantiate actual beliefs that therapists hold regarding deception. Since this study, there has been an increasing literature base validating likely cues to deception (see DePaulo et al., 2003).

Confidence in the beliefs held about cues to deception may be related to occupational experiences (Hart et al., 2010). Therapists have a unique profession in analyzing and processing human behavior. They are trained to attend to a variety of human behaviors within verbal and nonverbal domains. Therapists' experience, knowledge, and training with human behavior may instill a higher confidence in discerning deception. Similarly, professionals who had job experiences in which attending to human behavior was important (i.e., managers), rated their abilities to detect lies as significantly more confident than non-managers (Hart et al., 2006; 2010). In addition to therapists' beliefs and confidence in detecting deception, examining their attitudes towards deception may contribute to understanding the effects of deception in therapy.

Attitudes towards Deception

Many therapists operate on their personal and professional values (Rønnestad, & Skovholt, 2003). While some therapists see the two domains separately others strive for

an integration of both. Whether therapists seek integration or distinct domains, they hold personal and professional values that influence their behaviors, decisions, and practice. Attitudes towards deception may also be influenced by how important therapists perceive deception to be within therapy based on personal and professional values. These attitudes may affect behaviors (Bentler & Speckart, 1979; Fishbein & Ajzen, 1974) of therapists in interacting with clients who lie.

Personal Values

Many people do not prefer to be on the receiving end of a lie (Miller, Perlman, & Brehm, 2007). Therapists, like other people in their personal lives, seek honesty in most social relationships and dislike being the recipient of deceit (Kottler & Carlson, 2011). Having a partner lie about finances or infidelity may elicit anger from a therapist in her or his personal life.

Professional Values

The professional values therapists embrace are reflective of how honesty is valued (APA, 2002; 2010). Therapists appear to value honesty through various practices and policies. These values may be displayed within therapy through therapeutic processes such as transparency or even explicitly communicated. Honesty can be found within ethics, informed consent, and research practices.

The APA's (2002/2010) code of ethics suggests that psychologists adhere to five core principles: (a) beneficence and nonmaleficence, (b) fidelity and responsibility, (c) integrity, (d) justice, and (e) respect for people's rights and dignity. All of these ethical

principles encompass being honest and truthful. Specifically, integrity is often defined as the quality of being honest. These ethical principles often permeate many psychological practices. The APA ethical principles and code of ethics states that it "applies only to psychologists' activities that are part of their scientific, educational, or professional roles as psychologists" (p. 1061).

The therapeutic practice of informed consent reflects the value of honesty. Informed consent is crucial for beginning therapy by informing clients about the process of therapy and it is an ethically commanded practice (APA, 2002/2010). The informed consent promotes positive treatment outcome through enhanced client autonomy and empowerment (Beahrs & Gutheil, 2001). Therapists are to discuss their theoretical orientations, style of practice, expectations of therapy, fees, session lengths, and answer questions that clients may have. Discussing all of these matters prior to therapy is a way of truthfully informing the client of expectations for therapy. After being informed, the client makes a decision about beginning therapy. Lying about any area within the informed consent would be unethical and misleading of the client. Thus, informed consent reflects therapist values by modeling honesty before therapy begins. Outside of therapy, honesty can be found in other practices.

Research practices also must follow policies of honesty (APA, 2002; 2010). Therapists are expected to inform participants of the nature of any study and obtain permission from them to be included in the study. Some deception can be implemented in

research as long as it is not harmful for the participants and the participants were informed of the deception before including the data in the research study.

Importance of Deception in Therapy

The importance of deception may be an area that has been neglected in literature pertaining to therapy, counseling, clinical psychology, and psychiatry (see Reed, 1996). There may be various reasons that therapists do not perceive client deception as an important area for discussion, research, and training. DePaulo and colleagues (2003) stated "There are only a few studies in which people have been asked how they feel about the lies they tell in their everyday lives [and] the results suggest that people regard their everyday lies as little lies of little consequence or regret" (p. 76). Deception may be perceived as an area of little importance because it occurs so frequently and affects everyone. Thus, therapists who do not view deception as an area of interest may believe that lies are normative and generally are of little consequence.

Another reason that deception may not be considered important is due to the dissemination of knowledge about deception (Kottler & Carlson, 2011). The limited literature about deception and therapy suggests that deception should not be a primary concern for therapists. Literature which suggests that therapists are not interrogators, professional lie detectors, or even trained to detect deception, and that they should accept lying as a part of therapy (Kottler & Carlson, 2011), may contribute to lack of research and understanding deception in therapy.

If deception in therapy is considered an important construct, then perceived importance may vary depending on which therapist you ask. Some therapists may state that honesty is crucial for therapeutic growth, the relationship, as well as therapeutic outcome. Other therapists may be inclined to take a constructivist view (Prochaska & Norcross, 2010) and believe that there is no truth in therapy. Constructivists may operate from the assumption that therapists only know what clients tell them or that truth and falsehoods have no bearing on therapeutic work. However, deception exists in the world, at least as one person attempting to intentionally create a false belief in another. Stating that a therapist may never know if a client is lying is a likely claim. Therapists could be duped and never be the wiser. Though therapists may not be aware of deception within therapy, this does not extend to concluding that deception has no effects within therapy. Deception affects relationships and therapy is all about the relationship. In fact, even undetected deception damages relationships (Sagarin et al., 1998).

The psychotherapy theories by which therapists operate are the driving forces of practice. Theory often informs practice and establishes philosophical assumptions about the nature of humankind. The abundance of psychotherapy theories reflects the variety of philosophical views of human behavior. Theories hold differing perspectives on lying and its importance. Thus, psychotherapy theories should be examined when determining the importance of deception within therapy.

Purpose of the Study

There has only been one study that investigated therapists' attention to beliefs about cues to deception (Briggs, 1992). The design employed an open-question method to explore therapists' beliefs. However, there has been much literature outside the therapy domain that reveals nonverbal, verbal, and paraverbal indicators to deception (e.g., DePaulo et al., 2003; Vrij, 2008). There is no research which has investigated therapists' beliefs about cues to deception by utilizing a closed-question method based on the discovered nonverbal, verbal, and paraverbal indicators.

Based on findings of beliefs about deception within the workplace (Hart et al., 2006; 2010) and generally inaccurate beliefs held about deception (see Vrij, 2008), it is important to investigate therapist's beliefs and confidence in detecting deception. With the emphasis of deception detection in the literature and the dearth of research examining attitudes towards liars, it is important to explore therapists' attitudes towards deceit.

Many false beliefs about indicators to deception are perpetuated through police literature and other sources (Vrij, 2008). Professionals who are exposed to lies hold a number of false beliefs about indicators to deception (Hart et al., 2006, 2010). Similar to other professionals, therapists will hold a number of false beliefs about deception. Many therapists interact with people on a daily basis and one of their tasks is to detect discrepancies in client behavior (Ivey & Ivey 2003). Behavioral discrepancies may serve as indicators for detecting deception. Furthermore, some studies have revealed that therapists have higher accuracy ratings in detecting deception (Briggs, 1992; Ekman et

al., 1999). Therefore, it was predicted that therapists would use more valid nonverbal than verbal and paraverbal cues to detect deception. Therapists are trained to specifically attend to human behaviors and interact with humans in numerous situations and with a variety of concerns.

Most people dislike being the target of deception. According to Möllering (2009), people may intuit that "trust is good and deception is bad [which] matches the primary moral connotations of trust and deception" (p. 138). Due to perceptions of deception and the consequences of being duped in everyday life (DePaulo et al., 1996), in relationships (see Miller et al., 2007), and in therapy (Kottler & Calrson, 2011), people may hold negative attitudes towards liars. The attitudes that people hold can be predictive of future behavior (Bentler & Speckart, 1979; Fishbein & Ajzen, 1974). Therapists' behavior is often structured based on their values and attitudes (Rønnestad, & Skovholt, 2003). Thus, it is important to investigate the attitudes that therapists hold towards lies. It was predicted that therapists would hold negative attitudes towards clients who lie.

Relevance to the Field of Counseling Psychology

The current research enhances the field of counseling psychology by shedding light on the dynamics of deception in therapy. Deception is a common phenomenon and has been mostly investigated in basic research (see Vrij, 2008) or applied to intimate relationships (see Miller et al., 2007) or forensic areas (see Granhag & Strömwall, 2004). The presence of deception within therapy has been documented among various psychotherapists, in which therapists have discovered a variety of client lies (see Kottler

& Carlson, 2011). However, there is limited research pertaining to the intersection of deception with therapy and counseling psychology (e.g., Briggs, Ekman et al., 1999). The current research will attempt to contribute to two disciplines by further bridging social psychology with counseling and clinical psychology.

Counseling psychology distinguishes itself from other specialties in psychology by emphasizing the values of clients' strengths, cultural concerns, vocational assessment, and developmental issues (APA, 1999; Benjamin & Baker, 2004). Deception is pervasive across cultures (Bond & Atoum, 2000; Bond, et al., 1990) and stems from early development (Sodian, 1991).

The current research also attempts to contribute to the history and promise of interfacing social psychology with counseling psychology (Strong, Welsh, Corcoran, Hoyt, 1992). Counseling psychology has a history of applying social psychological principles to counseling, specifically with therapeutic processes (Strong et al., 1992). Exploring the nuances of deception in therapy serves counseling psychology, specifically, through adding to the knowledge base of therapeutic processes regarding an overlooked variable. Broadly, the current research benefits counseling psychology through promoting the interface of social and counseling psychology.

Therapy, as defined by Corsini and Wedding (2005), involves interaction between two parties. Client deception in therapy can introduce many variables which may affect the course of therapy. How deception is used in therapy, understood, and its effects on the clients and therapists are areas that benefit from increased attention to investigation.

Understanding the nature of deception in therapy may strengthen therapeutic relationships, increase positive outcomes, provide further insight for therapists, and enhance training models. Knowledge about therapists' beliefs and attitudes about deception specifically adds to the understanding of deception's role in therapy.

Research Questions and Hypotheses

Question 1. How accurate are therapists' beliefs about cues to deception?

Hypothesis 1A. It was predicted that therapists would hold beliefs that behavior changes as an indicator of deception.

Hypothesis 1B. It was predicted that therapists would hold a number of false beliefs about actual indicators of deception.

Question 2. Do therapists hold more accurate beliefs about nonverbal indicators than verbal or paraverbal indicators?

Hypothesis 2. It was predicted that therapists would hold more accurate beliefs about nonverbal indicators of deception than verbal or paraverbal indicators of deception.

Question 3. What attitudes will therapists have towards clients who lie?

Hypothesis 3. It was predicted that therapists would hold negative attitudes towards clients who lie.

Question 4. Does a relationship exist between therapists' worldviews and attitudes towards client deception?

Hypothesis 4. It was predicted that a relationship would exist between a positivist worldview and attitudes towards deception. More specifically, it was predicted that there

would be a positive correlation between therapists who endorse a positivist worldview and negative attitudes towards client deception.

CHAPTER III

METHOD

This section examines the participant criteria and demographics, the various instrumentation utilized, the procedure of the study, and the hypotheses and statistical design.

Participants

The sample size for the current study was calculated by using G*Power (Faul, Erdfelder, Buchner, & Lang, 2009). For computing a priori sample size with parameters of an effect size of .5, alpha .05, the sample size needed is 45. For computing a one-way ANOVA with effect size f of .25, alpha .05, 1 group, with 3 measurements, the sample size needed was 43.

The current study recruited 112 participants. Eligibility requirements for participants included: (a) at least 18 years old in order to consent to participate in the study, (b) must have completed at least one practicum course, and (c) were currently in training or have completed training in a counseling or clinical psychology field.

Demographics

All participants were contacted and recruited through the use of an APA internship database. The participants ranged in age from 25 to 69 years old ($M = 37.5$, $SD = 12.35$). The majority of participants were female (see Table 3).

Table 3

Sex of the Participants

Sex	*n*	Percentage
Female	65	69.9
Male	28	30.1
Intersex	0	0

Further, the majority of participants identified their gender as woman (Table 4).

Table 4

Gender of the Participants

Gender	*n*	Percentage
Woman	64	68.8
Man	28	30.1
Transgender	0	0

Note: Frequencies not adding to 93 and percentages not adding to 100% reflect missing data

The participants represented a range of ethnicities/races. The majority of participants were Caucasian/European American (see Table 5).

Table 5

Race/Ethnicity of the Participants

Race/Ethnicity	*n*	Percentage
Caucasian/European American	69	74.2
Multi racial	7	7.5
African American	6	6.5
Asian/Asian American/Pacific Islander	4	4.3
Biracial	3	3.2
Hispanic/Latina/Latino	2	2.2
Other	2	2.2

Note: Approximately 2% of participants identified as "Other" and specified their race/ethnicity as Middle Eastern and a combination of Caucasian/European American and Biracial.

The highest degree earned by the majority of participants was a Ph.D. (see Table 6).

Table 6

Highest Degree Earned

Degree	*n*	Percentage
Ph.D.	44	47.3
Master's degree	35	37.6
Psy.D.	14	15.1

The majority of participants were trained within a clinical psychology graduate program (see Table 7).

Table 7

Training Program

Program	*n*	Percentage
Clinical Psychology	59	63.4
Counseling Psychology	25	26.9

Note: Frequencies not adding to 93 and percentages not adding to 100% reflect missing data

The vast majority of participants did not hold any licenses but of the licenses held, the majority of participants were Licensed Psychologists (see Table 8).

Table 8

Licenses Held

License	*n*	Percentage
No license	52	55.9
Licensed Psychologist	38	40.9
Licensed Professional Counselor	2	2.2
Multiple Licenses	1	1.1

Note: One participant identified holding more than one license, in which the participant was a Licensed Psychologist and Licensed Marriage and Family Therapist.

A majority of the participants' current therapy work setting was at Veterans Affairs (see Table 9).

Table 9

Current Therapy Work Setting

Work Setting	*n*	Percentage
Veterans Affairs	38	40.9
Counseling Center	20	21.5
Hospital	16	17.2
Military	10	10.8
Other	9	9.7

Note: Of the nine participants who selected the "Other" category, six specified their current work setting as community mental health and the other three specified agency, outpatient medical setting, and residential treatment center.

Participants' identified a variety of theoretical orientations. Three theoretical orientations were equally represented: cognitive, psychodynamic/interpersonal, and integrationist/eclectic (see Table 10).

Table 10

Theoretical Orientation

Theoretical Orientation	*n*	Percentage
Cognitive	20	21.5
Psychodynamic/Interpersonal	20	21.5
Integrationist/Eclectic	20	21.5
Other	14	15.1
Behavioral	6	6.5
Humanistic/Existential/Experiential	4	4.3
Family/Systems	3	3.2
Solution-Focused	2	2.2
Narrative	2	2.2
Feminist/Multicultural	2	2.2

Note: Of the 14 participants who selected the "Other" category, seven specified their theoretical orientation as cognitive behavioral, two specified biopsychosocial, one specified cognitive-behavioral therapy/acceptance and commitment therapy, one specified acceptance and commitment therapy/mindfulness, one specified Adlerian Therapy, and one did not specify.

Table 11 displays participants' worldviews, which were measured on a 7 point Likert-type rating scale (1 = not at all, 7 = very much).

Table 11

Therapists' Worldviews

Worldview	*n*	Mean (*SD*)
Positivist	93	3.52 (1.44)
Constructivist	93	5.18 (1.31)

The participants' years of counseling experience ranged from less than 1 year to 40 years ($M = 10.44$, $SD = 9.54$). In asking participants to identify the approximate amount of direct hours that they have accrued in therapy there were 66 valid cases

ranging from 25 hours to 36,000 (M = 3370.83, SD = 5000.80). Some participants did not report how many direct hours that they have accumulated. Some of this missing data may be due to asking participants to recall an approximation of the amount of direct client hours they have accrued from their counseling experiences.

Table 12 displays participants' experience and training with deception, which was measured on a 7 point Likert-type rating scale (1 = none, 7 = very much)

Table 12

Therapist Training and Experience with Deception

Training Variable	*n*	Mean (*SD*)
Amount of deception literature read	93	2.78 (1.59)
Training with client deception	93	2.95 (1.63)
Training with deception detection	92	2.82 (1.77)

Instrumentation

The current study used three instruments: Demographics Questionnaire, the Detection of Deception Questionnaire, and the Therapist Attitudes Towards Deception Scale. All instruments were utilized to further understand therapists' beliefs and attitudes towards deception.

Demographics Questionnaire

Participants were asked to complete the Demographics Questionnaire (Appendix A). The questionnaire asked participants to provide information about age, sex, gender, ethnicity and race, education, licensure, theoretical orientation, therapeutic work setting,

worldview, estimated number of hours spent with clients, years of counseling experience, and previous training experiences with deception.

Detection of Deception Questionnaire

Participants were asked to complete a Detection of Deception Questionnaire (DDQ; Appendix B). The questionnaire was an adaptation of the questionnaire developed by Hart and colleagues (2006; 2010). The DDQ was developed as a closed-question questionnaire to assess managers and non-managers beliefs about cues to deception and confidence in detecting deception. The questionnaire asked participants for demographic information, amount of managerial experience, beliefs about cues to deception, and confidence in detecting deception. The researchers used a 7 point Likert-type rating scale for managers and non-managers to indicate their beliefs regarding various changes in behavior that occur when lying (1 = significant decrease in behavior, 4 = no change in behavior, 7 = significant increase in behavior). The scale was used to compare participants' responses to a non-behavioral change. This measure was adapted to meet the needs of the current study.

The DDQ, used in the current study, consisted of 30 items total. The questionnaire consisted of a 7 point Likert-type rating scale that asks participants to indicate various changes in behavior (1 = significant decrease in behavior, 4 = no change in behavior, 7 = significant increase in behavior) in response to detecting deception. The questionnaire also consisted of a 7 point Likert-type rating scale to indicate the level of confidence in

detecting deception (1 = not confident at all, 7 = extremely confident) and how often participants thought clients lie to them (1 = very rarely, 7 = very often).

The first two items asked participants to rate their confidence in detecting client deception and the frequency of lies that clients tell. The subsequent 28 items asked participants to indicate their beliefs about actual indicators of deception. The questionnaire contained 10 items related to distinct nonverbal behaviors and 18 items regarding verbal and paraverbal indicators. The 10 nonverbal indicators were the following: (a) eye contact, (b) eye blinks, (c) head movements, (d) hand and finger movements, (e) arm movements, (f) leg and foot movements, (g) smiles, (h) postural shifts, (i) shrugs, and (j) gestures. The 18 verbal and paraverbal indicators were as follows: (a) speech interruptions, (b) pauses, (c) latency to respond, (d) hectic pitch, (e) speech, (f) answer length, (g) short simple sentences, (h) plausible descriptions, (i) logical consistency, (j) detailed description, (k) unusual detail, (l) unnecessary detail, (m) description of feelings, (n) reporting what another had said, (o) describing interactions with others, (p) spontaneous corrections, (q) reporting a lack of memory for information, and (r) story contradictions. Participants were asked to indicate whether each of the specific behaviors increase, decrease, or remain the same when clients lie.

Therapist Attitudes Towards Deception Scale

The Therapist Attitudes Towards Deception Scale (TATDS; Appendix C) was constructed by the author to assess various attitudes therapists held towards clients who lie. The questionnaire consisted of 48 items which assessed attitudes towards clients who

lie in therapy. The initial 12 items were constructed by the author and asked participants to indicate on a 9 point Likert-type rating scale (1 = decrease, 5 = no change, 9 = increase) how their attitudes would change if a client's lie was discovered in therapy. These items were developed to measure therapists' specific and contextual attitudes towards clients who lie within the therapy.

The next 12 items were adapted from a scale that was constructed to measured physicians' attitudes towards patients who were obese (Foster et al., 2003). The scale was subsequently used to measure physical therapists' attitudes towards patients who were obese (Sack, Radler, Mairella, Tougher-Decker, & Khan, 2009). Foster and colleagues developed a scale of nine semantically differential items to measure physicians' attitudes about personal characteristics of people who were obese. The authors used a 7 point Likert-type scale to measure to opposing personal characteristics, such as "unpleasant" and "pleasant." The authors utilized the scale for descriptive statistics and did not include reliability or validity data.

The current study asked participants to endorse attitudes towards clients who lie in therapy compared to clients who do not lie in therapy based on adjectives used by Foster and colleagues. The 12 items asked participants to endorse attitudes towards clients who lie in therapy based on a 7 point Likert-type rating scale (e.g., 1 = Not very successful, 7 = Very successful). The 12 items consisted of a mix of positive (e.g., successful) and negative (e.g., weak) adjectives. They were randomly ordered within the

scale. These items were included to examine more global perceptions of the attributes of clients who lie.

The TATDS contained two subscales: (a) specific and (b) global. The specific attitudes subscale measured attitudes toward discovering a client's lie in therapy (items 1-12 on the TATDS); whereas global attitudes subscale measured attitudes towards clients who lie (items 13-24 on the TATDS; see Appendix C). Table 13 shows the internal consistency of each of these scales and the combined scales into a total attitude score.

Table 13

Internal Consistencies of TATDS

Scale	Mean (*SD*)	Range	α
Specific Attitudes	44.85 (3.70)	12-84	0.81
Global Attitudes	52.38 (6.94)	12-108	0.65
Total Attitude Score	97.08 (9.14)	24-192	0.83

Additional items were generated by the author for exploratory purposes. The remaining 24 items were related to participants' suspicion of clients, importance of honesty, self-reported deception behaviors, and perceptions of honesty in therapy on a 7 point Likert-type rating scale (1 = Not at all, 7 = Very much). The final item asked participants to indicate the percentage of clients they assume have lied during the course of their work in therapy.

Procedure

The various instruments that were used in the study to collect data were uploaded on Psychdata, which is a website designed for hosting online surveys (Locke & Keiser-

Clark, 2012). Then, an Excel database was constructed from accessing contact information from the Association of Psychology Postdoctoral and Internship Centers (APPIC) online directory for internship programs. Under the program-related search options, the criteria for internship sites was APA accredited programs and programs who accepted applicants from clinical and counseling graduate programs. This search yielded 421 internship institutions. The name, training director's name, and contact email were collected from each of the various training sites and entered into an excel document.

Upon collecting contact information, the researcher sent individual emails to each training director at the various internship sites. The email denoted the purpose of the study (Appendix D), asked the director for participation in forwarding the email to current interns and/or staff, and also provided the link to the study. Upon selecting the link to the study, hosted through Psychdata, participants were initially presented with an informed consent form (Appendix E), which asked participants to read and click continue if they agreed to participate in the current study. The informed consent discussed the nature and purpose of the study, the eligibility requirements to participate, the potential risks and benefits to the participant, and the right to terminate participation. After reading and consenting to participate in the research study, the participants were asked to complete the Demographic Questionnaire (Appendix A), the Detection of Deception Questionnaire (DDQ; Appendix B), and the Therapists' Attitudes Towards Deception Scale (TATDS; Appendix C).

All emails were sent out over the span of one month as the contact information was entered into an excel document. Upon sending the last email, the researcher allowed two weeks for all participants to have an opportunity to complete the surveys. Then, data were downloaded from Psychdata and entered into the Statistical Package for the Social Sciences (SPSS).

Hypotheses and Statistical Design

The researcher gathered data from Psychdata and organized it into SPSS. Then the data was coded and analyses were conducted in SPSS.

Research Questions and Hypotheses

Question 1. How accurate are therapists' beliefs about cues to deception?

Hypothesis 1A. It was predicted that therapists would hold beliefs that behavior changes as an indicator of deception. Therapists' beliefs about indicators of deception were compared to actual indicators of deception to determine the accuracy of therapists' beliefs. Using one-sample *t*-tests, each of the non-verbal, verbal, and paraverbal behavioral variables were analyzed individually to determine if therapists' beliefs about cues to deception differ significantly from a non-behavioral change, which would reveal that therapists believe certain behaviors change when clients are lying. A Bonferroni adjustment was applied to the analyses to avoid an increased Type I error, due to running multiple *t*-tests.

Hypothesis 1B. It was predicted that therapists would hold false beliefs about at least one indicator of deception. Therapists' beliefs about each of these behavioral

variables, whether a behavioral cue increased, decreased, or had no change, were compared to previous research findings on actual beliefs about indicators of deception. The label of the each belief (increase, decrease, or no change) was compared to actual indicators to reveal the accuracy of therapists' beliefs. The frequency of accurate beliefs, determined by a match in belief label (i.e., increase, decrease, or no change) was reported.

Question 2. Do therapists hold more accurate beliefs about nonverbal indicators than verbal or paraverbal indicators?

Hypothesis 2. It was predicted that therapists would hold more accurate beliefs about nonverbal indicators than verbal or paraverbal indicators.

The number of accurate beliefs was calculated for each participant and for each indicator category: verbal, paraverbal, and nonverbal. Then, a percentage of accurate beliefs for each indicator category was calculated for each participant. A one-way repeated measures ANOVA was used to compare the percentages of each indicator category. A priori planned comparisons was used to test the hypothesis that therapists would hold more accurate beliefs about nonverbal indicators of deception compared to verbal and paraverbal indicators.

Question 3. What attitudes would therapists have towards clients who lie?

Hypothesis 3. It was predicted that therapists will hold negative attitudes towards clients who lie.

The Therapists' Attitudes Towards Deception Scale was used to assess therapists' attitudes towards clients who lie. Items related to attitudes towards discovering a client's lie (1-12) were assessed by using one-sample *t*-tests for each of the 12 items to determine if therapists' ratings would demonstrate a statistically significant difference from a 5 rating, which would indicate an attitude change. Items related to attitudes towards clients who lie in therapy (13-24) were assessed by using one-sample *t*-tests for each of the 12 items to determine if therapists' ratings would demonstrate a statistically significant difference from a 4 rating, which would indicate an attitude change. Similar to the Hypothesis 1A, a Bonferroni adjustment was applied to the analyses to avoid an increased Type I error.

Question 4. Does a relationship exist between therapists' worldviews and attitudes towards client deception?

Hypothesis 4. It was predicted that a relationship would exist between a positivist worldview and attitudes towards deception. More specifically, it was predicted that there would be a positive correlation between therapists who endorse a positivist worldview and negative attitudes towards client deception.

Three correlation analyses were conducted to investigate the relationship between therapists' worldviews and their attitudes towards clients who lie. Bivariate correlations were conducted with each worldview score (i.e., positivist and constructivist) and the total attitude score. Also, a worldview score was obtained through subtracting the

constructivist rating from the positivist rating. A bivariate correlation was run to test the relationship between the worldview score and the total attitude score.

CHAPTER IV

RESULTS

Data was reviewed prior to analyses to determine exclusion procedures for any cases of missing data. After determining the data to be included in analyses, the statistical findings from the major research hypotheses are presented. Last, exploratory analyses are noted.

Preliminary Analyses

The current study recruited a total of 112 participants. Of the 112 participants nine participants agreed to participate in the study and did not complete any of the subsequent items. Thus, those nine participants were excluded from any analyses. Participants who did not complete information beyond the Demographics Questionnaire were not included in the statistical analyses, as the major hypotheses were specific to items beyond the Demographics Questionnaire. The total number of participants who were included in the statistical analyses of hypotheses was 93. Some data were also missing in a few areas of the various instruments. Any missing data was excluded from analyses. However, cases involving partial missing data were included in the analyses due to the effects not compromising statistical power and due to data representing one sample, therapists. The data were also examined for normality through the use of Normal Q-Q plots for each of the beliefs about indicators of deception and attitudes towards client deception. Skewness for every indicator and attitude score was less than one and kurtosis was less than three.

Outlier data was investigated to detect if there were consistencies in cases that endorsed extreme scores on each item, indicating a possible infrequency in response. There was no datum that consistently had extreme values on every item. Due to the current study investigating attitudes and beliefs, cases reflecting extreme values were included to reflect extreme values of attitudes or beliefs.

Analyses of Hypotheses

The current research project investigated four major research questions. Each research question and its hypothesis will be reported in this section.

Research Questions and Hypotheses

Question 1. How accurate are therapists' beliefs about cues to deception?

Hypothesis 1A. It was hypothesized that therapists would hold beliefs that behavior changes as an indicator of deception and a number of beliefs held will be discrepant from actual indicators of deception. First, one-sample *t*-tests were conducted on each of the 28 indicators of deception to determine if therapists' ratings were significantly different from 4, which would indicate that beliefs that behavior changes when clients lie. To avoid an increased Type I error due to running multiple *t*-tests, a Bonferroni adjustment was applied (Bonferroni correction = .002). Then, these beliefs were compared to actual indicators of deception to discern the accuracy of therapists' beliefs. A majority of beliefs held by therapists (71%) about indicators of deception was that behavior changes when lying (see Table 14). Of the 28 indicators of deception,

therapists believed that many (68%) behaviors increase as indicators of deception. This hypothesis was supported by the data.

Hypothesis 1B. It was predicted that therapists would hold false beliefs about at least one indicators of deception. Among the 28 indicators of deception, therapists held accurate beliefs about four indicators: (a) pitch, (b) latency, (c) logical consistency, and (d) describing interactions with others (see Table 14). This hypothesis was supported.

Table 14

Therapists' Beliefs About Lying-related Changes in Behavior Compared to a "No Change" Rating of 4.0

Deception Variable	Mean (*SD*)	*t*	Belief	Prior Research
Nonverbal Indicators				
Eye contact	3.06 (1.14)	-7.91*	Decrease	No change
Eye blinks	4.74 (0.99)	7.12*	Increase	No change
Head movements	4.29 (1.03)	2.72	Increase	No change
Hand and finger movements	4.65 (1.07)	5.83*	Increase	Decrease
Arm movements	4.13 (0.89)	1.40	No change	Decrease
Leg and foot movements	4.77 (0.96)	7.68*	Increase	Decrease
Smiles	4.26 (1.01)	2.47	Increase	No change
Postural shifts	5.06 (0.95)	10.77*	Increase	No change
Shrugs	4.35 (0.85)	4.00*	Increase	No change
Gestures	4.38 (0.91)	4.00*	Increase	No change
Paraverbal Indicators				
Speech interruptions	4.77 (0.93)	7.88*	Increase	No change
Pauses	4.67 (0.98)	6.54*	Increase	No change
Latency to respond	4.60 (1.15)	5.00*	Increase	Increase
Hectic speech	4.58 (0.95)	5.80*	Increase	No change
Pitch	4.71 (0.82)	8.39*	Increase	Increase
Answer length	4.69 (1.29)	5.13*	Increase	No change
Verbal Indicators				
Short simple sentences	3.42 (1.10)	-5.11*	Decrease	Increase
Plausible descriptions	4.04 (1.22)	0.34	No change	Decrease
Logical consistency	3.34 (1.05)	-6.05*	Decrease	Decrease
Detailed description	4.32 (1.35)	2.31	Increase	Decrease
Unusual detail	4.72 (1.12)	6.22*	Increase	No change

Cont'd

Unnecessary detail	4.86 (1.15)	7.08*	Increase	No change
Description of feelings	3.46 (1.11)	-4.68*	Decrease	No change
Describe what someone said	3.95 (1.23)	-0.42	No change	Decrease
Description of interactions	3.84 (1.15)	-1.35	No change	No change
Spontaneous corrections	4.03 (1.31)	0.24	No change	Decrease
Claim lack of memory	4.74 (1.06)	6.74*	Increase	Decrease
Story contradictions	5.08 (1.01)	10.24*	Increase	No change

Note: * $p<.002$

Question 2. Do therapists hold more accurate beliefs about nonverbal indicators than verbal or paraverbal indicators?

Hypothesis 2. It was predicted that therapists would hold more accurate beliefs about nonverbal indicators than verbal or paraverbal indicators. A one-way repeated measures ANOVA was used to compare the percentages of each deception indicator category. Results revealed a statistically significant difference for therapists' accuracy of beliefs between the indicators of deception, $F(2,91) = 11.8, p < .001$. More specifically, therapists held a higher percentage of accurate beliefs about paraverbal indicators ($M = 0.39$, $SD = 0.19$) than nonverbal indicators ($M = 0.29$, $SD = 0.19$; $p < .001$) and verbal indicators ($M = 0.29$, $SD = 0.13$; $p < .001$).

Question 3. What attitudes will therapists have towards clients who lie?

Hypothesis 3. It was predicted that therapists would hold negative attitudes towards clients who lie. One-sample *t*-tests were conducted on each of the items related to attitudes towards discovering a client's lie (items 1-12 on TATDS) to determine if therapists' ratings demonstrated a statistically significant difference from a 5 rating,

which would indicate an attitude change. A Bonferroni adjustment was utilized in the analyses (Bonferroni correction = .004). A statistically significant difference was found among 8 of the 12 attitude items, in which all 8 attitudes were negative (see Table 15). The 8 negative attitudes were: (a) decrease in liking the client, (b) increase in thinking negatively of client, (c) decrease in desire to interact with client, (d) decrease in enthusiasm to work with client, (e) decrease in judging client as a good client, (f) decrease in trusting the client, (g) decrease in thinking positively about client, and (h) decrease in viewing client as sincere.

Table 15

Therapists' Attitudes in Discovering a Client's Lie (Specific Attitudes Scale)

#	Attitude Item	*n*	Mean (*SD*)	*t*	Attitude Change
1	Liking the client	89	4.19 (0.98)	-7.823*	Decrease
2	Being angry at the client [RC]	89	5.24 (0.81)	2.741	Increase
3	Client as a bad person [RC]	89	4.83 (0.82)	-1.951	Decrease
4	Thinking negatively of client [RC]	87	5.31 (0.99)	2.918*	Increase
5	Judging client harshly [RC]	89	5.01 (0.96)	0.11	No change
6	Desire to interact with client	89	4.35 (1.24)	-4.942*	Decrease
7	Enthusiasm to work with client	89	4.21 (1.17)	-6.308*	Decrease
8	Judging client as a good client	89	4.35 (1.02)	-6.006*	Decrease
9	Speaking poorly of client [RC]	89	5.17 (0.93)	1.706	No change
10	Trusting the client	89	3.30 (1.14)	-14.013*	Decrease
11	Thinking positively about client	88	4.28 (0.90)	-7.493*	Decrease
12	Viewing client as sincere	89	3.43 (1.15)	-12.938*	Decrease

Note: * $p<.004$
[RC]: Indicates a reverse coding.

One-sample *t*-tests were also conducted on each of the items related to attitudes towards clients who lie in therapy compared to clients who do not lie in therapy (items

13-24 on TATDS) to determine if therapists' ratings demonstrated a statistically significant difference from a 4 rating, which would indicate an attitude change. A Bonferroni adjustment was utilized in the analyses (Bonferroni correction = .004). A statistically significant difference was found among 5 of the 12 attitude items, in which all 5 were negative attitudes (see Table 16). The 5 negative attitudes were: (a) decrease in successfulness, (b) decrease in compliance, (c) decrease in pleasantness, (d) decrease in likableness, and (e) decrease in being adjusted.

Table 16

Therapists' Attitudes Towards Clients who Lie in Therapy (Global Attitudes Scale)

#	Attitude Item	*n*	Mean (*SD*)	*t*	Attitude Change
13	Successful	89	3.27 (0.88)	-7.865*	Decrease
14	Pathological[RC]	89	4.21 (0.79)	2.549	Increase
15	Weak [RC]	89	3.98 (0.59)	-0.363	No Change
16	Compliant	87	3.24 (0.92)	-7.737*	Decrease
17	Predictable	89	3.85 (0.92)	-1.512	No change
18	Pleasant	89	3.69 (0.60)	-4.859*	Decrease
19	Lazy [RC]	89	3.94 (0.47)	-1.149	No change
20	Awkward [RC]	89	4.09 (0.47)	1.812	No change
21	Knowledgeable	89	3.99 (0.51)	-0.207	No change
22	Intelligent	89	4.02 (0.40)	0.532	No change
23	Likable	88	3.50 (0.59)	-7.987*	Decrease
24	Adjusted	89	3.61 (0.83)	-4.301*	Decrease

Note: * $p<.004$
[RC]: Indicates a reverse coding.

Therapists endorse negative attitudes towards discovering a client's lie in therapy as well as towards clients who lie in therapy. This hypothesis was supported.

Question 4. Does a relationship exist between therapists' worldviews and attitudes towards client deception?

Hypothesis 4. It was predicted that a relationship would exist between a positivist worldview and attitudes towards deception. More specifically, it was predicted that there would be a positive correlation between therapists who endorse a positivist worldview and negative attitudes towards client deception.

Three correlations were run to examine each worldview variable (i.e., positivist and constructivist) and a worldview score with the TATDS total attitude score. These analyses were conducted to examine each possible relationship between worldviews and attitudes. The worldview score was created to examine the difference between both worldview scales.

Bivariate correlations were run with each worldview variable and the TATDS total attitude score. There was not a statistically significant correlation found between the positivist worldview and the TATDS total attitude score, $r = -0.04$, $df = 76$, $p = 0.74$. Also, there was not a statistically significant correlation found between the constructivist worldview and the TADS total attitude score, $r = 0.05$, $df = 76$, $p = 0.66$.

The last analysis run was a bivariate correlation to test the relationship between a worldview score and the TATDS total attitude score. A worldview score was obtained through subtracting the constructivist rating from the positivist rating. There was not a statistically significant correlation found between the worldview score and the TATDS total attitude score, $r = 0.06$, $df = 76$, $p = 0.61$. Therapists' worldviews and their attitudes

towards client deception do not indicate a relationship. Therefore hypothesis 4 was not supported.

Exploratory Analyses

Additional analyses were conducted to explore the data beyond the major hypotheses. Therapists held negative attitudes towards discovering a client's lie in therapy and towards clients who lie in therapy. After discovering that Hypothesis 3 was supported, an exploratory analysis was conducted to test the differences between the specific attitude scale and the global attitude scale. Due to the differences in range for each scale (i.e., 1-9 and 1-7), a sum of negative attitudes was computed for each scale. For the specific attitude scale, a negative attitude was calculated if the value of the item was less than a score of five. For the global attitude scale, a negative attitude was calculated if the value of the item was less than a score of four.

A paired samples *t*-test was conducted to compare the number of negative attitudes held on the specific attitude scale to the global attitude scale. The results revealed a statistically significant difference; therapists endorsed more negative attitudes on the specific attitudes scale ($M = 5.70$, $SD = 3.38$) compared to the global attitude scale ($M = 3.27$, $SD = 2.31$; $p < .001$). Therefore, therapists held more negative attitudes towards discovering that a client was lying in therapy compared clients who lie.

The TATDS contained some items that asked participants to rate value and importance of honesty in therapy. An item asked participants to rate how much they valued honesty in therapy (1 = Not at all, 7 = Very much). Two other items asked how

important client honesty is for the therapeutic relationship and how important client honesty is for therapeutic outcome (1 = Not at all, 7 = Very important). Table 17 shows the means and standard deviations for these items.

Table 17

Therapist Ratings for Value and Importance of Honesty in Therapy

Item #	Item	*n*	Mean (*SD*)
33	Value honesty	88	5.43 (1.16)
34	Importance of honesty for relationship	87	5.11 (1.15)
35	Importance of honesty for outcome	87	5.17 (1.16)

A bivariate correlation was also conducted to investigate the relationship between the value of honesty in therapy and the importance of honesty for the therapeutic relationship and outcome. There was a statistically significant correlation found between how much therapist valued honesty and the importance of honesty for therapeutic relationship, $r = 0.71$, $df = 86$, $p = .001$, and outcome, $r = 0.68$, $df = 86$, $p < .001$. In other words, therapists who valued honesty viewed it as a necessary component for the therapeutic relationship and relates to therapy outcome.

The TATDS contained two items that asked therapists to identify when they believed that clients would be more likely to lie within the course of therapy (i.e., early or later). This exploration was based on research that indicates people tell less lies to those they feel more emotionally close (Vrij, 2000). A paired samples *t*-test was conducted to compare thinking clients lie in early sessions to thinking that clients lie in later sessions.

The results revealed a statistically significant difference; therapists believed clients lie are more likely to lie in early therapy sessions ($M = 4.76$, $SD = 1.16$) than in later therapy sessions ($M = 3.34$, $SD = 1.040$; $p < .001$). Therefore, therapists thought that clients are more likely to lie in the initial stages of therapy.

It was speculated that counseling experience might be related to attitudes towards client deception. A bivariate correlation between years of counseling experience and the total attitude score was calculated. There was not a statistically significant correlation found between years of counseling experience and the total attitude score was conducted, $r = 0.01$, $df = 92$, $p = 0.90$. Therefore, counseling experience was not related to attitudes towards client deception.

The TATDS also consisted of items that asked therapists to indicate how likely clients would lie about three different domains: emotions, behaviors, and thoughts (1 = Not at all, 7 = Very likely). A one-way repeated measures ANOVA compared the means of each of these three areas. Results revealed a statistically significant difference between therapists thoughts about client deception in these three domains, $F(2,84) = 27.62$, $p < .001$. More specifically, therapists believed that clients would be more likely to lie about behaviors ($M = 5.30$, $SD = 1.14$) than thoughts ($M = 4.53$, $SD = 1.19$; $p < .001$) and emotions ($M = 4.25$, $SD = 1.27$; $p < .001$).

CHAPTER V

DISCUSSION

In discussing the results from the current study, a discussion of findings is presented and integrated with previous literature pertaining to deception and therapy (e.g., Global Deception Research Team, 2006; Rønnestad, & Skovholt, 2003). The strengths of the current study are addressed. Then, limitations are considered and future directions suggested. Implications for research are discussed followed by implications for training, practice, and theory. Lastly, a conclusion is provided.

Discussion of Findings

The findings from the current study are discussed and integrated with previous research findings. Research questions and corresponding hypotheses related to therapists' beliefs about indicators of deception and attitudes towards client deception is discussed.

Research Questions and Hypotheses

Question 1. A series of analyses examined therapists' beliefs about indicators of deception. The findings supported Hypothesis 1A, which predicted that therapists would hold beliefs that behavior changes as an indicator of deception. A majority of therapists' beliefs (82%) were that behavior changes as an indicator of deception.

The findings that therapists held many beliefs that behavior changes when clients are deceptive are congruent with research findings that undergraduate university students, managers, police officers, and teachers believe that behaviors change when people are

deceptive (Colwell, Miller, Miller, & Lyons, 2006; Forrest et al., 2004; Hart, 2006; 2010; Reinhard, Dickhäuser, Marksteiner, & Sporer, 2011). Across cultures, people believe that behaviors change when people lie (Global Deception Research Team, 2006).

Results also supported Hypothesis 1B, which predicted that therapists would hold a number of inaccurate beliefs about indicators of deception. In the current study, therapists held accurate beliefs about 4 out of 28 indicators of deception. The large number of inaccurate beliefs is supported by other research (Vrij, 2008). Many people across cultures hold inaccurate beliefs (Global Deception Research Team, 2006).

The top two beliefs held, within 58 countries, are that liars avert their gaze and are nervous (Global Deception Research Team, 2006). These two beliefs are related to the current findings. Therapists held beliefs that eye contact decreased as an indicator of deception. Also, the majority of the therapists' beliefs (68%) about all 28 indicators of deception were that behavior increases. Other research has demonstrated similar results, in which officers' believe that behaviors increase when people lie (Colwell et al., 2006). The beliefs that behavior increases when clients lie may be indicative of commonly held beliefs that people are nervous when they lie (Global Deception Research Team, 2006; Vrij, 2008). An increase in many of the cues (e.g., higher pitched voice, less eye contact, speech hesitations) is often related to nervousness (Vrij, 2008).

Question 2. The second major research question examined whether therapists held more accurate beliefs about nonverbal indicators compared to verbal or paraverbal indicators. Hypothesis 2 predicted that therapists would hold more accurate beliefs about

nonverbal indicators of deception; however, Hypothesis 2 was not supported. Therapists, collectively, did not hold accurate beliefs for any of the nonverbal indicators of deception. Therapists' held the highest percentage of accurate beliefs about paraverbal indicators of deception.

Research that compared actual or objective nonverbal indicators to believed or subjective nonverbal indicators revealed that many beliefs about nonverbal indicators are inaccurate (Vrij, 2008). People often hold inaccurate beliefs about the diagnostic cues to deception, which are the cues that tend to change (Vrij, 2008). These nonverbal cues are (a) hand and finger movements, (b) arm movements, and (c) leg and foot movements (Vrij, 2008). All three of these diagnostic variables typically decrease; however, people often assume that hand and finger movements and leg and foot movements increase (Vrij, 2008).

The four beliefs that were accurately identified, by therapists in this study, as valid indicators of deception were: (a) pitch, (b) latency, (c) logical consistency, and (d) describing interactions with others. These findings match similar findings from a study that investigated managers' and non-managers beliefs about verbal and paraverbal indicators of deception (Hart et al., 2010). Hart and colleagues found that managers and undergraduate students accurately identified 3 out of the 18 verbal and paraverbal indicators of deception: (a) pitch, (b) latency, (c) and logical consistency. These three indicators were the same indicators accurately identified in the current study, with the additional indicator of describing interactions with others. Therapists' beliefs about cues

to deception appear to share some overlap between with managers and undergraduate students. Previous research hypothesized occupational differences in deception detection due to particular training or increased occupational exposure to deception (Colwell et al., 2006; Hart et al., 2006; Reinhard et al., 2011). These studies indicated that occupational differences do not contribute to increased accuracy of beliefs about cues to deception. This may suggest that beliefs about indicators of deception may precede occupational training and stem from other sources, such as cultural stereotypes of liars (Global Research Team, 2006).

A few reasons may explain the findings that therapists did not hold many accurate beliefs about cues to deception. Culturally constructed stereotypes about liars, therapists' training, and interest in deception detection may be some reasons for understanding the current findings (Colwell et al., 2006; Ekman et al., 1999; Global Research Team, 2006; Vrij, 2008). These reasons may also support the notion that similar beliefs about cues to deception are held across professions.

Three explanations have been proposed for the construction of the stereotype of a liar (Vrij, 2008). One explanation suggested a moral explanation of beliefs that lying-is-bad (Global Deception Research Team, 2006; Vrij, 2008). This moral explanation of the stereotype construction is based on beliefs that when people lie they should feel ashamed or nervous and avert their gaze (Vrij, 2008). A second explanation of the development of liar stereotypes is referred to as the exposure explanation (Vrij, 2008). This explanation suggests that popular media influences beliefs of what a liar looks like. Lastly, the

accusation explanation suggests that in accusing people as liars they become nervous and engage in behaviors such as gaze aversion (Vrij, 2008).

Beliefs related to stereotypes of a liar are often not indicative of actual cues to deception, such as gaze aversion (Global Research Team, 2006). Stereotypical beliefs about liars may be the contributing factor for understanding inaccurate beliefs about indicators of deception across occupations (Colwell et al., 2006; Hart et al., 2006) and finding no relationship between occupational experience and detection accuracy (DePaulo & Pfeifer, 1986). In the current study, deeply held stereotypical beliefs about liars may have been the reason that therapists held a number of inaccurate beliefs about cues to deception. Therefore, beliefs about indicators of deception might be better predicted by constructed stereotypes of a liar rather than occupational experience.

In the current study, therapists reported, on average, minimal training in client deception or deception detection. Not having the proper training regarding accurate cues to indicators of deception and dispelling myths of deception may maintain inaccurate beliefs (Colwell et al., 2006). Having a vested interest in deception may increase accurate beliefs about cues to deception. Along with minimal training, therapists in the current study reported having read minimal literature pertaining to deception. Therapists who have an interest in deception may read more deception literature or seek deception workshops and seminars. Previous literature on the accuracy of deception detection in therapists revealed that clinical psychologists who had an interest in deception demonstrated a statistically significant difference in detecting deception compared to

clinical psychologists with no interest in deception (Ekman et al., 1999). Thus, interest in deception and its detection might yield more accurate beliefs about indicators of deception. Therapists who dedicate time to reading deception literature, attending deception presentations, and discussing client deception with colleagues and supervisors would learn about actual indicators of deception.

Question 3. Other analyses were conducted to examine therapists' attitudes towards client deception. Hypothesis 3, predicting that therapists would possess more negative attitudes towards clients who lie in therapy, was supported. Therapists' attitudes towards discovering a client's lie had demonstrated statistically significant changes for 10 of the 12 attitudes. Nine of the 10 attitudes were negative. Six out of 12 attitudes towards clients who lie in therapy compared to clients who do not lie in therapy revealed a statistically significant change. The six changes in attitudes were negative.

Therapists held a number of negative attitudes towards client deception. These negative attitudes may be a result of therapists' personal and professional values. Therapists' professional development is influenced from an integration of personal and professional experiences (Rønnestad & Skovholt, 2003). As therapists develop, they create a therapy role that becomes congruent with personal values and attitudes (Rønnestad, & Skovholt, 2003). Some reasons that people have negative attitudes towards liars are that people generally assume that most interactions are honest (Bond & DePaulo, 2006) and typically do not like to be the target of deception (Kottler & Carlson, 2011; Miller, Perlman, & Brehm, 2007). Liars are viewed as less pleasant and less

cooperative compared to truth-tellers (DePaulo & Morris, 2004). In addition to personal values and attitudes, therapists are professionally encouraged to value honesty and avoid deception towards clients and research participants, as noted in the APA Code (APA, 2002; 2010).

Question 4. The last major research question examined the relationship between therapists' worldview and attitudes toward client deception. Hypothesis 4 predicted that there would be a positive correlation between therapists who endorse a positivist worldview and negative attitudes towards client deception. Hypothesis 4 was not supported. There was no statistically significant relationship between worldviews and attitudes towards client deception.

Therapists negative attitudes may stem from personal and professional values previously noted rather than from an endorsed therapeutic worldview. The dislike of being the victim of deception (Kottler & Carlson, 2011; Miller, Perlman, & Brehm, 2007) along with negative views of liars (DePaulo & Morris, 2004) may be more pervasive than therapists' worldviews.

Exploratory Analyses

Several exploratory analyses were conducted to examine the post-hoc comparisons, the effect of demographic variables on attitudes toward client deception, and to report other descriptive statistics. Among these analyses, attitude scales were compared to investigate any differences between specific or global attitudes. Then, the relationship between therapists' attitudes and the value and importance of honesty in therapy were explored. This

was followed by an investigation of when therapists perceive clients lie more likely to lie during therapy. Next, the relationship between therapists' counseling experience and attitudes were explored. Lastly, the domains of client deception were explored.

Each attitude scale was compared to explore if a difference existed in the type of attitudes held towards client deception. Scores on the specific attitude scale were compared to scores on the global attitude scale. The specific attitude scale asked participants to indicate how discovering a client's lie might affect things such as "liking the client." The global attitude scale asked participants to make more global attributions about clients who lie compared to clients who do not lie by using opposing adjectives such as "successful."

It is important to note that though therapists held a number of negative attitudes towards client deception, there was a difference between specific and global attitudes. Therapists held more negative attitudes towards the situational aspect of discovering a client's lie compared to global perceptions of attributions of deceptive clients. These findings may be due to not wanting to be on the receiving end of deception (Kottler & Carlson, 2011; Miller, Perlman, & Brehm, 2007). Therapists have a variety of emotional responses in discovering a client's lie (Kottler & Carlson, 2011). Negative attitudes towards clients might be a reaction towards being the victim of deception. Therapists may be less likely to make global attributions towards clients who lie because of unconditional positive regard towards clients (Rogers, 1961). Unconditional positive regard, also termed "positive affective attitude," is valuing the client outside of any behavioral contingencies (Rogers, p. 47).

Another possible explanation is that bad is stronger than good, in that bad events carry more weight and saliency than good events (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001; Fiske, 1980). Thus, discovering a client's lie in therapy may elicit negative attitudes towards a client due to the saliency of having a bad event directed at a therapist. On the other hand, asking therapists to rate clients who lie compared to those who do not lie in therapy with various adjectives may be more ambiguous and possibly interpreted as affecting others rather than oneself.

Some of the therapists' negative attitudes towards client deception may also come from the value and importance of honesty within therapy. An analysis was conducted to investigate whether a relationship existed between the value of honesty in therapy and the importance of honesty for the therapeutic relationship and outcome. A positive correlation was found between valuing honesty in therapy and the importance for honesty in therapy. Also, valuing honesty in therapy was positively correlated with therapeutic outcome.

The therapeutic relationship consists of contributions from the therapist and client (Orlinsky et al., 2004) and has been reported to be a significant factor in therapeutic outcome (Lambert & Ogles, 2004). Client lies may directly violate the therapeutic relationship and potentially effect therapeutic outcome. Thus, therapists may value honesty and hold negative attitudes towards client deception due to the desire to promote the therapeutic relationship and outcome. The drive to perpetuate the therapeutic relationship and overall positive outcome may inflate the value of client honesty and

negative attitudes towards client deception. Therapists are also inclined to value honesty and may have negative attitudes towards client deception because they typically work collaboratively with clients to establish and maintain the therapeutic alliance (Newman & Strauss, 2003).

Therapists' perceptions about client deception changes within the course of therapy. An analysis was conducted to explore when therapists believed that clients would be more likely to lie during the course of therapy (i.e., early or later). This exploration revealed that participants believed clients lie more in early therapy sessions than in later therapy sessions. The findings related to therapists' thoughts about clients being more likely to lie during early sessions as compared to later sessions is supported by other deception literature. People are less likely to tell lies to those whom they feel more emotionally close (Vrij, 2000). The therapeutic relationship typically develops over the course of therapy, allowing for the therapeutic bond between client and therapist to be strengthened (Derlega, Hendrick, Winstead, & Berg, 1992). In relation to the previous research findings, therapists may believe that clients develop the therapeutic bond over the course of therapy and would be less willing to lie over time.

In exploring demographic variables, counseling experience related to attitudes towards client deception was investigated. The analysis did not reveal a significant relationship between the therapists' attitudes towards client deception and years of counseling experience. The lack of any significant relationship between attitudes and therapists' experience suggested that negative attitudes held by therapists were not

accounted for by the amount of years therapists had been providing therapy. Thus, negative attitudes do not vary with the amount of one's therapy experience. Also, therapists' attitudes did not correlate with their worldviews (i.e., constructivist and positivist). Thus, therapists' attitudes must be rooted in something beyond experience and adopted worldview. These findings may suggest that attitudes towards client deception might be embedded in personal and professional values (Rønnestad & Skovholt, 2003) or stereotypes about liars (Vrij, 2008).

Lastly, an analysis explored therapists' beliefs about the likelihood of clients lying about three different domains: emotions, behaviors, and thoughts. Results revealed that participants believed clients would be more likely to lie about behaviors compared to thoughts and emotions Emotions were believed to be the least likely domain about which clients would lie.

These findings may be the result of therapists' beliefs that many of the client's behaviors occur outside of therapy and may be difficult to validate due to confidentiality concerns (Kottler, 2011) or access to information (Helm, 2011). Within therapy, thoughts and emotions may be more easily accessible to validate. It takes cognitive resources to fabricate false narratives (Vrij, 2008). Therapists may believe that using cognitive resources in therapy may make it more difficult to lie about thoughts. Therapists may also believe that clients are least likely to lie about emotions because of the difficulty in concealing emotions compared to thoughts or behaviors. Emotional responses may be more difficult to conceal and microexpressions may surface (Ekman, 2009).

Strengths of the Study

Counseling psychology carries a history of an interface with social psychological research (Strong et al., 1992). A bulk of deception literature has focused on its detection (see Vrij, 2008). Yet, there has remained a dearth of literature examining deception in the therapeutic context (Briggs, 1992; Kottler & Carlson, 2011). The present study encourages the interface through exploring deception related to therapy.

In examining therapists' beliefs and attitudes towards deception, the current study recruited therapists representing a range of ages (25 to 69 years), experience (less than 1 year to 40 years; 25 to 36, 000 direct client contact hours), and theoretical orientations. Therapists were recruited from various agencies across North America.

Another strength of the current study is evidenced through empirically examining therapists' attitudes towards deception (i.e., TATDS). Some literature has discussed therapists' reactions towards client deception (e.g., Kottler & Carlson, 2011; Newman & Strauss, 2003), though these accounts did not provide empirical data. The current study used an adaptation from a scale used to measure physician's attitudes (Foster et al., 2003) and a self-constructed scale, intended to measure therapists' attitudes in discovering a client's lie.

Limitations and Future Research Directions

There were some limitations to the current study. The study recruited participants online through a respondent-driven sampling method. This method was employed to reach specialized populations, namely counseling and clinical psychology interns and

psychologists. Rates of the online surveys were unable to be calculated due to not having information related to how many participants received the questionnaires.

Nineteen participants did not complete questionnaires beyond the demographic questionnaire. Due to the nature of the study being conducted online, the researcher could not determine the reasons that the participants chose to not complete the study. A possible explanation might be due to greater frequency of online studies having higher attrition rates (Peytchev, 2009).

Many of the participants who were recruited worked primarily at Veterans Affairs, university counseling centers, and hospitals (n = 80%). Therapists in a private practice setting may place an importance in client deception. Private practice psychologists and therapists may work with clients who are mandated for treatment and must follow legal procedures. Forensic psychologists were also not represented in the study. One potential participant, who worked within a prison, notified the researcher of additional requirements necessary to pass along the current study to other interns and psychologists. Thus, psychologists who have a vested interest in deception and skills in working with client deception were not represented in the current study.

Another limitation of the current study is the lack of external validity. The nature of the current study was investigating beliefs and attitudes of therapists outside of the therapeutic environment. Endorsed beliefs about indicators of deception may not be the actual beliefs utilized or employed when interacting with clients. Beliefs that are not activated may be useless in detecting deception (Forrest et al, 2004). Therapists may not

activate these beliefs when making decisions in therapy when detecting client deception. It is not known if therapists rely only on the four accurate beliefs they endorsed about indicators of deception and if so, then how often.

It is also unclear if other therapeutic or situational factors contribute to activating particular beliefs. Suspicion has been suggested to be an activator of beliefs about cues to deception (Forrest et al., 2004). People who are suspicious attend more to cues associated with deception (DePaulo, Lassiter, & Stone, 1982). Future research might examine belief activation and belief reliance within the therapeutic situation.

Implications for Research

The current study contributes to current research literature on deception. The findings that therapists held many inaccurate beliefs about indicators of deception appears to parallel other research (Vrij, 2008). Inaccurate beliefs about indicators of deception are held across other professional groups (Colwell et al., 2006; Hart et al., 2006). Therapists, like other professional groups, do not appear to possess an advantage in holding a higher number of accurate beliefs about indicators of deception. These reasons may also support the notion that similar beliefs about cues to deception are held across professions. Future research could explore what indicators therapists might use within therapy.

The current study also contributes to deception literature through exploring attitudes towards deception. The current research database contains a dearth of literature

examining attitudes towards deception. Some literature has informally addressed attitudes towards being duped as a therapist (Kottler & Carlson, 2011), consequences of deception (DePaulo & Kashy, 1998; Sagarin et al., 1998), and the pleasantness or cooperativeness of liars (DePaulo & Morris, 2004). The current study adds to research in explicitly measuring attitudes towards deception. Further research might implement the attitude scale utilized in the current study (i.e., TATDS) to further examine the dynamics of attitudinal roles within deception and its detection.

Along with measuring attitudes, it may be important to explore the effect therapists' attitudes may have on behavior. Attitude research has suggested that attitudes can be predictive of future behavior (Bentler & Speckart, 1979; Fishbein & Ajzen, 1974). Specifically, therapists' attitudes can affect posttreatment outcome (Sandell et al., 2007). Though the current study found that therapists hold a number of negative attitudes towards clients, there are also some attitudes that did not change. It is not known if therapists rely on their attitudes collectively when counseling or if some attitudes were suppressed. The current research did not examine the direct effects of attitudes on therapeutic variables. Thus, it is unknown if therapists have high attitude-behavior consistency regarding attitudes towards. Future designs might explore the effect of therapists' negative attitudes towards clients on therapist behavioral variables.

Implications for Training

Therapists do not typically receive formal training as deception detection experts (Stedman, 2006). The emphasis of training therapists is more concerned with training

competent practitioners. However, in receiving training some therapists believe that "We are rarely trained to recognize when we are being deceived" (Helm, 2011, p. 82). The findings from the current study suggest that therapists have not traditionally been exposed to much training in the area of deception. These findings are consistent with previous research which suggested client deception was rarely discussed (Reed, 1996) but often a topic of interest for counselors (Miller, 1992).

Results from the current study suggest implications for training therapists in the area of client deception. The negative attitudes that therapists hold towards clients who lie in conjunction with many inaccurate beliefs about indicators of deception is a sufficient reason to promote training models in dealing with client deception. Clients may be considered liars based on inaccurate beliefs about deception (Global Deception research Team, 2006) and the therapeutic relationship may be affected by therapists' attitudes towards those suspected liars (Newman & Strauss, 2003)

Incorporating formal or informal training within practica may provide a solution to avoiding the pitfalls of inaccurately believing that a client is a liar or holding negative attitudes towards clients who are deemed liars. Vrij (2008) suggested that inaccurate beliefs about cues to deception last because of confirmation biases, belief perseverance, and poor feedback regarding deception. Training may allow therapists to explore their beliefs and attitudes about client deception while receiving feedback. Therapists-in-training may be afforded the opportunity to review literature related to accuracy in

deception detection, beliefs about cues to deception, and relational or attitudinal components of deception.

Beyond reviewing literature and self-awareness, training might address the three reasons that deception in therapy is not typically discussed, as noted previously. These three reasons are fear of incompetence (Kottler & Carlson, 2011), a truth bias towards clients (Kottler & Carlson, 2011; Newman & Strauss, 2003; O'Sullivan, 2003), and the perceived therapist role (Barnett, 2011). Supervisors might normalize the counseling experience for clients by addressing a case in which they were duped. A supervisors' confession may allow therapists to ask questions about client deception and realize that being duped does not equate to incompetence.

Secondly, supervisors and professors might address the myth that all clients are honest. Therapists may be biased towards clients telling truths and overlook client deception (Newman & Strauss, 2003). A belief that clients enter therapy seeking help and that most social interactions reflect more truth than deception may perpetuate the truth bias (Newman & Strauss). Examining biases allows people to dispel myths about deception (Vrij, 2008) and evaluate their own attitudes towards client deception (Stevens, 2011). After evaluating a case of client deception, Stevens reported, "I live my life with an attitude that I would rather be fooled than put too much psychological energy and time from protecting myself from being fooled" (p. 77). As with any bias, it is important for therapists to understand and be aware of their preemptive notions, attitudes, and beliefs. Given that lies are told about 2 times per day (DePaulo & Bell, 1996; DePaulo & Kashy,

1998; Kashy & DePaulo, 1996) in many different situations (DePaulo, 2009) including therapy (Kottler & Carlson, 2010), it may be important to train therapists to expect lying as a normative process within therapy and to understand that there is no real reason for clients to trust therapists no matter how much they perceive their own good intentions.

Thirdly, further examining therapists' roles may enhance training (Barnett, 2011). Delineating the similarities and differences between being an interrogator, professional deception detector, and therapist may aid in training therapists (Newman & Strauss, 2003). Though therapists are not formally trained to be interrogators it does not mean that they do not encounter deception. Helping therapists understand their roles in client deception may advance training and help formulate therapists' identities (Kottler & Carlson, 2011; Newman & Strauss, 2003).

Implications for Practice

Therapists believe that clients lie and hold a number of inaccurate beliefs about actual indicators of deception. If therapists rely on their inaccurate beliefs about cues to deception when determining if clients lie, then their accuracy in detecting deception is impaired (Forrest et al., 2004). The consequences of relying on inaccurate beliefs about client deception may affect case conceptualization (Newman & Strauss, 2003). Implications for practice may also be contingent on other factors such as the importance of detecting deception (Ekman et al., 1999) and the effects of therapists' attitudes (Newman & Strauss). Further implications reinforce the need to incorporate assessments as a part of psychological evaluations (Meehl, 1954).

Case conceptualization is built around information provided by clients and false information may negatively affect that process (Newman & Strauss, 2003). Client deception can affect conceptualization by placing a burden on the therapist to reconcile the client's presenting concern with the client's reported history (Newman & Strauss, 2003). A client may lie about the reason for entering therapy and that false presenting concern may be difficult to understand in the context of the client's reported history.

Therapeutic contexts may vary in the degree of importance for detecting deception. The consequences for relying on inaccurate beliefs about cues to deception may be more severe for situations where the stakes to detect deception are high. The forensic settings usually place a high degree of importance in detecting deception (Christianson & Merckelbach, 2004; Granhag & Strömwall, 2004; Kassin, 2004). Therapists may be more motivated to detect client deception when evaluating a client within these contexts.

Therapists may also place more importance on detecting deception when they serve clientele who are mandated by the judicial system to attend therapy. Usually, clients who have been mandated to treatment have stipulations regarding their behaviors, which they are to avoid behaviors that contribute to their criminality (Ginsburg, Mann, Rotgers, & Weekes, 2002). Therapists are typically required to report any violations of clients' agreements to the courts ("Court-referred clients," 2010). Mandated clients may often enter therapy with a lack of motivation for treatment and may display antisocial

attitudes (Ginsburg et al., 2002). Therefore, therapists may place a higher degree of importance on detecting client deception when working with mandated populations.

Consequences for relying on inaccurate beliefs about cues to deception may also be noteworthy if therapists' negative attitudes towards clients who lie are reflected in their decisions about which clients are liars. Essentially, therapists may hold negative attitudes towards clients who they believe to be liars in therapy. This may affect therapeutic alliance, relationship, and outcome (Lambert & Ogles, 2004; Newman & Strauss, 2003; Orlinsky et al., 2004). The current study revealed a relationship between valuing honesty in therapy with the therapeutic relationship and outcome. Thus, therapists value honesty for therapeutic gains and hold negative attitudes towards clients who lie.

In reconciling inaccurate beliefs about cues to deception and negative attitudes towards client deception, some clinical implications for client deception have been suggested by a few authors (Kottler and Carlson, 2011; Newman & Strauss, 2003). Kottler and Carlson suggested that therapists perpetuate a myth that clients are honest and therapists should accept lying as a part of therapy. This implication contains the crucial idea of acknowledging that deception occurs in therapy; however, it suggests a passive role for therapists. Therapists may benefit from seeking to understand their limitations with deception detection (Bond & DePaulo, 2006), dispelling myths about stereotypical behaviors of liars (Global Deception Research Team, 2006), and actively exploring their attitudes towards client deception (Kottler & Carlson, 2011; Newman & Strauss, 2003).

Kottler and Carlson (2011) also suggested that the client is in charge of discussing lies and therapists are not interrogators. It may be important for a therapist to discuss client deception with clients. At the onset of therapy, therapists might benefit from discussing their limitations with deception detection and sharing their willingness to allow clients to discuss their deceit. The therapist's inclination to discuss these issues is a part of the therapist's bond contribution, which is related to positive outcomes (Orlinksy et al., 2004). It might be advantageous to discuss therapists' roles with clients, addressing preconceived ideas about therapists being interrogators. For therapists, it might be important to note that though they are not trained as interrogators, they still hold beliefs about cues to deception and these beliefs may affect behavior (Newman & Strauss, 2003)

Understanding therapists' roles is equally as important to understanding therapists' limitations. People are generally not good at detecting deception (Bond & DePaulo, 2006) and therapists' clinical judgment alone has been questioned (Meehl, 1954). To remedy this concern, psychologists have incorporated assessments into their practice (Baker & Benjamin, 2000). Some assessments have included deception detection components (Greene, 2000; Groth-Mamat, 2009). Utilizing assessments within psychological evaluations is an integral aspect of clinical judgment and appears to be important for working with client deception.

Implications for Theory

Impression management has been a theory suggested for understanding deception (DePaulo et al., 2003). Kottler and Carlson (2011) suggested that client deception is often about impression management. The current research may offer additional implications for this theory. Clients deception may be motivated out of a managing an impression within therapy. Clients may create an image of who they want to be or think they should be (Orlinsky et al., 2004). Therapists formulate their impressions of clients early on in therapy (Morrant, 1981). The current findings suggest that therapists think clients are more likely to lie in early sessions compared to later sessions.

The implication from the current research for impression management theory is that it may not account for the actual impressions made if lies are discovered. Clients may be motivated to lie to manage a particular impression (Kottler & Carlson, 2011); however, their impression may be sacrificed if deception is detected. Impressions of clients may be affected even if lies go undetected (Sagarin et al., 1998). Current findings suggest that therapists hold negative attitudes towards clients who lie in therapy. Thus, a discovered lie may negatively affect a client's impression.

Exploring therapists' beliefs and attitudes towards client deception can inform psychotherapy theory. Many psychotherapy theories are rooted in interviewing skills (Ivey & Ivey, 2003). Different theories may view client deception as serving a specific function. Therapists' inaccurate beliefs about cues to deception may inform theoretical approaches of the limitations in deception detection. Understanding client deception in

terms of meaning, as suggested by Kottler and Carlson (2011), and its functioning within therapy may inform psychotherapy theory.

Conclusions

Deception occurs in everyday life (DePaulo et al., 1996). People are deceptive about a variety of things (Vrij, 2000), deception affects people (Sagarin, 1998), and deception about a transgression is less forgivable (Schweitzer, Hershey, Bradlow, 2006). Deception seems so commonplace within interpersonal relationships that it is not surprising that people also lie in therapy (Kottler & Carlson, 2011). Many day to day lies may not be of a grave consequence to most interpersonal relationships. Lies can be serious (DePaulo et al., 2004) and consequential in relationships (DePaulo & Kashy, 1998), even when they are undetected (Sagarin et al., 1998). So, how do therapists handle lies within the interpersonal context of therapy and what affect does deception have for therapy? There has been a dearth of literature in the area of deception and counseling.

The current study investigated the beliefs and attitudes that therapists hold towards client deception. "Beliefs about liars may be older than recorded history" (Global Deception Research Team, 2006, p. 60). The findings from the current study revealed that therapists hold a number of inaccurate beliefs about what a liar looks like. Some of the beliefs may be embedded in stereotypes of liars. Findings also revealed that therapists hold a number of negative attitudes towards clients who lie.

Future researchers are encouraged to further explore deception within the context of therapy. Specifically, researchers should investigate how therapists' beliefs and

attitudes about deception affect clients, therapeutic process, therapeutic relationship, and outcome. Overall, the study further contributes to the field of counseling psychology by seeking to expand the promise of interface between counseling and social psychology disciplines.

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APPENDIX A

Demographic Questionnaire

Age:_____

Sex: ___Male ____Female ____Intersex

Gender: ___Woman ____Man ____Transgender

Race/Ethnicity:

____ 1) African American/Black

____ 2) Caucasian/European American

____ 3) Asian/Asian American/Pacific Islander

____ 4) Native American/Alaskan Native

____ 5) Hispanic/Latina/Latino

____ 6) Bi Racial

____ 7) Multi racial

____ 8) Other: _____

Education:

___ 4 year college degree

___ Master's degree

___ Psy.D.

___ Ph.D.

Training Program:

___ Clinical

___ Counseling

License:

___ Licensed Marriage and Family Therapist

___ Licensed Chemical Dependency Counselor

___ Licensed Professional Counselor

___ Licensed Psychologist

Current Therapy Work Setting:

___ Counseling Center

___ Hospital

___ Veterans Affairs

___ Military

___ Private Practice

___ Other: _____

Theoretical Orientation (Please select only 1):

___ Cognitive

___ Behavioral

___ Emotion Focused

___ Humanistic/Existential/Experiential

___ Psychodynamic/Interpersonal

___ Solution-Focused

___ Narrative

___ Family/Systems

___ Feminist/Multicultural

___ Integrationist/Eclectic

___ Other: _____

Worldview:

Constructivist:
Defined as "emphasizing the client's unique, subjective perspective or self-constructed narrative as contrasted with objective or consensual reality" (Prochaska & Norcross, 2010, p. 433).

1	2	3	4	5	6	7
Not at all						Very Much

Positivist:
Defined as "the nature of the universe can be known, and the scientist's goal is discover each and every object in the universe, and their relationship to each other" (Heppner, Wampold, & Kivlighan, 2008, p. 7-8).

1	2	3	4	5	6	7
Not at all						Very Much

Training:

How much literature have you read on deception (books or articles)?

1	2	3	4	5	6	7
None						Very Much

How much training have you had with client deception?

1	2	3	4	5	6	7
None						Very Much

How much training have you had with deception detection?

1	2	3	4	5	6	7
None						Very Much

How many years of counseling experience?_____

How many direct contact hours?_____

APPENDIX B

Detection of Deception Questionnaire

For the following questions, *circle* the number that most closely corresponds with your opinions.

1. **How confident are you that you can detect when clients are lying to you?**

1	2	3	4	5	6	7
Not very confident						Extremely confident

2. **How often do you think clients lie to you?**

1	2	3	4	5	6	7
Very rarely						Very often

Please indicate whether the following behaviors increase or decrease when people lie to you.

3. **Eye contact**:

1	2	3	4	5	6	7
Decreases a lot			Does not change			Increases a lot

4. **Eyeblinks**:

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

5. **Head movements**:

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

6. **Smiles**:

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

7. **Hand and finger movements**:

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

8. **Arm movements**:

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

9. **Leg and foot movements**:

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

10. **Postural shifts**:

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

11. **Shrugs**:

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

12. **Gestures:**

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

13. **The number of speech interruptions such as "uh" and "um":**

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

14. **The number of pauses or hesitations in speech:**

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

15. **The amount of time before beginning to respond to a question:**

1	2	3	4	5	6	7
Decreases a lot			Does not change			Increases a lot

16. **Hectic speech patterns:**

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

17. **Changes in the pitch of voice:**

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

18. **The length of answers:**

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

19. **The use of short, simple sentences in stories and explanations:**

1	2	3	4	5	6	7
Decreases a lot			Does not change			Increases a lot

20. **The use of plausible descriptions in stories and explanations:**

1	2	3	4	5	6	7
Decreases a lot			Does not change			Increases a lot

21. **Logically consistent stories and explanations:**

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

22. **The amount of detailed descriptions in stories and explanations:**

1	2	3	4	5	6	7
Decreases a lot			Does not change			Increases a lot

23. **Unusual details in descriptions:**

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

24. **Unnecessary details in descriptions:**

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

25. **Descriptions of their own feelings or the feeling of others:**

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

26. **Recounting exactly what somebody had said in stories and explanations:**

1	2	3	4	5	6	7
Decreases a lot			Does not change			Increases a lot

27. **Descriptions of interactions with others in stories and explanations:**

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

28. **Spontaneous corrections in stories and explanations:**

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

29. **Claiming a lack of memory for certain events or information:**

1	2	3	4	5	6	7
Decreases a lot			Does not change			Increases a lot

30. **Stories with contradictions**:

1	2	3	4	5	6	7
Decrease a lot			Do not change			Increase a lot

APPENDIX C

Therapist Attitudes Towards Deception Scale

If you discovered that a client was lying to you, how would that affect:

1. Liking the client?

1	2	3	4	5	6	7	8	9
Significantly Decrease				No Change				Significantly Increase

2. Being angry at the client?

1	2	3	4	5	6	7	8	9
Significantly Decrease				No Change				Significantly Increase

3. Seeing the client as a bad person?

1	2	3	4	5	6	7	8	9
Significantly Decrease				No Change				Significantly Increase

4. Thinking negatively about the client?

1	2	3	4	5	6	7	8	9
Significantly Decrease				No Change				Significantly Increase

5. Judging the client harshly?

1	2	3	4	5	6	7	8	9
Significantly Decrease				No Change				Significantly Increase

6. Desire to interact with the client?

1	2	3	4	5	6	7	8	9
Significantly Decrease				No Change				Significantly Increase

7. Enthusiasm to work with the client?

1	2	3	4	5	6	7	8	9
Significantly Decrease				No Change				Significantly Increase

8. Judging the client as a good client?

1	2	3	4	5	6	7	8	9
Significantly Decrease				No Change				Significantly Increase

9. Speaking poorly of the client with others?

1	2	3	4	5	6	7	8	9
Significantly Decrease				No Change				Significantly Increase

10. Trusting the client?

1	2	3	4	5	6	7	8	9
Significantly Decrease				No Change				Significantly Increase

11. Thinking positively about the client?

1	2	3	4	5	6	7	8	9
Significantly Decrease				No Change				Significantly Increase

12. Viewing the client as sincere?

1	2	3	4	5	6	7	8	9
Significantly Decrease				No Change				Significantly Increase

13-24. Clients who lie in therapy compared clients who do not lie in therapy are:

1	2	3	4	5	6	7
Not very Successful						Very Successful

1	2	3	4	5	6	7
Not very Pathological						Very Pathological

1 Not very Weak	2	3	4	5	6	7 Very Weak
1 Not very Compliant	2	3	4	5	6	7 Very Compliant
1 Not very Predictable	2	3	4	5	6	7 Very Predictable
1 Not very Pleasant	2	3	4	5	6	7 Very Pleasant
1 Not very Lazy	2	3	4	5	6	7 Very Lazy
1 Not very Awkward	2	3	4	5	6	7 Very Awkward
1 Not very Knowledgeable	2	3	4	5	6	7 Very Knowledgeable
1 Not very Intelligent	2	3	4	5	6	7 Very Intelligent
1 Not very Likeable	2	3	4	5	6	7 Very Likeable
1 Not very Adjusted	2	3	4	5	6	7 Very Adjusted

25. How embarrassed would you be if you discovered a client's lie?

1	2	3	4	5	6	7
Not at all						Very Much

26. How angry would you be if you discovered a client's lie?

1	2	3	4	5	6	7
Not at all						Very Much

27. How surprised would you be if you discovered a client's lie?

1	2	3	4	5	6	7
Not at all						Very Much

28. How suspicious are you that clients are lying?

1	2	3	4	5	6	7
Not at all						Very Much

29. How important is detecting client's lies (truth)?

1	2	3	4	5	6	7
Not at all						Very Much

30. How often do you think clients lie in early therapy sessions?

1	2	3	4	5	6	7
Not at all						Very Much

31. How often do you think clients lie in later therapy sessions?

1	2	3	4	5	6	7
Not at all						Very Much

32. How often do you think your clients lie within a session?

1	2	3	4	5	6	7
Not at all						Very Much

33. How much do you value honesty in therapy?

1	2	3	4	5	6	7
Not at all						Very Much

34. How important is client honesty for the therapeutic relationship?

1	2	3	4	5	6	7
Not at all						Very Important

35. How important is client honesty for successful outcome?

1	2	3	4	5	6	7
Not at all						Very Important

36. How likely are you to explicitly ask a client if s/he is lying?

1	2	3	4	5	6	7
Not at all						Very Likely

37. How likely are you to think that a client is lying from a non-verbal discrepancy (i.e., differences between nonverbal behavior and verbal content)?

1	2	3	4	5	6	7
Not at all						Very Likely

38. How likely would a typical client lie about emotions?

1	2	3	4	5	6	7
Not at all						Very Likely

39. How likely would a typical client lie about thoughts?

1	2	3	4	5	6	7
Not at all						Very Likely

40. How likely would a typical client lie about behaviors?

1	2	3	4	5	6	7
Not at all						Very Likely

41. In catching a client's lie, how likely would you be to terminate?

1	2	3	4	5	6	7
Not at all						Very Likely

42. In catching a client's lie, how likely would you be to refer?

1	2	3	4	5	6	7
Not at All						Very Likely

43. How likely are you to discuss a suspected lie with your client?

1	2	3	4	5	6	7
Not at all						Very Likely

44. How often do you lie in therapy?

1	2	3	4	5	6	7
Never						Very Often

45. How often do you lie to clients in therapy?

1	2	3	4	5	6	7
Never						Very Often

46. How often do you intentionally keep information from clients in therapy?

1	2	3	4	5	6	7
Never						Very Often

47. How often do you intentionally keep information from clients in therapy if it protects them?

1	2	3	4	5	6	7
Never						Very Often

48. What percentage of clients on your case load are liars? _____

APPENDIX D

Email Request

Greetings Dr. XX,

I would greatly appreciate any assistance with my dissertation by forwarding this email to current interns and/or staff.

You are being asked to participate in a research study for Mr. Curtis's dissertation (TWU-IRB #16897) at Texas Woman's University. The purpose of the current study is to assess therapists' beliefs and attitudes towards deception. This research is intended to provide clarity about the therapists' beliefs regarding deception and their attitudes towards clients who lie. You are only permitted to participate once in the current study. Eligibility requirements for participants will include: (a) at least 18 years old, (b) must have completed at least one practicum course, and (c) are currently or have completed training in a counseling or clinical psychology program.

The link to the study:

https://www.psychdata.com/s.asp?SID=146480

Sincerely,
Drew Curtis

Drew Curtis, M.A.
SWPA Graduate Student Representative
Counseling Psychology Doctoral Candidate
Texas Woman's University

APPENDIX E

Informed Consent

Title: THERAPISTS' BELIEFS AND ATTITUDES TOWARDS CLIENT DECEPTION

Investigator: Drew A. Curtis, M.A. 940-898-2303

Advisor: Jenelle C. Fitch, Ph.D. 940-898-2312

Purpose of the Study

You are being asked to participate in a research study for Mr. Curtis's dissertation at Texas Woman's University. The purpose of the current study is to assess therapists' beliefs and attitudes towards deception. This research is intended to provide clarity about the therapists' beliefs regarding deception and their attitudes towards clients who lie. You are only permitted to participate once in the current study. Eligibility requirements for participants will include: (a) at least 18 years old, (b) must have completed at least one practicum course, and (c) are currently or have completed training in a counseling or clinical psychology program.

Description of Procedures

The study consists of participants completing, online, a packet of questionnaires regarding therapists' beliefs and attitudes towards deception. Participants will be asked to initially respond to a demographic section and then will be asked to complete the beliefs and attitudes toward deception section. The beliefs and attitudes questionnaires will consist of 50 items. Completing the study will take approximately 20 to 30 minutes.

Participation and Benefits

Your involvement in this research study is completely voluntary, and you may discontinue your participation in this study at any time without penalty. The only direct benefits of this study to you are that you are helping a graduate student collect data for his dissertation and are welcome to inquire about the results of the study. The researchers will benefit from this study by learning more about therapists' beliefs and attitudes towards deception. If you wish to receive information about the results of this study, please request that information by email from the researcher listed at the top of this form.

Potential Risks

The following are risks related to your participation in this study and steps that the researcher will take to minimize those risks:

There is a risk of loss confidentiality. You will not use your name or any other identifying information. You may risk a loss of confidentiality if you choose to email the researcher to ask for results of the study. If you choose to email the researcher, then the researcher will

immediately delete such emails after responding to them. Confidentiality will be protected to the extent that is allowed by law. There is a potential risk of loss of confidentiality in all email, downloading, and internet transactions.

There is a risk of loss of time. You will lose up to 30 minutes of your time by participating in this study.

There is a risk of coercion. Your participation is completely voluntary, and you may terminate your participation in this study at any time without penalty.

There is a risk of fatigue and/or emotional discomfort. Participants may take a break or discontinue their participation in the study without any negative consequences. If you do feel distressed or experience emotional discomfort, please use the following information to seek support:

> Online referrals for counseling services in your area:
> American Psychological Association
> Psychologist Locator Service
> http://locator.apa.org/

There is a risk of loss of anonymity. You will complete the questionnaire packet online. There may or may not be other people in this room. If other people in the room recognize you, you will lose your anonymity. If this causes you emotional discomfort, you may terminate your participation or seek counseling from the above noted counseling service providers.

The researchers will try to prevent any problems that could happen because of this research. You should let the researchers know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Questions Regarding the Study

If you have any questions about the study, please contact the researchers; their phone numbers are at the top of this form. If you have questions about your rights as a participant in the research or regarding how the study was conducted, feel free to contact the Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via email at IRB@twu.edu.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to participate as a participant in this study and understand that I have the right to withdraw from the study at any

time without in any way affecting my person or experimental credit. I hereby consent to participate in the study.

By clicking the option "I agree", you will be consenting to participate in the study.