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Deception in psychotherapy: Frequency, typology and relationship

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Abstract

Deception in therapy has been documented anecdotally through various narratives of therapists. The investigation of its occurrence within therapy has largely been overlooked. We explored the reported frequency of deception within psychotherapy, the types of deception used within therapy, the likelihood of people lying to a therapist compared to other groups of people, and client perceptions of the types of deception that therapists use. Ninety-one participants were provided with a series of deception examples, asked questions about the use of these types of deception within therapy, and asked generally about their use of deception in therapy. We found that a majority of the participants had been deceptive in therapy, and a majority were willing to be deceptive in future therapeutic contexts. Participants were more likely to use white lies than other forms of deception in therapy. Lastly, participants were less likely to lie to therapists compared to strangers and acquaintances. Implications for research and practice are discussed.

KEYWORDS

deception, lies, psychotherapy, relationship, client deception, therapist

1 | INTRODUCTION

When people communicate with each other, there is typically a presumption of honesty; however, people lie (Levine, 2014). In classic diary studies, people report lying, on average, twice a day (DePaulo & Bell, 1996; DePaulo & Kashy, 1998; Kashy & DePaulo, 1996). However, recent research indicates that the distribution of lies is positively skewed, with a small set of people telling many lies and most people telling fewer than two lies per day (Serota & Levine, 2015). Deception takes on a variety of forms such as outright lies, exaggerations, omissions and subtle lies (DePaulo, Kashy, Kirkendol, Wyer, & Epstein, 1996; Vrij, 2000). While there are numerous forms of human deception, the common thread that ties them together is an intent to mislead others. Vrij (2008) discussed various definitions of deception that had been used in the past, noting their shortcomings. He ultimately submitted that deception is "a successful or unsuccessful deliberate attempt, without forewarning, to create in another a belief which the communicator considers to be untrue" (p. 15).

1.1 | Background

Over the past several decades, there has been a tremendous amount of basic research investigating human deception (see Vrij, 2008). This research has examined deception in a variety of contexts including intimate relationships (Cole, 2001; Peterson, 1996), in the workplace (Hart, Hudson, Fillmore, & Griffith, 2006; Shulman, 2011) and in forensic areas (Granhag & Strömwall, 2004). However, the prevalence of deception within psychotherapeutic settings has been mostly overlooked. In fact, it has been suggested that "surprisingly little has been written in the counseling journals on the topic of lying" (Miller, 1992, p. 25).

While psychotherapy involves an exchange between a therapist and a client, often perceived as honest (Curtis & Hart, 2015; Kottler & Carlson, 2011), deception is occasionally found woven into components of practice. Deceitfulness is one of the criteria for antisocial personality disorder (301.7) found in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association;

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APA, 2013). The DSM-5 also terms lying, motivated by external incentive, as malingering (V65.2). Within psychometrics, deception has been documented as a measure or scale in some assessments (e.g. Greene, 2000; Guenther & Otto, 2010). The Minnesota Multiphasic Personality Inventory-II (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 2001) contains scales that reveal if a client is attempting to lie or be deceptive in different manners (Greene, 2000). The scant research investigating deception in therapy has focused on psychologists' ability to detect deception, finding that counsellors and psychologists achieve 62%–85% accuracy rates when attempting to discern lies from truths, where 50% would represent chance levels of accuracy (e.g. Briggs, 1992; Ekman, O'Sullivan, & Frank, 1999). However, meta-analyses and other literature suggest that accuracy for detecting deception is not much higher than chance for laypeople (54%) and law enforcement professionals (56%; Bond & DePaulo, 2006; Vrij, 2000).

More recently, there has been a re-emergence of research and literature regarding deception in therapy. One study investigated therapists' beliefs and attitudes towards client deception (Curtis & Hart, 2015). Curtis and Hart (2015) recruited 112 therapists and asked them to identify their beliefs about indicators of deception and subsequently identify their attitudes towards clients who lie. The results found that therapists possessed a number of inaccurate beliefs about actual indicators of deception (e.g. eye gaze aversion when lying), held a number of negative attitudes towards client deception (e.g. liking the client less) and lied to their clients in therapy.

While investigating psychologists' ability to detect deception and their beliefs and attitudes towards client deception are worthwhile pursuits, the prevalence of client deception within psychotherapy has remained largely unstudied. Some literature has referenced pathological aspects of lying, termed pseudologia phantastica (e.g. Garlipp, 2017; Muzinic, Kozaric-Kovacic, & Marinic, 2016). Additionally, in their book, *Duped*, Kottler and Carlson (2011) documented a number of anecdotal accounts of psychotherapists discovering that their clients had lied in therapy. Some of these reports included fabricating an entire therapy experience (Grzegorek, 2011) and intentionally omitting information about having a terminal illness (Rochlan, 2011). Thus, there is clear evidence that some clients do deceive their therapists.

Even though psychologists' stories provide anecdotal evidence for the presence of deception within psychotherapy, there remains a dearth of empirical investigation. One recent study explored the occurrence of lying in psychotherapy, finding that 93% of 547 psychotherapy patients reported having lied to a therapist (Blanchard & Farber, 2016). Due to the present study having been conducted prior to the Blanchard and Farber (2016) study, it was not designed as a replication or intended for direct comparison.

In the current study, we sought to broaden the understanding of deception in therapy. We collected empirical data on the frequency of deception in therapy, the types of deception used and the influence of relational roles on deception. Given the previously noted research showing that many people report lying in their close relationships and in therapy, we predicted that the majority (>50%) of participants who had been in therapy would report that they had been deceptive within therapy at least once. Further, we predicted that the use of white lies and omissions would be more prevalent than other types of deception. Previous studies have found that people tell fewer lies to people with whom they are in emotionally close relationships (Vrij, 2008). Based on those findings, we predicted that participants would report being more likely to lie to a therapist than a significant other and family member, and we predicted that they would be less likely to lie to a therapist than social acquaintances and complete strangers. Based on the findings of Curtis (2013) that therapists believe clients are more likely to lie in earlier compared to later sessions, we predicted that people would report more willingness to lie to a therapist during the first session compared to subsequent sessions, due to the lack of emotional connection early in the relationship. Lastly, we predicted that people would be more likely to lie to a therapist that they did not like compared to a therapist they did like.

2 | METHOD

2.1 | Participants

Participants were a convenience sample of undergraduate students recruited from a south-western university in the United States. Recruitment occurred through a departmental research administration system. Some participants received course credit, and others received extra credit. There were 252 participants, but all analyses were conducted only on the 91 participants who indicated that they had been or were currently in therapy. Participants ranged in age from 18 and 30 (M = 20.34, SD = 2.59), and most were female (78%). Participants indicated a variety of ethnicities: Caucasian (52.7%), Hispanic/Latina(o) (25.3%), African American (7.7%), Asian (3.3%) and dual or mixed heritage (11%). Participants endorsed having attended a variety of therapy from individual counselling (78%), family therapy (27.5%), group (2.2%) and couples (1.1%). A small percentage of individuals reported attending mandated treatment (6.6%), and some participants reported experiences with testing and assessment (12.1%). Participants reported seeing between one and four therapists, with most participants reporting seeing only one therapist (63.7%). Participants also reported a range of times seeing a therapist, from one session to 10 years, with a mode of 1 year (n = 16).

2.2 | Materials

The current study used a demographic questionnaire, therapy examples and a deception in therapy survey. The demographic questionnaire asked participants to indicate their age, sex, gender, ethnicity and race, education and experiences with counselling or therapy.

A total of 12 deception examples were used in the current study. The first six examples were the same that Peterson (1996) used to explore deception in intimate relationships (Appendix 1). These six examples portrayed different forms of deception, including (a) omission, (b) failed deception, (c) half-truth, (d) white lie, (e) distortion and (f) a blatant lie. The remaining six examples were the same types of deception used by Peterson (1996), but the wording was changed to reflect the context of therapy (Appendix 1). Following each example,

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participants were asked to answer eight questions in response to the example. Similar to Peterson (1996), the questions following the examples did not contain words such as "lie" or "deception" for the concern of bias or activating a lying or liar schema, which could lead to a social desirability bias. Instead, the questions asked participants to rate the type of communication or statement within the example and whether they endorsed its use and how they thought or felt about it. Participants were asked to respond to each of the eight questions using a 5-point scale:

1. Own Use ("Have you ever made this type of statement to a therapist?" 5 = Often; 1 = Never)
2. Future Use ("How often would you make this type of statement to a therapist?" 5 = Often; 1 = Never)
3. Therapist Use ("In your opinion, how often would a therapist make this type of statement to you?" 5 = Often; 1 = Never)
4. Own Guilt ("How have you felt [or do you imagine feeling] after making this type of statement to a therapist?" 5 = Extremely Guilty; 1 = Extremely Pleased)
5. Speaker Blame ("How would you rate clients who use this type of communication frequently with therapists?" 5 = Extremely Blameworthy; 1 = Extremely Praiseworthy)
6. Destructiveness ("What effect do you think a client's frequent use of communications of this type have on the therapy relationship?" 5 = Extremely Destructive; 1 = Extremely Helpful)
7. Dishonesty ("How would you rate the honesty of this statement?" 5 = Completely dishonest; 1 = Completely honest)
8. Preference for argument over deception ("If you were faced with a choice between using this type of communication vs. having a quarrel or an argument with a therapist, which would you choose?" 5 = Definitely the argument; 1 = Definitely this type of statement).

The deception in therapy survey was developed by the authors to assess explicit reports of deception. The questionnaire opened with a statement indicating that the researchers do not condone or condemn deception but were interested in studying it scientifically. Additionally, the survey defined deception for the participants as "deception occurs any time you *intentionally try to mislead someone.* If you are uncertain as to whether a particular communication qualified as a lie, you should record it." Following this prompt, participants answered self-report questions assessing the frequency of their use of deception within psychotherapy and how likely they might be to deceive a therapist compared to people in other types of social relationships (1 = significantly disagree; 4 = no difference; 7 significantly agree; see Appendix 2). The questions were analysed individually to compare participants' responses to a no difference anchor, similar to other deception studies (Curtis, 2015; Curtis & Hart, 2015).

2.3 | Procedure

The study was approved by an institutional review board. The study consisted of online surveys that were hosted on PsychData. Upon selecting the study's link, participants were presented with an informed consent. After consenting to participate in the research study, the participants were asked to complete the demographic form. Then, participants read a series of scenarios and responded to questions about each example. Next, participants were asked to complete the deception in therapy survey. After participants completed the questionnaire, they were provided with a debriefing form.

3 | RESULTS

3.1 | Frequency of use

Frequency analyses were conducted on the items that asked if participants have ever used this type of statement for all 12 examples to determine the percentage of participants who endorsed using any type of deception with a therapist. These items asked participants if

TABLE 1 Frequency of endorsed use of deception types

		Use		No use	
	Type of lie	Freq	Per cent	Freq	Per cent
Relational examples	Omission	33	36.3	58	63.7
	Failed Deception	39	42.9	52	57.1
	Half-Truth	46	50.5	45	49.5
	White Lie	59	64.8	32	35.2
	Distortion	51	56	40	44
	Blatant Lie	35	38.5	56	61.5
Therapy examples	Omission	49	53.8	42	46.2
	Failed Deception	51	56	40	44
	Half-Truth	53	58.2	38	41.8
	White Lie	58	63.7	33	36.3
	Distortion	54	59.3	37	40.7
	Blatant Lie	33	36.3	58	63.7
Total of any use		81	89	10	11

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TABLE 2 Mean frequencies of use, likelihood to use and therapist use for types of deception

	Type of deception					
	Omission	Failed deception	Half-truth	White lie	Distortion	Blatant lie
Patient use	2.07 (1.22)	2.16 (1.24)	2.12 (1.24)	2.57 (1.45)	2.26 (1.30)	1.70 (1.09)
Patient Future use	2.16 (1.18)	2.16 (1.09)	2.24 (1.15)	2.57 (1.35)	2.16 (1.13)	1.87 (1.16)
Therapist use	2.10 (1.01)	1.79 (0.97)	1.85 (1.36)	2.36 (1.36)	2.14 (1.09)	1.92 (1.09)

Note: Standard deviations are in parentheses.

they used deception without explicitly using the words lie or deception. Across all 12 examples, the percentage of participants who endorsed having used any type of lie (e.g. omission, half-truth) was 89% (see Table 1). The percentage of participants who endorsed using any type of lie across the six therapy-specific vignettes was 82.2%. This percentage of use is close to that found in another study looking at frequency of deception within therapy, in that 93% reported telling some lie to their therapist and 72.6% endorsed a therapy-related deception (Blanchard & Farber, 2016).

A frequency analysis was conducted on the explicit question asking "have you ever been deceptive in therapy?", which revealed that over half of the participants who had been in therapy reported that they had been deceptive in therapy (52.7%). Additionally, the majority of participants reported that they would be somewhat to very likely to lie to a therapist in the future (75.8%) and somewhat to very likely to intentionally keep information from a therapist (81.3%). When asked to report the total number of times a participant has been deceptive in therapy, 85.7% of participants indicated at least once.

Of the participants who indicated using deception within therapy, on average, they reported using deception approximately twice in a 50-min therapy session, with zero as the most frequent response (M = 1.59 lies per session, SD = 2.44, Mdn = 1, mode = 0, N = 62, max = 13 lies, 95% CI = 0.97–2.21). This is similar to the average number of lies people tell per day. Additionally, reported lying behaviour within a session was positively skewed, with skewness of 2.73 (SE = 0.30) and kurtosis of 8.91 (SE = 0.60). The skewed distribution is similar to that found in the general population, in that most people tell few lies per day and fewer people tell many lies (Serota, Levine, & Boster, 2010). Thus, while most participants have been deceptive in therapy, they are not frequently lying.

Correlation analyses were conducted to examine if there was a relationship between participants' age and the frequency of deception used in therapy. There were no statistically significant findings for age and times endorsing the use of deception across vignettes ($r(83) = -.045$, $p = .69$), lies told in one session ($r(57) = -.173$, $p = .20$) and total number of times reported to be deceptive in therapy ($r(58) = -.127$, $p = .34$).

3.2 | Type of lies used in therapy

A one-way repeated-measures ANOVA was conducted to compare the types of deception participants used in therapy. Results revealed a statistically significant difference between deception types ($F(5, 85) = 7.15$, $p < .001$, Wilks' $\Lambda = 0.70$, $\eta_p^2 = 0.30$; see Table 2). Pairwise comparisons indicated that participants reported using white lies, told to protect the therapist, more than all other types of lies ($p < .05$). Additionally, blatant lies were endorsed least compared to all other lies ($p < .05$).

A one-way repeated-measures ANOVA was conducted to compare the types of deception participants said they would be willing to use in future interactions with therapists. Results revealed a statistically significant difference between deception types ($F(5, 86) = 4.07$, $p = .002$, Wilks' $\Lambda = 0.81$, $\eta_p^2 = 0.19$). White lies were endorsed for future use more than other types of lies ($p < .05$), and blatant lies were endorsed the least ($p < .05$; see Table 2).

A one-way repeated-measures ANOVA was conducted to compare the types of deception participants thought therapists had used towards them, as a within-subjects factor. Results revealed a statistically significant difference between deception types ($F(5, 82) = 4.31$, $p = .002$, Wilks' $\Lambda = 0.79$, $\eta_p^2 = 0.21$). White lies were indicated more than failed deception, half-truth and blatant lies ($p < .05$), and failed deception was indicated as least likely compared to omission, white lies and distortions ($p < .05$; see Table 2).

3.3 | Moral evaluations of deception

A repeated-measures MANOVA was conducted to compare the types of lies as a repeated-measures variable across the measures of morality: perceived dishonesty, blame for patients who use this type of deception with therapists, and personal guilt after deceiving a therapist with this type of deception. The results showed a statistically significant difference between the types of lies across all measures, $F(15, 74) = 5.98$, $p < .001$, Wilks' $\Lambda = 0.45$, $\eta_p^2 = 0.55$. Univariate tests also indicated statistically significant differences between the types of lies and guilt ($F(5, 440) = 6.38$, $p < .001$, $\eta_p^2 = 0.07$), dishonesty ($F(5, 440) = 13.21$, $p < .001$, $\eta_p^2 = 0.13$) and blame ($F(5, 440) = 5.82$, $p < .001$, $\eta_p^2 = 0.06$). Pairwise comparison revealed that participants would feel less guilt using distortions compared to all other types of lies and most guilt using blatant lies with a therapist compared to all other types of lies ($p < .05$). Half-truths were deemed more honest than omissions, failed deceptions, white lies and blatant lies, and blatant lies were perceived as the most dishonest ($p < .05$). Blatant lies were also rated as most blameworthy ($p < .05$). See Table 3 for means and standard deviations of moral ratings across types of deception.

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TABLE 3 Mean frequencies of moral ratings for the types of deception

	Type of deception					
	Omission	Failed deception	Half-truth	White lie	Distortion	Blatant lie
Guilt	3.64 (0.99)	3.61 (0.90)	3.52 (0.91)	3.49 (0.93)	3.26 (1.01)	3.93 (1.07)
Dishonesty	2.18 (0.92)	2.07 (0.95)	2.39 (0.89)	2.08 (0.96)	2.38 (0.96)	1.62 (0.94)
Blame	3.53 (1.00)	3.67 (0.84)	3.51 (0.83)	3.38 (0.98)	3.39 (0.95)	3.92 (1.11)

Note: Standard deviations are in parentheses.

TABLE 4 Mean frequencies of perceived relationship consequences for the types of deception

	Type of deception					
	Omission	Failed deception	Half-truth	White lie	Distortion	Blatant lie
Destructiveness	3.55 (0.99)	3.60 (0.85)	3.48 (0.81)	3.49 (1.07)	3.46 (0.95)	3.93 (1.13)
Use over Argument	2.90 (1.27)	2.89 (0.88)	2.71 (0.99)	2.70 (1.29)	2.93 (1.14)	3.27 (1.30)

Note: Standard deviations are in parentheses.

TABLE 5 Lying to a therapist compared to other relationships

Relationship	*n*	*M*	*SD*	*t*	Sig.
Close friend	91	4.13	2.01	0.63	.532
Significant other	91	3.45	2.17	−2.42	.018
Complete stranger*	91	2.98	1.79	−5.43	.000
Family member	89	3.56	1.90	−2.17	.032
Social acquaintance*	89	3.10	1.74	−4.88	.000
Primary care physician*	91	3.38	1.72	−3.42	.001
Teacher/professor*	54	3.22	1.63	−3.50	.001

*Statistical significance with Bonferroni correction = .007.

3.4 | Relational consequences

A repeated-measures MANOVA was conducted to test types of lies as a repeated-measures variable across the measures of relational consequence: effect on the therapy relationship and preference to use deception to avoid conflict. The results showed a statistically significant difference between the types of lies across all measures ($F(10, 74) = 2.72$, $p = .007$, Wilks' $\Lambda = 0.73$, $\eta_p^2 = 0.27$). Due to the sphericity assumption not being met, a Greenhouse–Geisser correction was applied to univariate analyses, as indicated by Field (1998). Univariate tests indicated statistically significant differences between the types of lies used and their destructiveness ($F(4.28, 354.95) = 3.92$, $p = .003$, $\eta_p^2 = 0.05$) and preference for use to avoid an argument ($F(4.28, 355.19) = 3.75$, $p = .004$, $\eta_p^2 = 0.04$). Pairwise comparisons revealed that the blatant lie was deemed more destructive than all other types of lies ($p < .05$). Additionally, participants indicated they would be less likely to use blatant lies to avoid an argument with a therapist compared to other types of lies ($p < .05$; see Table 4).

3.5 | Relational roles

One-sample *t* tests were conducted on each item comparing the likelihood of lying to a therapist compared to other types of people, with a no change anchor of four (Bonferroni correction = .007). People indicated that they would be less likely to lie to a therapist than a complete stranger, social acquaintance, primary care physician and teacher or professor (see Table 5). There was no significant difference in their likelihood of lying to a therapist compared to a close friend, a family member or a significant other.

In examining whether participants would be more willing to lie to a therapist in the first session compared to subsequent sessions, we conducted a one-sample *t* test, with a no change anchor of four, on participant agreement with the item that stated, "I would be more likely to be deceptive with a therapist during the first meeting compared to subsequent meetings." Results revealed a statistically significant difference in agreement, in that participants reported that they were more likely to lie in the first meeting compared to subsequent meetings ($M = 4.78$, $SD = 2.11$; $t(90) = 3.5$, $p = .001$, $d = 0.37$). Correlational analyses revealed that participants' likelihood to lie more in a first meeting was not related to the number of therapists that they have seen ($r(90) = .015$, $p = .89$), duration of therapy ($r(89) = -.133$, $p = .21$) or reported satisfaction with therapy ($r(90) = -.069$, $p = .52$). Lastly, a one-sample *t* test was used to examine whether people agreed that they would be more willing to lie to a therapist that they liked compared to one they did not like, with a no change anchor of four. There was no statistically significant difference ($p = .08$).

4 | DISCUSSION

The current study examined deception within the psychotherapeutic context, specifically examining the frequencies of lying behaviour,

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the types of deceptions used in therapy and the likelihood of people lying to a therapist compared to others. In line with our hypotheses, we found that a majority of people who have been in therapy have lied to a therapist, and even more are willing to lie to a therapist in the future. These findings provide empirical support for the anecdotal accounts of deception in therapy (Kottler & Carlson, 2011). Most participants (89%) endorsed using at least one form of deception (e.g. omission, white lie) in therapy, and most (85.7%) indicated being deceptive at least once when explicitly asked to report the number of times that they have been deceptive in therapy. This frequency is similar to Blanchard and Farber's (2016) finding that most participants (93%) reported lying in therapy in relation to at least one of 58 topics and a majority (72.6%) have lied about a therapy-related topic. However, when participants were explicitly asked if they have ever been deceptive in therapy, a little over half (52.7%) indicated that they had. Thus, frequencies of people who have been deceptive in therapy tend to be higher when asking participants to endorse whether a type of communication had been used compared to outright asking about the total number of times that deception has been used. Explicitly asking participants to report a dichotomous response with regard to whether they had been deceptive in therapy yielded lower frequencies. Lower frequencies on a dichotomous item may be due to a lack of recall or lack of desire to endorse a liar schema.

The average number of lies told per 50-min therapy session was approximately two lies per session, although the distribution of the frequency of lie-telling was skewed. Some participants reported telling as many as 13 lies per session, while the majority of participants reported telling zero lies per session. The finding that most people tell few lies per session and some people tell many lies per session parallels the research on deception occurring within nonclinical contexts (Serota et al., 2010). Serota et al. (2010) referred to the small number of people who tell many more lies as prolific liars. Alternatively, some of the people who reported telling a large number of lies may be pathological liars (Curtis, 2019; Healy & Healy, 1915).

People reported using various types of lies within therapy. White lies were the most frequently reported. White lies, sometimes referred to as altruistic lies or benevolent deception, are told for another person's benefit (Lindskold & Walters, 1983). These lies are generally seen as more acceptable and more permissible to use within relationships (Cargill & Curtis, 2017; Peterson, 1996). The white lies that patients endorse telling to a therapist are those with the intent to protect or benefit the therapist, such as lies told to spare a therapist's feeling. The least frequently reported lies were blatant lies. These lies involve explicitly stating a falsehood. Blatant lies are likely to be the least used lies because they are perceived as less moral and more consequential in relationships compared to other lies. These findings parallel research on types of lies told in intimate relationships and within parental relationships (Cargill & Curtis, 2017; Peterson, 1996).

With regard to relational roles, people reported being more likely to lie to a complete stranger, social acquaintance, primary care physician and teacher or professor than to a therapist. In contrast, the participants were no more or less willing to lie to a therapist than a family member, significant other or close friend. This may be indicative of the propensity to lie to others based on relational roles and emotional closeness. For instance, people are more likely to lie in a job interview than they are to lie to close friends (Robinson, Shepherd, & Heywood, 1998). Job interviews tend to facilitate conditions of impression management, may have less perceived costs when considering the consequences of lying and generally lack emotional closeness with the interviewer. People tend to tell fewer lies to those with whom they have more emotionally close connections (DePaulo & Kashy, 1998; Vrij, 2000). In therapy, the relationship is a significant factor in treatment outcome (Flückiger, Del Re, Wampold, & Horvath, 2018). People may be less willing to lie in therapeutic relationships compared to other relationships because of the critical importance of closeness for the relationship and treatment effectiveness.

The development of emotional closeness tends to diminish the likelihood of lying, as people tell fewer lies to those with whom they are more emotionally close (DePaulo & Kashy, 1998; DePaulo et al., 1996; Vrij, 2000). Thus, it may not be surprising that we found that participants reported a greater willingness to lie within the first session of therapy compared to subsequent sessions. The first session of therapy does not typically begin with a strong emotional connection but is often focused on self-presentation. Self-presentation is a suggested motivation of deceptive behaviour (DePaulo et al., 2003). People may be more likely to lie at the onset of therapy due to a desire to present in a particular manner and may become less likely to lie as therapy continues and the therapeutic relationship has strengthened. In fact, Curtis (2013) found that therapists believe that clients are more likely to lie in the initial stages of therapy compared to subsequent stages. Interestingly, the likability of the therapist did not affect whether people would be more or less willing to lie to a therapist. Thus, motivations to lie to a therapist appear to be more for self-presentation and oriented towards the therapist, regardless of whether the therapist is likable.

The current study provides insights into the prevalence and frequency of deception within therapy. Additionally, our study highlights the types of deception that are likely to be used in therapy and also sheds light on the likelihood for deception to occur in the initial stages of therapy. These findings may be informative for therapists in training or in practice. Therapists generally receive little to no training on the topic of deception in therapy (Curtis, 2013). Our findings can do much to facilitate training and practice within this area. Previous research has shown that educating college students and doctoral physical therapy students about deception can effectively reduce erroneous beliefs and negative attitudes towards patients (Curtis & Dickens, 2016; Curtis, Huang, & Nicks, 2018).

4.1 | Limitations

While our findings add to research in deception and inform practitioners, there are some limitations worth mentioning. The current study was conducted with a sample of university students who were relatively young. While there were no significant correlations found between age and frequency of use in the current study, the oldest participant was 30 years old. One study reported a small correlation between age and endorsed topics of deception, in that younger

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clients may be more likely to lie about various topics in therapy (Blanchard & Farber, 2016). However, Blanchard and Farber (2016) examined the number of topics endorsed instead of a frequency of using deception within therapy. Future research may want to further explore how age is related with regard to the frequency of deception used within therapy. Participants may not be representative of the general population of people who have been in therapy. Additionally, we surveyed participants who reported attending therapy and asked them to report on past use of deception within therapy. This type of retrospective reporting may be affected by forgetting or memory distortions. It would be advantageous to study people who are currently in therapy. Future research might also explore in more depth the small percentage of individuals who tell a large number of lies in therapy. Telling many lies in therapy may be related to antisocial personality disorder, malingering, factitious disorder, or pathological lying (APA, 2013; Curtis, 2019; Healy & Healy, 1915).

5 | CONCLUSION

Patient deception may occur more than therapists believe. This may be in part due to a truth bias and the value of honesty for the therapeutic relationship and outcome (Curtis & Hart, 2015; Levine, 2014). Patient deception challenges this presumption of honesty and potentially threatens the relationship and therapeutic outcome, as therapists hold many negative attitudes towards patients who lie (Curtis & Hart, 2015). It is important for therapists to recognise that some patients are deceptive in therapy, which may take the form of white lies to partial or half-truths or outright falsifications. Also, while most patients have lied in therapy, they do not lie often. It is also important to acknowledge that many of the lies that patients tell are not told with malicious intent. A great number of these lies are other-oriented, or for the benefit of the therapist. Others are told in order to avoid embarrassment, rather than to take advantage of the therapist. Additionally, patients appear to lie less frequently as therapy progresses. In discovering a patient's deception, it may be more advantageous for a therapist to consider the function of the deception rather than take a defensive position and hold negative attitudes towards the patient (Curtis & Hart, 2015; Kottler & Carlson, 2011). By understanding the roles that deception plays within the therapeutic relationship, therapists may be in a better position to effectively engage with their clients and build an honest therapeutic alliance.

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APPENDIX 1

Deception examples

Scenario 1 (Omission): Person A had a precious vase, which was cherished. One day, Person B caught the vase with their sleeve and accidentally broke it. Later, when Person A came home, the wind was blowing fiercely. Seeing the fragmented vase on the floor, Person A exclaimed: "Oh dear I should have closed that window. The wind has blown over my vase." Person B said nothing.

Scenario 2 (Failed Deception): Person A promised Person B to buy groceries after work. But during the morning, Person A decided not to go shopping. So, Person A rang Person B and said, "I can't shop after work. The boss has just called a meeting for this evening." At the time Person A phoned, no meeting was scheduled. But, to Person A's surprise, later in the afternoon the boss *did* actually call such a meeting.

Scenario 3 (Half-Truth): Person A asks Person B where they were at lunchtime as Person A tried repeatedly to phone them and Person B never answered. Person B actually spent most of the two-hour lunch break with a friend but did not want Person A to know this. So Person B said: "Lunchtime today? Oh, yes. I took the car in for its service." In fact, the car was dropped off at the garage en route to lunch with the friend.

Scenario 4 (White Lie): Person A does not like their partner's new haircut. But Person A knows how self-conscious Person B is and thinks Person B feels it is too short. So, when Person B asked what their partner thinks, Person A says: "Your haircut looks very nice. Short hair suits you."

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Scenario 5 (Distortion): Person A sent Person B to buy pickled onions for a new recipe. Person B took a little while to find the onions and then met a friend and got to chatting until completely losing track of time. Person B worried that Person A would be annoyed at how long shopping has taken. So when Person B got home they said: "I hope you appreciate these onions. It took me *ages* to find a shop that carried them."

Scenario 6 (Blatant Lie): Person A borrowed Person B's car and put a small dent in it. When Person B asked about the dent, Person A said: "The dent was already there when I took the car. You must have done it without noticing. Or maybe someone bumped it when you left it in the car park yesterday."

Therapy deception examples

Scenario 7 (Omission): The therapist had assigned homework the previous session, but the client forgot to do it. When the session began, the therapist looked at their notes and stated, "I did not write in my notes whether I gave you homework or not. I must have forgot to assign any to you." The client did not say anything.

Scenario 8 (Failed Deception): The client decided that they did not feel like going to therapy because their friends were going to see a new movie that just came out. They phoned the therapist and stated that they had a stomach bug and would have to reschedule. That night, the client's stomach began to ache. At the time that the client phoned the therapist, they were not sick.

Scenario 9 (Half-Truth): The therapist asked the client if they had done the homework that they assigned. The client answered no, due to a business meeting taking up most of their time. The client did attend a business meeting, but it only took up 15 min of his time.

Scenario 10 (White Lie): The therapist asked the client how therapy has been. The client, not wanting to hurt the therapist's feelings, stated that "therapy has been going well" even though the client did not like therapy or the therapist very much.

Scenario 11 (Distortion): The therapist asked the client if the client wanted to discuss the client's personal relationship. The client stated "my current relationship has been the greatest relationship in my life and I am so happy to have found a loving person" (when in fact the client's relationship has been about as average as past relationships).

Scenario 12 (Blatant Lie): The therapist asked the client, at point blank, whether the client had ever had sexual relationships outside of the current relationship. The client stated, "No, I have not" (when the client had actually had sexual relationships outside of the client's current relationship).

APPENDIX 2

Deception in therapy survey

The investigators do not condone or condemn deception; rather, they were studying it scientifically and trying to learn the answers to some of the most fundamental questions about the phenomenon.

What you should count as deception: deception occurs any time you *intentionally try to mislead someone*. If you are uncertain as to whether a particular communication qualified as a lie, they should record it.

Have you ever been deceptive in therapy? Yes or No

On average, how many times have you been deceptive over the course of therapy? _____

What is the total number of times you have been deceptive in a 50 min therapy session? _____

What is the total number of times you have been deceptive in therapy? _____

How likely would you be to lie to a therapist?

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

How likely would you intentionally keep information from a therapist?

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

I would be more likely to be deceptive with a therapist during the first meeting compared to subsequent meetings.

1	2	3	4	5	6	7
Significantly disagree			No difference			Significantly agree

I would be more likely to be deceptive with a therapist I did not like compared to a therapist that I liked:

1	2	3	4	5	6	7
Significantly disagree			No difference			Significantly agree

I would be more likely to be deceptive with a therapist than a close friend:

1	2	3	4	5	6	7
Significantly disagree			No difference			Significantly agree

I would be more likely to be deceptive with a therapist than a significant other:

1	2	3	4	5	6	7
Significantly disagree			No difference			Significantly agree

I would be more likely to be deceptive with a therapist than a complete stranger:

1	2	3	4	5	6	7
Significantly disagree			No difference			Significantly agree

I would be more likely to be deceptive with a therapist than a family member:

1	2	3	4	5	6	7
Significantly disagree			No difference			Significantly agree

I would be more likely to be deceptive with a therapist than a social acquaintance:

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1	2	3	4	5	6	7
Significantly disagree			No difference			Significantly agree

I would be more likely to be deceptive with a therapist than a primary care physician:

1	2	3	4	5	6	7
Significantly disagree			No difference			Significantly agree

I would be more likely to be deceptive with a therapist than a teacher/professor:

1	2	3	4	5	6	7
Significantly disagree			No difference			Significantly agree

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