The Nature, Motives, and Perceived Consequences of Therapist Dishonesty

Devlin A. Jackson

Submitted in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy
in the Graduate School of Arts and Sciences

COLUMBIA UNIVERSITY

2020

© 2020
Devlin A. Jackson
All Rights Reserved

ABSTRACT

The Nature, Motives, and Perceived Consequences of Therapist Dishonesty

Devlin A. Jackson

Honest communication between therapists and their clients is an essential part of good psychotherapy. Previous research has examined the impact of dishonesty on the part of the client; however, the topic of *therapist* dishonesty has remained virtually unexplored. This study examined the prevalence, motivations, and perceived consequences of therapist dishonesty as part of the psychotherapy process. Specifically, the present study asked therapists to report the topics about which they are more and less likely to be less than completely honest with their clients in session and looked for common characteristics among therapists who reported being more frequently dishonest with their clients. Therapists' reported motivations for and perceived consequences of dishonesty with their clients was also examined. Findings revealed that the vast majority of therapists report having been dishonest with their clients at least once and that therapists are significantly more likely to engage in covert dishonesty than overt dishonesty. Most therapists described using dishonesty in service of their clients' therapy or wellbeing and with no perceived negative consequences. Novice therapists reported using dishonesty with their clients more frequently than therapists with more years of experience. The use of dishonesty and its relationship to therapist disclosure, clinical tact, and the role of hope in psychotherapy is discussed. Directions for future research, as well as implications for training programs and ethical guidelines put forth by the American Psychological Association, are discussed.

Keywords: Therapist dishonesty, therapist honesty, therapist disclosure, clinical tact, hope in psychotherapy

TABLE OF CONTENTS

List of Tables and Figures	iv
Acknowledgements	v
The Nature, Motives, and Perceived Consequences of Therapist Dishonesty	1
Literature Review.....	1
Client dishonesty in psychotherapy	1
Therapist self-disclosure	2
Therapist dishonesty	4
The Role of Therapist Honesty	5
Possible Motives of Therapist Dishonesty	8
Clinical tact.	8
Therapeutic lying.	9
Therapist self-care.....	10
Avoiding shame.	11
Possible Factors Affecting Therapist Dishonesty	12
Years of experience.	13
Current events in the therapist's life.	13
Workplace characteristics (including supervision).	14
Client characteristics.....	15
Modality.	16
Possible Consequences of Therapist Dishonesty	16
Missed opportunities.	16
Therapeutic alliance rupture.	17
Unpleasant intrapersonal and interpersonal effects.	17
Helpful tactfulness.	18
Initial PATCH Survey	18
Initial PATCH survey results.....	19
Limitations of the initial PATCH survey.....	22
Purpose of the Current Study	24
Research Questions.....	25
Research question 1.	25
Research question 2.	25
Research question 3.	25
Research question 4.	25

Research question 5.	26
Method	26
Participants.....	26
Data Collection Procedures.....	28
Approval obtained for the current study.	28
Collection of original data.	28
Measures	30
Data Analysis Procedures	33
Results.....	34
Descriptive Statistics Results for Research Questions 1 and 2.....	34
Most frequent topics of covert dishonesty.	35
Most frequent topics of overt dishonesty.	35
Least frequent topics of covert dishonesty.....	35
Least frequent topics of overt dishonesty.....	35
Latent Class Analyses Results for Research Question 3.....	36
Results of a Grounded Theory Analysis for Research Question 4.....	39
Structure of the qualitative data.	39
Code and Category Descriptions.	39
Results of a Grounded Theory Analysis for Research Question 5.....	42
Structure of the qualitative data.	42
Code and Category Descriptions for Immediate Consequences.....	42
Category Descriptions for Later Consequences.....	43
Discussion	44
Most therapists have been dishonest with their clients.....	45
Therapist dishonesty exists, but is not especially common	50
Therapists report more covert lies than overt ones	51
Most therapist dishonesty is reportedly in service of the client and/or therapy.....	52
Self-preservation motivates some therapist dishonesty	55
A minority of therapist dishonesty is motivated by legal or ethical issues.....	57
Covert dishonesty is used to conceal negative feelings	59
Overt dishonesty is used to maintain personal boundaries	62
Novice therapists are more likely to be dishonest with clients.....	63
Most therapists perceive no consequences of their dishonesty with clients	65
Limitations and Future Directions	67

Conclusions.....	72
References.....	75
Tables	86
Figures.....	110
Appendix A: PATCH2 Recruitment Email	112
Appendix B: PATCH2 Informed Consent.....	113
Appendix C: PATCH2 Survey	116

List of Tables and Figures

Table 1: *Participant Demographics: Quantitative Section*

Table 2: *Participant Demographics: Qualitative Section*

Table 3: *Therapist perceptions of the frequency of topics about which they have been covertly dishonest*

Table 4: *Therapist perceptions of the frequency of topics about which they have been overtly dishonest*

Table 5: *Fit indices for one-to-three-class latent classes of therapists (covert dishonesty)*

Table 6: *Fit indices for one-to-three-class latent classes of therapists (overt dishonesty)*

Table 7: *Reported motives (with examples) for therapist dishonesty in psychotherapy*

Table 8: *Reported perceived immediate consequences (with examples) for therapist dishonesty*

Table 9: *Reported perceived later consequences (with examples) for therapist dishonesty*

Table 10: *Percent of therapists who reported having been covertly dishonest at least once, by topic*

Table 11: *Percent of therapists who reported having been overtly dishonest at least once, by topic*

Acknowledgements

First and foremost, I would like to thank my faculty advisor, Dr. Barry Farber, without whose support, encouragement, care, understanding, and wonderful good humor I would not be completing this project today. I feel extraordinarily fortunate to have benefitted not only from Dr. Farber's wisdom and curiosity about the workings of psychotherapy, but also from his genuine interest in the development and wellness of his students in this program. Others often credit my ability to forge ahead throughout this process to my type-A nature and nearly constant intake of chocolate, but the truth is that Dr. Farber's unwavering support has made everything possible, and for that I am endlessly grateful.

I would also like to thank Amar Mandavia, Catherine Crumb, and Daniel Sauermilch for their tireless and enthusiastic support of this project, as well as Mandy Newman, Hannah Lindenmeyer, Tao Lin, Mila Kirstie Kulsa, Elyse Blake, Xinyao Zhang, and Jeffrey Wainstein, in designing and conducting the study. I have been very fortunate to have worked with a wonderful team.

I extend my sincerest thanks, as well, to my committee members—Dr. Elissa Perry, Dr. Michael Slepian, Dr. Marie Miville, and Dr. Jesse Geller—for their thoughtful and poignant feedback and suggestions, as well as their enthusiasm and encouragement about this project and related future research.

And last, but certainly not least, to my sweet daughter, who tolerated my preoccupation with my laptop for many afternoons, and to my loving, supportive, and remarkably honest husband, whose herculean husband-and-father strength over the past five years (and the past year in particular) pushed us all over this finish line. And that's the honest truth.

The Nature, Motives, and Perceived Consequences of Therapist Dishonesty

Honesty and dishonesty are inherent to all interactions in our public and private lives. Individuals in virtually all interpersonal interactions weigh the extent to which they reveal, conceal, or even misrepresent the truth and may choose to deceive others for numerous reasons, in a variety of ways, and in many different contexts (Vrij, 2000). In the same way, honesty and dishonesty are fundamental elements of the discourse between therapists and clients in psychotherapy. As in any interpersonal interaction, therapists and clients in psychotherapy make decisions about how they wish to present themselves and what, how, and when they wish to share information. In the original conception of psychoanalysis, Freud's "rules" called for patients to be as honest as possible in session, freely expressing "whatever comes into their heads, even if they think it unimportant or irrelevant or nonsensical" (Freud, 1904, p. 267). While the parameters of psychotherapy have evolved since its beginnings, contemporary psychotherapists still count on their clients to be honest—or at the very least not actively misleading—in order to build the trust necessary to establish an effective working alliance and, of course, to get accurate enough information to be able to be helpful. But what about dishonesty in therapy on the part of the therapist? When, how, and with what purpose and consequences does this tend to occur? The primary aim of this study was to examine the use of dishonesty in the other partner in the therapeutic dyad: the therapist him or herself.

Literature Review

Client dishonesty in psychotherapy

A growing body of research continues to examine the prevalence, motivations, and consequences of *client* dishonesty in psychotherapy (e.g., Blanchard & Farber, 2016; Farber,

Berano, & Capobianco, 2004; Farber & Hall, 2002; Hill, Gelso, & Mohr, 2000; Hook & Andrews, 2005; Kelly & Yuan, 2009; Love & Farber, 2018). Together, the existing literature suggests that client dishonesty is virtually ubiquitous and that certain topics tend to be lied about more often than others (i.e., sex, substance abuse, suicidality, and feelings about the therapist and the therapy itself). Research by Farber, Blanchard, and Love (2019), utilizing a database of over 1,000 clients, looked at the nature, motivation, and extent of client dishonesty broadly defined (i.e., overt mistruths, concealment, avoidance, secrets). In their study, clients reported lying and concealing in therapy at higher rates than previously reported: 93% of participants reported having lied to their therapist, and 72.6% reported lying about at least one therapy-related topic. Ascertaining definitive empirical links between non-disclosure or dishonesty and therapeutic outcome has proven especially difficult (Farber, 2006; Stiles, 1995); however, there exists a general consensus among all who have written about the topic: non-disclosure and dishonesty about significant personal issues interfere with clinical progress and the integrity of the therapeutic relationship.

Therapist self-disclosure

Whereas *client* dishonesty in psychotherapy has received considerable empirical attention in recent years, the subject of *therapist* dishonesty remains almost entirely unexplored. Research that has come closest to touching on therapist honesty has focused on the nature and extent of therapist self-disclosures—the private information that therapists choose to share about themselves with their clients in session (e.g., Farber, 2006; Henretty et al., 2014; Henretty & Levitt, 2010; Knox & Hill, 2003). Previous research has found that therapist self-disclosures have a direct impact on the course of therapy. According to a meta-analysis by Henretty et al.

(2014), clients whose therapists self-disclosed rated their therapists more favorably and rated themselves more likely to self-disclose in session. In particular, therapists' self-disclosures with the greatest impact were reportedly: those that exposed a similarity between the therapist and client; concerned thoughts and/or feelings about the client or the therapy itself; concerned occurrences in the therapist's life; and discussed negative thoughts or feelings about the client or therapy (e.g., expressing sadness about something a client discussed). The extent to which therapists choose to self-disclose in their practices varies widely from therapist to therapist, and even from client to client.

While there is some overlap between therapist self-disclosure and therapist dishonesty, the two are not the same. A therapist may rightly choose to disclose to a client that he or she has been through a similar experience to something the client is describing in session or may choose to keep that information to him or herself. However, a decision by a therapist not to disclose private information about him or herself is not inherently dishonest. In other words, choosing to be less than completely open (i.e., opting not to self-disclose) is not equivalent to being less than completely honest (i.e., behaving in a way that misleads). In contrast to therapist non-disclosure, therapist dishonesty consists, for the most part, of actions, such as behaviors or words, spoken or withheld, that are *meant to deceive or mislead*. Of course, in "real life," these distinctions can be blurred: for example, if a client reveals to his therapist that he is gay, the therapist's decision not to reveal that the same is true for him (if it is) could be seen as misleading, especially if the client has shared that information in a way that seems to be asking whether the therapist can relate. It is likely that certain situations tempt even the most skilled therapists to be less than completely honest with their clients, whether covertly (i.e., by omission, opting not to correct a client's misperception) or overtly (i.e., commission, providing untrue information). Thus, while the

literature on therapist self-disclosure is informative, especially in terms of the reasons therapists give for sharing private information with their clients in session, it says little about the nature, extent, motivations, or consequences of the instances in which therapists choose to be less than completely honest with their clients. The present study seeks to fill this gap in existing research.

Therapist dishonesty

Information specifically on therapist dishonesty exists almost exclusively anecdotally in opinion pieces and blogs, with a few therapists using online journals to reflect on times in their practices when they were less than completely honest with their clients (Burgo, 2013; Hurd, 2011; Oberg, 2013). In his 2013 blog post entitled “Lying to our Clients,” Joseph Burgo reflected on the topic, touching on the difference between non-disclosure and dishonesty:

It’s one thing to keep my opinion to myself, quite another to give voice to the very opposite of that I truly believe. [...] In thinking back over my years of practice, I can identify several instances where I lied to my clients, all of them involving shame or feelings of embarrassment. [...] What about deliberate falsehoods? It undermines the integrity of the therapist. It corrupts the entire therapeutic process which is, after all, devoted to uncovering the truth no matter what.

Anecdotal accounts like this one bring up several important questions that remain entirely unexplored by previous research: What motivates a therapist to be less than completely honest with a client? Is dishonesty more common in certain circumstances, or with certain types of clients, than others? And, perhaps most importantly, what if any effect does therapist dishonesty have on the therapy itself? Is complete honesty on the part of the therapist an essential element of good or effective psychotherapy?

Freud would likely answer this last question in the affirmative, at least in his earlier publications. In his 1915 piece “Observations on Transference-Love,” Freud discussed the importance of honesty on the part of the psychoanalyst, describing it as fundamental to the practice:

[T]he psycho-analytic treatment is founded on truthfulness. A great part of its educative effect and its ethical value lies in this very fact. It is dangerous to depart from this sure foundation. When a man’s life has become bound up with the analytic technique, he finds himself at a loss altogether for the lies and the guile which are otherwise so indispensable to a physician, and if for once with the best intentions he attempts to use them he is likely to betray himself. Since we demand strict truthfulness from our patients, we jeopardize our whole authority if we let ourselves be caught by them in a departure from the truth. (p. 383)

The Role of Therapist Honesty

Many contemporary psychotherapists regard the importance of honesty in the same way. According to Nancy McWilliams (2004), “Artificiality and posturing have no place in analytic therapy, mainly because they are discordant with the effort to foster an unflinching emotional honesty” (p. 52). Likewise, Judith Beck (2015), in describing the fundamentals of Cognitive Behavior Therapy, propounded, “It is essential to start building trust and rapport with patients from your first contact with them” (p. 17). In line with these sentiments, the importance of truthfulness in psychotherapy is emphasized in the APA’s *Ethical Principles of Psychologists and Code of Conduct*, under “Integrity,” one of its five General Principles, as follows:

Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques. (American Psychological Association, 2017)

Despite this emphasis on “accuracy, honesty, and truthfulness” in the field’s ethical guidelines and among psychotherapy’s preeminent theorists and educators, there exists almost no research on therapist dishonesty. A handful of surveys and opinion pieces in the medical field have explored the topic of clinician dishonesty, particularly among those working with patients with dementia or paranoia. Current consensus in the medical community is that doctors should tell their patients the truth “even when this may cause foreseeable, additional harm to patients” (Howe, 2008). Despite this, it is not uncommon for psychiatrists to withhold information that they believe might minimize the likelihood of a patient continuing treatment if disclosed. “Therapeutic lying,” a contemporary term coined to describe lies that are considered to be in a patient’s best interest, has recently emerged in the medical community, primarily in treatment of patients suffering from dementia (Sprinks, 2013). According to a 2013 survey of psychiatrists in the UK, 69% admitted to lying to “someone lacking capacity when they thought it was in the person’s best interests” (Sprinks, 2013). Larissa MacFarquhar (2018) addressed this issue in her

New Yorker article, *The Comforting Fictions of Dementia Care*, confronting the difficult ethical questions associated with dementia care:

To lie is to violate the respect that one person owes another; but lying to a person with dementia can protect them from awful truths that they have no power to alter. If a woman asks for her husband, having forgotten that he is dead, should you tell her the truth and cause her terrible grief, knowing that this fresh bereavement will likely repeat itself, over and over, day after day? Or should you just tell her that he is at the office? And is direct lying different from various forms of passive lying—encouraging delusions, or allowing existing delusions to persist? What is more important—dignity or happiness?

Clinicians working with patients with schizophrenia face a similar conflict between respecting their patients' autonomy and avoiding harm. Many psychiatrists treating patients with schizophrenia with paranoia believe that the use of "partial truths" increases the effectiveness of treatment, for example, by presenting prescribed medications as treatment for stress and anxiety, rather than as treatment for delusions (Howe, 2008).

As noted earlier, there has been only a very limited amount of empirical work on the topic of psychotherapist dishonesty. In one study that touched briefly on the topic, Curtis and Hart (2015) found that therapists held negative attitudes toward deceptive clients, yet admitted to being deceptive toward clients themselves. Although the primary focus of the study was therapists' attitudes and beliefs about client deception, the survey included a few follow-up questions about dishonesty on the part of the therapists themselves. Of the 112 clinical and counseling psychologists surveyed, a staggering 96% reported that they had deceived their clients "through intentionally withholding information from them in therapy if they thought it

protected them” (p. 285). Furthermore, 81% reported having *overtly lied* to their clients in session. Based on a 7-point Likert scale (1 = Never and 7 = Very Often), therapists in their study were significantly more likely to intentionally withhold information from clients if they believed it was protecting the client ($M = 4.04$, $SD = 1.75$) than for any other reason ($M = 3.57$; $SD = 1.72$), $p < .001$. Likewise, therapists were significantly more likely to intentionally withhold information for protective reasons than to overtly lie to clients ($M = 2.27$, $SD = 1.16$), $p < .001$.

Possible Motives of Therapist Dishonesty

Clinical tact. Virtually all accounts of therapist dishonesty in anecdotal accounts and the scant existing research center around the therapist’s employment of clinical tact, a sensitivity and adroitness in discussing the “touchy” topics that arise in psychotherapy. In fact, the word “tact” is derived from the Latin “tactus” meaning “touch,” alluding to the deftness with which one handles a situation. Clinical tact refers to choices that a therapist makes regarding interventions in session that take into account what he or she believes will be most effective for a particular client at a particular time. As such, attempts to be tactful frequently involve decisions about whether to be completely honest with clients in session, or whether such honesty would be counterproductive.

Although Freud (1923; 1925) mentioned tact in his writings, the first to write extensively on the value of clinical tact was Hungarian psychoanalyst, Sándor Ferenczi, in his 1928 paper “The Elasticity of Psycho-Analytic Technique.” Ferenczi defined tact as “the capacity for empathy” and, in practice, knowing if, when, and how to intervene in session. Freud, in correspondence with Ferenczi following this publication, commended Ferenczi’s work, explaining that his own writings on psychoanalysis had primarily been warnings of “what one

should not do,” with the intention of leaving the rest of the process to the analyst’s employment of “tact,” a topic he had been reluctant to tackle. Specifically, Freud expressed his concern that it was not possible to provide guidelines or rules for clinical tact due to its subjectivity and the multitude of factors involved in the interaction between analyst and patient. Freud believed tact involved “a weighing out, which remains mostly preconscious, of the various reactions that we expect from our interventions. [...] It is first and foremost a matter of the quantitative assessment of the dynamic factors in the situation.” He added that, “Rules for these measurements can naturally not be made; the analyst’s experience and normality will have to be the decisive factors” (Freud & Ferenczi, 2000).

In a review of the correspondence between Freud and Ferenczi on the issue of tact, Robinson (2014) suggested that, “Taken together empathy, tact and being natural speak of the analyst’s freedom to use himself beyond the level of consciousness in the process of analysis: his bodily self in the empathy; his unconscious as a receiving instrument for the patient’s unconscious; his evenly suspended attention as complimentary [sic] to the patient’s free association” (p. 334). However, despite its ubiquity in clinical practice, clinical tact—like therapist dishonesty—has remained largely absent from recent literature, likely due to the subject’s complicated and highly subjective nature.

Therapeutic lying. Although a relatively new term, the practice of “therapeutic lying” itself is not new. As discussed above, clinicians (i.e., therapists, medical doctors, etc.) working with patients with forms of dementia and schizophrenia sometimes opt to be less than completely honest when they believe that the truth would cause more harm than good (Sprinks, 2013). In a similar way, it is possible that therapists choose to be less than completely honest when doing so is deemed in the best interest of the client. In fact, recent research has shown that the greater the

compassion individuals feel towards another, the more likely they are to engage in prosocial lying, or “lies intended to benefit others” (Lupoli, Jampol, & Oveis, 2017). For experienced psychotherapists, it is possible, even likely, that this kind of prosocial lying in the client’s best interest is commonplace, perhaps so much so that it goes unnoticed by the therapist him or herself. As Farber et al. (2019) explain:

Most deceptive messages—and arguably almost all messages—are mixtures of true and false information that must be judiciously blended to meet the goals of the communicator. Social communication requires a constant awareness of our audience as well as high-speed calculations about how others will respond to our remarks. These calculations allow us to deploy small instances of deceit—a cautious change of wording or a raised eyebrow to feign interest—which are so ubiquitous they often escape our conscious awareness. (p. 39)

Therapist self-care. Therapists may sometimes choose to be less than completely honest for the sake of their own self-care, such as taking an afternoon off or minimizing the number of especially difficult clients in their caseload. Examples from anecdotal accounts include feigning unavailability in order to leave work early, claiming a full client load to avoid taking on a new client, and coming up with reasons to refer out a difficult client. While these acts of dishonesty have obvious benefits for the therapist, they also protect clients from painful feelings. For example, while one reason for terminating with a particular client might in fact be that he or she is unpleasant to work with, a simultaneous truth may be that another therapist will be better equipped to help him or her. Again, a tactful response spares a client the pain of knowing that he

or she is difficult to work with or that his or her therapist would rather go home than see him or her for an afternoon session.

Avoiding shame. Due to the lack of existing research on therapist dishonesty, we can turn to studies of client dishonesty to learn more about what might motivate therapists to be less than completely honest with their clients. Research indicates that one of the most common motives behind client dishonesty in therapy is the avoidance of shame (Farber et al., 2019), which is likely a motivator behind therapist dishonesty as well (e.g., Burgo, 2013). Therapist mistakes, such as drifting off in session, forgetting something a client said, being late, or failing to show up, pose a threat to the therapist's self-image and professional image in the eyes of the client, tempting even experienced therapists to cover them up. Of course, being dishonest for the sake of covering up mistakes in therapy (e.g., denying drowsiness, pretending to remember something, fabricating an excuse for tardiness or an absence) can not only "save face" for the therapist, but spares the client the painful feelings associated with the therapist's misstep (e.g., feeling dull or forgettable). These kinds of tactful "prosocial lies" serve a potential dual purpose: avoidance of shame for both the therapist and the client.

Avoiding distractions. Another reason for therapist dishonesty that appears in anecdotal accounts is to avoid distractions in session. Freud (1910) and Ferenczi (1928) both discussed the utility of tact to minimize distractions and defensiveness and redirect the patient's attention to what might be avoided. For example, a therapist whose client is discussing a particular movie or celebrity may opt to respond as if he or she knows what the client is talking about so as to avoid diverting the conversation to an explanation of the topic. As with other acts of therapist dishonesty, a therapist's reasons for this type of dishonesty may also be twofold: in addition to avoiding a tangential conversation, feigning awareness of what the client is referring to also

reduces the emotional distance between therapist and client, another decision that may be grounded in clinical tact.

Clinical tact, therapeutic lying, therapist self-care, and avoiding shame and distractions are just a few of the possible reasons behind therapist dishonesty. It is likely that most cases of therapist dishonesty involve more than one reason; although, as Freud pointed out, these reasons may not be in the therapist's awareness at the time (Freud & Ferenczi, 2000). Clinical judgment and related decisions about honesty in psychotherapy are a substantial part of therapy process and warrant exploration and understanding to inform clinical training and practice. This study intends to fill this gap in existing research.

Possible Factors Affecting Therapist Dishonesty

The lack of research leaves much about the reasons for therapist dishonesty to speculation and extrapolation. Existing psychotherapy literature suggests that certain characteristics, detailed below, may influence therapists' decisions about whether and when they are less than completely honest with their clients. The lack of research in this area led our lab at Teachers College to develop a preliminary, exploratory survey entitled Psychotherapists' Assessment of Truth, Candor, and Honesty (PATCH) (Jackson & Farber, 2018). This survey, described in detail in a later section, electronically surveyed 271 psychotherapists and presented them with a total of 23 clinical topics to report the extent to which they had ever been less than completely honest with their clients. Although this original PATCH survey provided valuable initial information about the prevalence of therapist dishonesty, it did not ask about therapists' reasons for being less than completely honest with their clients, a topic which this subsequent study intends to address.

Years of experience. As with any profession, psychotherapists evolve over the course of their years in practice. Habits, practices, comfort and adroitness handling difficult situations, and even theoretical orientations can develop and adapt with experience. In particular, over time therapists learn to make effective decisions about if, when, and how to intervene, interject, and even self-disclose. The difference in this regard between novice and experienced therapists is explained by Geller (2003):

Therapists who have found their own voice may experience the coming together of [...] conceptually distinguishable stages of decision making as an organic event. One can experience the decision to self-disclose as inherent in the decision to pursue a particular treatment goal. Beginners, by contrast, often find themselves trying to choose between conflicting modes of realizing a particular goal, all of which feel as if they have a legitimate claim. (p. 544)

In line with this, it is likely that therapists' decisions around honesty and dishonesty evolve with experience as well. Results of the original PATCH survey showed that therapists with five or more years of experience were more frequently dishonest than those with fewer than five years in the field, indicating a possible change in the use of dishonesty relative to years of practice experience (Jackson & Farber, 2018).

Current events in the therapist's life. Understandably, the distraction and stress of certain life events could cause even experienced therapists to be less than completely honest with their clients, whether attempting to cover up a personal issue or simply working to manage competing demands of their time. Therapists coping with significant health issues have reported difficulties in their usual practice, including the use of defenses and errors in judgment (Abend, 1982; Arlow, 1990; Gerson, 1996). Gerson (1996) explained:

Personal experiences of the analyst that, through choice or necessity, are carried into the analytic setting require us to closely examine issues of boundaries and role definition.

Particularly when these experiences are disturbing and preoccupying for the analyst, requiring immediate response or long-term working through, the analyst must contend with a series of problems that bear upon the integrity of the analytic process.” (p. 36)

Original PATCH survey results showed that therapists over 30 were more frequently dishonest than their younger counterparts; however, further investigation of the data revealed nuances in the relationship between age and use of dishonesty. Specifically, the group of therapists who were most likely to be dishonest with their clients were between the ages of 30 and 45 (Jackson & Farber, 2018). Although, as noted earlier, the original PATCH survey did not ask about motivations for dishonesty, these results suggest that something about this age window engenders greater dishonesty, such as the added stress of a developing career, family obligations, and parenthood—which, for most women with advanced degrees, does not begin until their 30s (Livingston, 2015). It is possible that the increase in responsibilities and related stress elicits the use of certain shortcuts, such as “white lies.”

Workplace characteristics (including supervision). As with the effects of events in the therapist’s personal life, the daily expectations, events, demands, and constraints of his or her workplace also likely affect the tendency to be dishonest with clients. Factors including workplace norms, the extent to which the therapist feels in control of his or her schedule, whether the environment is fast-paced or high stress, and whether he or she is actively supervised could all affect the extent to which a therapist engages in dishonesty with clients. Results of the original PATCH survey revealed that therapists in private practice were significantly more likely

to be dishonest with their clients than were therapists working in clinics or hospitals (Jackson & Farber, 2018).

Client characteristics. A client's individual characteristics, such as his or her diagnosis, age, and the number of years he or she has been in therapy with the therapist, may also contribute to the therapist's decisions about dishonesty with him or her in session. For example, symptoms and behaviors associated with certain diagnoses (such as with patients with dementia or schizophrenia, discussed earlier) may prompt therapists to be less than completely honest if they believe the complete truth is likely to cause more harm than good. In this regard, Sledge (1989) contented that "the analyst's use of tact should be invisible except in extreme cases of psychopathology where the potential for disharmonious relationships is very high" (Sledge, 1989, p. 145). Although the subject of the relationship between therapist dishonesty and client characteristics has not yet been explored empirically, literature on client characteristics and therapist self-disclosure provides some insight into therapists' decisions about utilizing complete honesty with clients. Specifically, therapist self-disclosure has been recommended for clients with whom the therapist has a strong working alliance (Bishop & Lane, 2001; Gallucci, 2002; Myers & Hayes, 2006) or shares a commonality that is likely to be discovered by the client, such as sexual orientation or hometown (Frost, 1998; Kranzberg, 1998; Miller & Stiver, 1997; Satterly, 2006; Solomon, 1994). On the other hand, therapist self-disclosure is not recommended for use with clients who have poor boundaries (Epstein, 1994; Goldstein, 1994), struggle with their sense of identity (Raines, 1996; Simone et al.), are likely to put others' needs ahead of their own (Epstein, 1994; Goldstein, 1994), have been diagnosed with personality disorders (Mathews, 1988; Simone et al., 1998), or who seem uncomfortable with therapist self-disclosures (Henretty & Levitt, 2009). These self-disclosure recommendations may well translate to

therapists' practices around dishonesty with certain clients, suggesting that complete honesty is not necessarily suited for all clinical situations.

Modality. Virtually all theoretical orientations regard therapist genuineness as “important for significant progress in psychotherapy and, in fact, fundamental to the formation of a working alliance” (Lambert, 1992). However, truthful and upfront responses from the therapist are more central to certain modalities—such as Dialectical Behavior Therapy which emphasizes “radical genuineness” on the part of the therapist, or Rational Emotive Behavior Therapy which often utilizes bluntness—than others, such as psychoanalysis, in which the therapist's responses in session are less frequent. Such differences across modalities may account for different dishonesty practices. On the one hand, therapists who practice modalities in which their honest reactions are a central part of the process may be more likely to be more honest with their clients than therapists whose modalities simply involve fewer therapist responses, by design. On the other hand, therapists practicing in modalities in which their honest reactions are expected may find themselves occasionally skirting the completely honest truth, choosing to be less than completely honest instead. Therapists practicing psychoanalysis, for example, may largely avoid dishonest responses by way of simply responding less—a characteristic of the modality itself. It is likely that differences in modality are related to different uses of therapist dishonesty, as functions of the modality's regard for therapist honesty (e.g., is blunt truthfulness emphasized?) and the composition of the modality itself (e.g., how much talking does the therapist do?).

Possible Consequences of Therapist Dishonesty

Missed opportunities. A significant potential consequence of therapist dishonesty is the missed opportunity to work through the very situations that the dishonesty is used to avoid. For

example, a therapist may choose to come up with an excuse to avoid telling his or her client the truth about having forgotten about their session, because he or she believes that the truth would be too painful for the client to bear. However, an honest explanation, while potentially painful for the client, also provides a potentially fruitful opportunity to discuss the client's feelings about having been forgotten. All topics of potential dishonesty contain such opportunities: a frank conversation with a client about the way his or her behavior is frustrating to the therapist; upfront feedback about a lack of progress being made; a candid comment about feeling bored by discussing the same topic again and again. Each of these honest disclosures, while possibly very difficult to share, may contain an opening to rich therapeutic dialogue.

Therapeutic alliance rupture. Therapists who choose to be dishonest with their clients also risk a significant rupture in the therapeutic alliance, should their dishonesty ever come to light. Freud (1915), in one essay on the topic, explained his belief that the analyst who is dishonest with his client “is likely to betray himself” and advised against the practice (p. 383). Anecdotal accounts from clients who believed they caught their therapists in a lie contain portrayals of the painful rupture that can follow (Johnson, 2013; Jones, 2018; Anonymous, 2013).

Unpleasant intrapersonal and interpersonal effects. Other troublesome effects of therapist dishonesty may be experienced internally by the therapist and are perhaps more difficult to identify, such as feelings of regret, shame, or other conflict. Research by Slepian et al. (2018) found that secret-keeping (i.e., *deliberately* concealing information) indirectly intensified individuals' experiences of fatigue “by evoking feelings of isolation and a motivational conflict with one's affiliation goals” (p. 1129). Research by Lee et al. (2019) indicated that regular use of dishonesty negatively impacted an individual's ability to accurately read others' emotional states.

Importantly, recent research suggests that the use of dishonesty compounds over time, as the brain adapts to its use. A study by Garret et al. (2016) revealed that the amygdala became less sensitive to dishonest behavior, relative to previous acts of dishonesty, uncovering “a biological mechanism that supports a ‘slippery slope’: what begins as small acts of dishonesty can escalate into larger transgressions” (p. 1727).

Helpful tactfulness. Importantly, the consequences of therapist dishonesty are not all bad. First-hand accounts from therapists also include reports of the ways in which they felt their deception helped ease a difficult clinical situation, such as a therapist telling a client that their own tardiness to session was due to an emergency, rather than truthfully explaining that they forgot the client’s appointment. Clinical tact, as described earlier, involves moment to moment decisions about what should (and should not) be said in session, which sometimes involves being less than completely honest. Oftentimes clinical tact involves waiting until a more appropriate time to speak candidly about something, such as a client’s diagnosis or the therapist’s honest reaction to something that comes up in session.

These hypothetical consequences may only scratch the surface of the short- and long-term consequences of therapist dishonesty, currently unknown due to the lack of research in this area. The present study seeks to learn not only about the nature and content of therapist deception but to understand therapists’ perceptions of the effects (positive and negative) of their less than complete honesty.

Initial PATCH Survey

To begin our exploration of therapist dishonesty, our lab at Teachers College designed a preliminary electronic survey entitled Psychotherapists’ Assessment of Truth, Candor, and

Honesty (PATCH) (Jackson & Farber, 2018). Specifically, the lab sought to learn how frequently and to what extent therapists report being less than completely honest with their clients in session, about what topics, and in what way. The exploratory survey, which was distributed electronically to practicing psychotherapists all over the United States, presented 271 participants in 38 states and 12 countries with a total of 23 clinical topics, chosen on the basis of the existing anecdotal accounts of therapist dishonesty (e.g., online blogs) and informal discussions with current psychotherapists. For each topic, participants were provided with a question about the extent to which they had ever been less than completely honest with a client about that topic (e.g., “How often, if ever, have you been less than completely honest with a client about your feelings of frustration or disappointment with him or her?”) and asked to indicate his or her answer on a 7-point Likert scale (where 1 = Never; 4 = Sometimes; 7 = Frequently).

In order to examine the nature of reported dishonesty, specifically the potential differences between reports of overt and covert dishonesty, participants were also provided with two follow-up questions that asked them to specify, using the same scale, how often this involved overtly telling a client things that were not true (e.g., “How often, if ever, has this involved telling a client things about your feelings of frustration or disappointment that weren’t entirely true?”) and how often this involved not correcting a client’s misperception (e.g., “How often, if ever, has this involved not correcting a client’s misperception about your feelings of frustration or disappointment?”). Participants were asked to answer these three questions (i.e., overall, overt, and covert) for each of the 23 topics on the survey.

Initial PATCH survey results. The results of this survey provided a first look at the extent to which psychotherapists engage in dishonesty with their clients, as well as the nature and content of the dishonesty. The top three “overall” lies (i.e., topics about which therapists

reported they were ever less than completely honest) were about feelings of frustration or disappointment with a client ($M = 3.30, SD = 1.4$), liking or disliking a client ($M = 3.18, SD = 1.67$), and their own physical or emotional state ($M = 3.14, SD = 1.58$). The top three “overt” lies (i.e., topics about which therapists reported actively saying something less than completely true) were about feelings of frustration or disappointment with a client ($M = 2.46, SD = 1.40$), clinical availability ($M = 2.36, SD = 1.50$), and liking or disliking a client ($M = 2.33, SD = 1.53$). The top three “covert” lies (i.e., topics about which therapists did not correct a client’s misperception) were about liking or disliking a client ($M = 2.81, SD = 1.71$), their own personal beliefs or values ($M = 2.76, SD = 1.66$), and forgetting something a client said previously in session ($M = 2.75, SD = 1.58$). Liking or disliking a client—anecdotally, more often *disliking* a client—was a topic that consistently evoked high scores across all three questions (i.e., overall, overt, and covert), indicating that it’s not uncommon for therapists to have feelings about their clients that they distort, or at least conceal. Personal beliefs or values, on the other hand, only appeared in the top three for covert dishonesty, suggesting that therapists are less likely to overtly share an untruth about their beliefs than they are to allow a client to believe something about them that is not true. Notably, on none of the items on the survey did mean overall scores exceed “4” (i.e., “sometimes”) on the 7-point scale.

Our results also provided insight into the topics that therapists are rarely ever dishonest about. The bottom three “overall” lies by therapists were about their trainings or credentials ($M = 1.33, SD = 0.88$), their fee structures ($M = 1.51, SD = 1.09$), and their reasons for terminating ($M = 1.74, SD = 1.10$). The bottom three “overt” lies were about their training or credentials ($M = 1.14, SD = 0.60$), their fee structure ($M = 1.37, SD = 0.94$), and their romantic or sexual feelings towards a client ($M = 1.40, SD = 1.15$). The bottom three “covert” lies were identical to

the “overt,” about training or credentials ($M = 1.42$, $SD = 1.04$), fee structure ($M = 1.49$, $SD = 1.11$), and romantic or sexual feelings towards a client ($M = 1.57$, $SD = 1.27$). For both the overt and covert questions, nearly all therapists reported never lying about their training or credentials, their fee structures, and—to our surprise—their romantic or sexual feelings towards clients.

In order to identify possible patterns in dishonesty among therapists with different demographics (i.e., training, modality, years in practice, etc.), we performed a Latent Class Analysis (LCA), a measurement model that allows for classification of participants into exhaustive, mutually exclusive groups, or “latent classes,” based on their answers to categorical or continuous observed variables. As predicted, two groups emerged for all three types of lies: a “low” dishonesty class (Class 1) and a “high” dishonesty class (Class 2). Next, we looked for any significant differences between the demographic makeup of these two classes. Analyses revealed significant differences between the two classes on certain demographics: members of the “low” dishonesty class were significantly more likely to be practicing primarily in clinics and hospitals, students (not yet licensed), younger than 30, and with fewer than five years in practice; members of the “high” dishonesty class were significantly more likely to be practicing primarily in private practice, licensed, older than 30, and with five or more years in practice.

Our preliminary research highlighted an important finding: the majority of therapists who completed this survey reported having been dishonest at least once about 18 of the 23 topics. In fact, 89% of therapists reported having been dishonest at least once about their feelings of frustration or disappointment, 84% reported having been dishonest at least once about their physical or mental state and about having forgotten something a client had said previously in session, and 81% reported having been dishonest at least once about their confidence in being able to help. While very few therapists reported being dishonest “Frequently” about any of the

topics, responses indicated that most therapists have been less than completely honest with their clients at some point in their careers.

Limitations of the initial PATCH survey. The results of the initial PATCH survey provided a good rudimentary map of a landscape that was otherwise uncharted. However, the data highlighted shortcomings in the content and design of our demographic and survey questions that limited our analyses. Specifically, the demographic section of our initial survey contained questions that could be improved to obtain more accurate data. First, two of the demographic questions (i.e., “How many clients do you currently see?” and “How many years have you been seeing clients?”) provided participants with text boxes that allowed for free-form responses to questions for which a forced numeric answer would have been advantageous. For example, several participants provided text responses that failed to provide the numeric value needed for analyses (e.g., “2 new clients per month”). Second, the initial set of demographic questions did not accommodate international participants (i.e., psychotherapists practicing outside of the United States). Third, the original demographic section asked participants to indicate all of the modalities in which they currently practice, which failed to provide us with useful information about their *primary* modality. Fourth, we provided participants with a free-form text box to let us know about their clinical specialty, if any, which elicited verbose, sometimes hard to parse responses, rather than helping us group participants by specialty (e.g., addiction, anxiety, children/adolescents, etc.).

The body of the survey itself also contained limitations that clouded the data. First, the design of each question asked participants to select their answers from a 7-point Likert scale (where 1 = Never; 4 = Sometimes; 7 = Frequently). However, the design did not include an option for participants to select if they had not encountered a particular situation before, and as a

result, it was not clear if participants who selected “1 = Never” on an item did so because they were always completely honest about that topic, or because they had never encountered that situation before. Second, the original PATCH survey included a three-question format which asked participants to report overall how often, if ever, they had been less than completely honest about each clinical topic and then provided them with two follow-up questions per topic. These follow-up questions sought to differentiate between acts of *covert* dishonesty (e.g., “How often, if ever, did this involve not correcting a client’s misperception?”) and *overt* dishonesty (e.g., “How often, if ever, did this involve telling a client something less than completely true?”). However, results showed that the “overall” average for 21 of the 23 topics was greater than the averages for both the “overt” and “covert” questions on the same topics, indicating that this question format failed to capture existing differences between the prevalence of overt and covert dishonesty.

Third, participants in the original survey were provided with the primary investigator’s contact information to use for questions or feedback, which elicited recommendations for two changes to the question content. Specifically, participants suggested that the question about “knowledge of someone or something” be split into two separate questions (i.e., knowledge of *someone* outside of session; knowledge of *something* outside of session). Similarly, participants suggested that the question about “physical or mental state” be split (i.e., feeling physically unwell; feeling emotionally unwell). Participants also suggested the addition of a question on dishonesty about feeling bored in session, a topic we had previously overlooked. Lastly, while the original survey provided a reasonably good initial look at the topics about which therapists occasionally are (or are not) dishonest, it did not provide any information about the

motivations—including dishonesty that serves a necessary clinical aim, such as “tact”—or perceived consequences of this dishonesty.

Purpose of the Current Study

The purpose of this dissertation is to make methodological improvements to the previous research to better explore the prevalence, motivations, and consequences of therapist dishonesty and understand its effects on therapy itself. Specific improvements to the original PATCH survey addressed shortcomings in the survey design and content, based on feedback from participants and our lab’s experiences working with the data collected from the original PATCH survey, all of which will be detailed in the following sections. It is believed that a better understanding of the ways in which dishonesty is utilized by therapists in clinical practice will benefit the field of psychology by increasing awareness and informing practice regarding the short- and long-term consequences of dishonesty on therapy process and outcome. Despite the paucity of existing research on the topic of therapist dishonesty, existing anecdotal evidence and the results of our initial PATCH survey suggest that therapists, like individuals in any interpersonal situation, are occasionally dishonest, highlighting a need for further research to inform psychotherapy training and practice.

The current study collected data using a three-part online survey distributed to psychotherapists across the United States and internationally. The revised survey (see Appendix C) is based on our lab’s original PATCH survey, modified according to the observed limitations and feedback discussed above. The revised survey is designed to collect data on the frequency of therapist dishonesty on a total of 26 topics, with one new topic added to the previous list of 23 (i.e., feeling bored in session), and two previous topics split into two (i.e., knowledge of *someone*

and knowledge of *something*, and feeling *physically unwell* and feeling *emotionally unwell*), and one topic (i.e., physical or mental health) replaced (i.e., mental health history). The most substantial addition to this revised survey is the addition of a qualitative third section, designed to capture the motivations and perceived consequences of therapist dishonesty. To this end, the revised survey provides participants with an opportunity to describe, in their own words, the most recent time when they recall having been less than completely honest with a client. In addition to describing it as they remember it, this question also asks participants to recall their feelings at the time, their reasons for being less than completely honest (e.g., tactfulness, shame, etc.) and what, if any, consequences followed. Each of the three parts of the survey will be described in detail below.

Research Questions

This study explores an area that remains virtually untouched by previous research, and as such, no a priori hypotheses have been generated. In sum, the current study seeks to understand the following:

Research question 1. How often are therapists less than completely honest with their clients?

Research question 2. About what topics are therapists more likely to be less than completely honest with their clients?

Research question 3. Are some therapists (e.g., certain clinical specialties or theoretical orientations) more likely to engage in dishonesty than others?

Research question 4. For what reasons are therapists more likely to be less than completely honest with their clients?

Research question 5. According to therapists, what consequences, if any, does therapist dishonesty have on the delivery and outcome of the therapy itself?

Method

This study consists of an analysis of the data collected using the Psychotherapists Assessment of Tact, Concealment, and Honesty II (PATCH2) survey by the Psychotherapy, Affirmation, and Disclosure Lab at Teachers College, Columbia University. The data used for this study were collected by means of an online survey in order to both obtain a sample with the most possible participants from a geographically diverse population and to provide participants with an anonymous medium to maximize comfort discussing a potentially sensitive subject. Data were collected from April 3rd, 2019 to May 18th, 2019.

Participants

The PATCH2 survey includes a total of 401 participants who completed at least 90% of the survey and are current practicing psychotherapists or psychotherapy trainees. Participants range in age from 22 – 88 years ($M = 46.25$, $SD = 15.59$) and 72.8% are female ($n = 292$). A total of 47 states are represented (all but Montana, South Carolina, and Wyoming), in addition to 11% international participants ($n = 44$) from 11 countries and 1 U.S. territory (Canada, Switzerland, Germany, Brazil, China, Australia, Chile, Ecuador, England, Greece, and Puerto Rico). The majority of participants are heterosexual (82.0%), with 6.0% gay/lesbian, 9.2% bisexual, and 2.7% self-identifying as other. Most participants are married (63.3%), and 19.5% are single, 17.0% in a relationship. Participants are 83.3% White ($n = 334$), 4.2% Hispanic/Latino ($n = 17$), 4% Asian/Asian American ($n = 16$), 2.5% Black or African American

($n = 10$), 1% preferred not to say ($n = 4$), and 5% self-identified as other ($n = 20$). This sample is representative of the current ethnicity, age, and gender demographics of psychotherapists in the United States, of which 84% are White, 5% Hispanic, 4% Black/African American, 4% Asian, 2% other, mean age 50, median age 49, 65% women (American Psychological Association, 2018).

Most participants (62.6%) work in private practice ($n = 251$), 102 work in a clinical or hospital (25.4%), and 48 work in a combination of private practice and clinic or hospital settings (12%). Participants report a wide array of highest degree types, with the majority having completed a Ph.D. (29.9%, $n = 120$), 21.2% a licensable M.A. ($n = 85$), 15.2% M.S.W. degree ($n = 61$), 10.7% current graduate students in mental health programs ($n = 43$), 9.5% a Psy.D. degree ($n = 38$), 5.7% M.D. (23%), and 7.7% indicating “other” ($n = 31$). A significant minority of participants also report having graduated from, or being currently enrolled in, a post-doctoral or post-degree training program (29.7%, $n = 119$). Participants’ years of practice experience range from 1 to 53 years ($M = 16.48$, $SD = 12.66$). The most popular primary modalities among respondents are Psychodynamic Psychotherapy (29.9%, $n = 120$) and Cognitive Behavioral Therapy (29.2%, $n = 117$), but many other modalities and theoretical orientations are represented, including Integrated/Eclectic Psychotherapy (21.2%, $n = 85$), Humanistic Therapy (5.5%, $n = 22$), Dialectical Behavior Therapy (4.2%, $n = 17$), Interpersonal Therapy (2.0%, $n = 8$), and other (8.0%, $n = 32$). The majority of participants self-reported no primary clinical specialty (44.1%, $n = 177$), but some specialties were reported, namely, trauma (14.2%, $n = 57$), children/adolescents (7.7%, $n = 31$), anxiety (6.5%, $n = 26$), addiction (5.2%, $n = 21$), relationships/couples counseling (4.5%, $n = 18$), depression (2.2%, $n = 9$), Borderline Personality (1.0%, $n = 4$), and other (14.5%, $n = 58$). Most participants are not currently in their own

psychotherapy (63.6%, $n = 255$) and a little less than half are currently in supervision (43.1%, $n = 173$).

A comparison of individuals who completed at least 90% of the survey ($n = 401$) and those who dropped out ($n = 133$) showed that completers were more likely to be in private practice or in both private practice and working in a hospital or clinical setting ($p = .005$), to have a Ph.D. ($p < .001$), to have no clinical specialty ($p = .003$), and not be in supervision ($p < .001$), while dropouts were more likely to work in a hospital or clinical setting, have a Master's level degree, have some clinical specialty, and to be in supervision.

Data Collection Procedures

Approval obtained for the current study. A proposal for this study, including a copy of the survey and informed consent document, was submitted to the Institutional Review Board at Columbia University Teachers College and was approved on March 19, 2019. The study was exempted from further committee review because the information obtained by the survey is recorded such that the participants remain anonymous.

Collection of original data. Participants were recruited by contacting over 4,000 individual email addresses collected from online business listings on Google Maps and Psychology Today. Participants were also recruited internationally (i.e., Western and Central Europe & China). Email addresses of therapists from these regions were collected via the websites of region-specific psychology organizations and unions as well as psychology departments of prominent research universities. Recruitment emails were sent in batches using Constant Contact, an email marketing service for creating and sending personalized emails to large numbers of email addresses. In addition, individual recruitment emails were sent to clinical

and counseling psychology training directors and to coordinators at institutes, associations, and various psychology groups, societies, and listservs throughout the United States and internationally. The survey was also posted on several closed Facebook groups for therapists and therapist trainees.

The recruitment email, entitled “Psychotherapy Honesty Study,” was sent from a Columbia University Teachers College email account set up specifically for the purposes of the PATCH project and invited practicing therapists to participate in a survey for a new research project on therapist honesty. A link to the survey was included in the body of the email, which took participants to the online survey, beginning with the Informed Consent document, including a list of questions and answers about the study, and contact information for the principal investigator and faculty advisor. The recruitment email, informed consent, and full survey can be found in Appendices A, B, and C, respectively.

Anonymity of participants was maintained throughout the study by not asking for names or other identifying information. All collected data were kept on a password protected computer at all times. At the conclusion of the survey, participants were given the option to provide their contact information to participate in a follow-up interview on the subject of therapist honesty by clicking a link that would bring them to a separate, unattached, survey in order to protect their identities. All participants were provided with contact information for the principal investigator and faculty advisor for the study, Dr. Barry Farber, and were encouraged to contact him with any questions, comments, or concerns.

Measures

The Psychotherapists Assessment of Tact, Concealment, and Honesty (PATCH2) is an online self-report survey created using the Qualtrics web-based survey development platform. The survey consists of three parts with a total of 73 quantitative and qualitative questions and had a median completion time of 17.42 minutes. Part I consists of 15 standard demographic questions (e.g., age, gender, ethnicity, etc.) and therapist-specific questions (e.g., clinical work setting, highest degree type, number of clients, number of years in practice, country and/or state(s) in which they practice, primary modality, and primary clinical specialty (if any)). Participants are also asked to report whether they are currently in their own psychotherapy and whether they are currently in supervision.

While very similar to the demographic section of the original PATCH survey, certain questions in this section of the revised survey have been altered to address the shortcomings described above. For example, while the previous version of the survey allowed participants to check every modality in which they currently practice, the revised survey asks participants to indicate their *primary* modality. Similarly, while the original survey provided participants with an open text box to describe their primary clinical specialty (if any), the revised survey provides a list of options based on the responses collected from the original survey (e.g., addiction, anxiety, children/adolescents, etc.), in addition to an “other” option, which allows participants to provide their own text if desired. The format of the demographic questions on the original PATCH survey was highly beneficial to our initial exploratory research; however, these changes to the format allow for cleaner analyses when looking for relationships between demographics and prevalence of therapist dishonesty.

Part II consists of a list of 26 clinical situations in which therapists might be less than completely honest, derived from the list of 23 topics used in the original PATCH survey with some changes discussed below. Each topic is presented in a two-part question: the first question asks participants to report if they have ever given a client the impression of something that was less than completely true (e.g., “Have you ever given a client the impression that you were paying attention when in fact you weren’t?”); the second question asks participants if they have ever explicitly told a client something that was less than completely true (e.g., “Have you ever explicitly told a client that you were paying attention when in fact you weren’t?”). Participants are asked to provide their answers using a 7-point Likert scale (1 = Never, 4 = Sometimes, 7 = Frequently), as well as an “N/A” option that states “This has not come up for me.” The N/A option was added since the original PATCH survey to address concerns that participants who had never encountered a particular situation (e.g., those who had never been sexually attracted to a client) were selecting “1 = Never,” giving the impression that they had only ever been completely honest in that situation, when in actuality it had not come up for them in their practice. Without an “N/A” option present for individuals for whom a particular situation had not come up, it is likely that the data contained depressed means as a result. By altering the question format to differentiate between participants who had never encountered a particular situation and participants who had only ever been completely honest in that situation, it was anticipated that the results may differ from the original PATCH survey.

As noted previously, the PATCH2 survey includes three more questions in this section than the previous version, due to adding a question about boredom and splitting two original questions into two. Specifically, the original question that asked about “knowledge of someone or something” was split into “knowledge of someone” and “knowledge of something” and the

original question that asked about “physical or mental state” was split into individual questions about “feeling physically unwell” and “feeling emotionally unwell.” These changes were based on feedback from participants in response to the original PATCH survey.

In order to gain a more in-depth look at therapists’ own perceptions of their use of dishonesty, Part III of the survey consisted of an entirely new qualitative section. Unlike the existing survey questions, which ask participants to rate a series of predetermined clinical situations, this section asked participants to recall and describe the most recent time when they were less than completely honest with a client. This approach provided a look at the types of dishonesty therapists recall occurring most recently, as well as their perspectives on the motivations and consequences of the dishonesty. By asking for the most recent example, rather than a most memorable example, we hoped to capture the most common or day-to-day examples of therapist dishonesty, as opposed to the most sensational.

Participants were first asked to describe the situation in detail as they remember it. Participants were then provided with a set of follow-up questions asking them to elaborate, if they have not already, on their reasons for being less than completely honest, the feelings they experienced, the immediate consequences of their decision, the later consequences of their decision, and whether they would handle the situation any differently today. Each of these open-ended questions provided a text box for free-form written responses.

Responses to all open-ended questions were coded using an adapted “grounded theory” approach to qualitative research, a method that seeks to identify substantive and formal theories that emerge from textual responses by means of the researcher becoming “grounded” in the data, reading the material, and identifying themes by selecting intuitive textual examples (Denzin & Lincoln, 1994, pp. 782-3). Due to the dearth of existing literature on the topic, the data were

coded using a version of Glaser's method of grounded theory that borrows from a consensual qualitative research approach, keeping the reading of the data broad in order to sensitize the researcher to a wide variety of possible themes in the data (Heath & Cowley, 2004; Hill, Thompson, & Williams, 1997). According to Glaser's approach, specifying what the reader wants to know about therapist dishonesty could result in the researcher's preconceptions bending the research towards the researcher's experiences (Heath & Cowley, 2004). Informed by Glaser's approach, codes were developed via a consensual coding scheme after the responses were collected, focusing on the nature of the situations (e.g., type of client, type of treatment, etc.), motivations, and consequences that participants described. Similar methods, including a comparable adaptation of grounded theory, have been previously used in psychotherapy research to construct comprehensive interpretations of qualitative data (Elliott et al., 1994). Further description of the coders and coding scheme is provided in a later section of this chapter.

As with the original PATCH survey, the revised survey concludes with two follow-up questions about honesty. The first asked participants to indicate on a 7-point Likert scale how self-disclosing they are with clients in session (where 1 = Not very self-disclosing; 4 = Somewhat self-disclosing; and 7 = Very self-disclosing). The second question asked participants to indicate how honest they feel they have been in completing the survey (where 1 = Not very honest; 4 = Somewhat honest; and 7 = Very honest).

Data Analysis Procedures

To assess how often therapists are less than completely honest with their clients (**research question 1**) and about what topics therapists are more likely to be less than completely honest with their clients (**research question 2**), descriptive statistics were performed on the 26

items contained in the survey to determine the most frequent and infrequent topics of therapist dishonesty.

Next, to explore whether some therapists (e.g., certain clinical specialties or theoretical orientations) are more likely to engage in dishonesty than others (**research question 3**), latent class analyses (LCAs) were performed to identify possible classes in the data, representing patterns in dishonesty among therapists. Because the PATCH2 survey included an “N/A” option, this response needed to be recoded in a way that would not significantly positively or negatively impact the results of the LCA, but would provide numerical values for these responses in order to run the analyses. The N/A responses were automatically coded in Qualtrics with numerical values of “8,” which would have positively skewed our results had they been left in this format. To address this, each response of “8” was removed and excluded from the analysis. The classes that emerged from the LCAs were then explored to identify possible differences in their demographics based on the participants’ responses to the demographic portion of the survey. In order to explore the reasons that therapists give for being dishonest (**research question 4**), and therapists’ perceived consequences of their dishonesty (**research question 5**), the open-ended text responses were coded using the “grounded theory” approach of qualitative research described above.

Results

Descriptive Statistics Results for Research Questions 1 and 2

This study first sought to answer the following questions: How often are therapists less than completely honest with their clients?; About what topics are therapists more likely to be less than completely honest with their clients?

Most frequent topics of covert dishonesty. As Table 3 indicates, the top three “covert” lies (i.e., topics about which therapists did not correct a client’s misperception) were about feeling emotionally unwell ($M = 3.60, SD = 1.66$), feeling physically unwell ($M = 3.54, SD = 1.66$), and feeling frustrated ($M = 3.35, SD = 1.44$).

Most frequent topics of overt dishonesty. As Table 4 indicates, top three “overt” lies (i.e., topics about which therapists reported actively saying something less than completely true) were about availability ($M = 2.57, SD = 1.51$), feeling emotionally unwell ($M = 2.41, SD = 1.67$), and feeling physically unwell ($M = 2.40, SD = 1.58$).

Least frequent topics of covert dishonesty. The bottom three “covert” lies were identical to the “overt,” about training or credentials ($M = 1.14, SD = 0.47$), hourly rate or fee structure ($M = 1.20, SD = 0.65$), and clients’ diagnoses ($M = 1.58, SD = 0.92$).

Least frequent topics of overt dishonesty. The bottom three “overt” lies were about their training or credentials ($M = 1.04, SD = 0.26$), their hourly rate or fee structure ($M = 1.16, SD = 0.58$), and clients’ diagnoses ($M = 1.26, SD = 0.64$).

To determine whether there was a significant difference between therapists’ reported use of covert and overt dishonesty, a paired-samples t-test was conducted to compare therapists’ reported overall covert dishonesty (summed across all items) to their reported overall overt dishonesty (also summed across all items). There was a significant difference in the overall scores for use of covert dishonesty ($M = 55.93, SD = 18.02$) and overt dishonesty ($M = 40.65, SD = 15.39$); $t(400) = 32.27, p = .000$.

Latent Class Analyses Results for Research Question 3

This study next sought to answer the following question: Are some therapists (e.g., certain clinical specialties or theoretical orientations) more likely to engage in dishonesty than others? Following the same procedure as the initial PATCH survey, Latent Class Analyses (LCAs) were performed to identify possible patterns in dishonesty among therapists with different demographics (i.e., training, modality, years in practice, etc.). Consistent with the results of the original PATCH survey—and as indicated in Figure 1 and Figure 2—two classes emerged for both types of dishonesty (i.e., overt and covert): a class of therapists who acknowledge dishonesty relatively infrequently (the “lower lying” class: Class 1), and a class of therapists who acknowledge dishonesty relatively frequently (the “higher lying” class: Class 2). Analyses again revealed significant differences between the two classes on certain demographics, for both overt and covert dishonesty.

Regarding overt dishonesty, LCA revealed two distinct classes of therapists: a lower lying class (Class 1) and a higher lying class (Class 2). These two classes differed significantly across all 26 items in the survey, with members of Class 1 consistently reporting lying less frequently on all 26 topics when compared to Class 2. Analyses revealed significant differences between the members of these two classes on several demographics. Specifically, members of the “higher overt lying” class were significantly younger and had been practicing for less time than their counterparts in the “lower overt lying” class. In addition, when compared to the “lower overt lying” class, members of the “higher overt lying” class were more likely to have a master’s than a doctorate, less likely to practice CBT than psychodynamic psychotherapy as their primary

modality, and more likely to have identified “addiction” and “other” as their clinical specialty than “no specialty.”

Specifically, therapists with a master’s degree were 2.89 [95% CI 1.38 - 6.07] times more likely to be in the “higher overt lying” class than those with a doctoral degree. Therapists who were practicing CBT as their primary modality [Exp(B) = 0.41, 95% CI 0.17 - 0.99, $p = 0.04$] were significantly less likely to be in the “higher covert lying” group when compared to those who were primarily practicing psychodynamic therapy. Therapists who identified “other” as their clinical specialty were 3.30 [95% CI 1.37 - 7.96] times more likely to be in the “higher overt lying” class than those who identified “no primary specialty.” Therapists who identified “addiction” as their clinical specialty were 5.43 times more likely to be in the “higher overt lying” class than those who identified “no primary specialty.” Therapists in the “lower overt lying” class were significantly older ($M = 47.02$, $SD = 15.71$) than those in the “higher overt lying” class ($M = 41.50$, $SD = 14.01$). Therapists in the “lower overt lying” class had significantly more years of clinical practice ($M = 17.07$, $SD = 12.93$) when compared to those in the “higher overt lying” class ($M = 12.82$, $SD = 10.16$).

Regarding covert dishonesty, LCA again revealed two distinct classes of therapists: again, a lower lying class (Class 1) and a higher lying class (Class 2). As with the overt dishonesty, these two classes differed significantly across all 26 items, with members of Class 1 lying consistently less frequently than members of Class 2. The profiles of these two groups again differed significantly on certain demographics. Again, members of the “higher covert lying” class were significantly younger and had been practicing for less time than their counterparts in the “lower covert lying” class. Members of the “higher covert lying” class were also significantly more likely to be in supervision, more likely to work in a clinic or hospital, less

likely to practice CBT than psychodynamic as their primary modality, and less likely to have trauma as a clinical specialty.

Specifically, therapists in the “lower covert lying” class (60.9%) were significantly more likely to not be in supervision ($p < .05$) when compared to therapists in the “higher covert lying” class. Therapists who practice in a clinic or hospital were 3.30 [95% CI 1.42 – 7.7] times more likely to be in the “higher covert lying” class than therapists who practice in both clinics/hospitals and private practice. Therapists who identified their primary modality as “other” were significantly less likely to be in the “higher covert lying” class ($p < 0.05$) when compared to therapists who primarily practice psychodynamic psychotherapy. Therapists who primarily practice CBT were significantly less likely to be in the “higher covert lying” class ($p < .05$) when compared to those who primarily practice psychodynamic psychotherapy. Therapists who identified “trauma” as a clinical specialty were significantly less likely to be in the “higher covert lying” class ($p < 0.05$) than those who reported no clinical specialty. Therapists in the “lower covert lying” class were significantly older ($M = 48.31$, $SD = 15.70$) than those in the “higher covert lying” class ($M = 41.40$, $SD = 14.24$). Therapists in the “lower covert lying” class had significantly more years of clinical practice ($M = 17.87$, $SD = 12.98$) when compared to those in the “higher covert lying” class ($M = 13.20$, $SD = 11.25$).

Other patterns also emerged: the “lower overt lying” class differed significantly from the “higher overt lying” class based on their covert lying behaviors. In other words, members of the “lower overt lying” class ($n = 345$) were significantly more likely to also be members of the “lower covert lying” class (80.6%), when compared to members of the “higher covert lying” class (19.4%). Likewise, members of the “higher overt lying” class ($n = 56$) were significantly

more likely to also be members of the “higher covert lying” class (94.6%), when compared to members of the “lower covert lying” class (5.4%).

Results of a Grounded Theory Analysis for Research Question 4

This study next sought to answer the following question: For what reasons are therapists more likely to be less than completely honest with their clients?

Structure of the qualitative data. Of the 341 therapists (85% of the total sample) who completed the qualitative section of the survey (i.e., provided a response to the prompt to recall and describe the most recent time when they were less than completely honest with a client in session), all provided a response to the prompt to describe their reasons for being less than completely honest (research question 4). The 341 responses to this question were coded into one of eight mutually exclusive content categories. The number of respondents endorsing each of these eight motives is presented in Table 7. Sample quotations drawn from text entered by respondents are provided for each motive.

Code and Category Descriptions. The following sections describe each of the eight mutually exclusive categories, including language provided to coders in the codebook. Raw qualitative data were coded using a version of a grounded theory coding scheme similar to that of Elliott et al. (1994), which borrowed from both consensual and grounded theory approaches (Elliott et al., 1994; Levitt, 2015). Initial thematic codes (at most 5) were assigned to a single meaning unit one variable at a time with the intention of accurately and succinctly encapsulating meaning. Following this step, the code group—consisting of graduate research assistants at Teachers College, Columbia University—cross analyzed all initial codes per variable in order to develop a final set of consensually agreed upon concepts. The coding group was comprised of

four coders and one auditor (two international students and three American); moreover, coders represented a diversity of identities, including sexual and racial/ethnic minority identities. The final step of the coding process produced a codebook of categories informed by apparent trends and similarities among the consensually agreed upon concepts. The codebook was then used to attribute raw data points to specific categories. Eight categories emerged from this process: Treatment strategy; harmful to patient; self-preservation; bond; legal/ethical; focus on patient; unbeneficial to patient; and impression management.

Treatment Strategy. A plurality (20.5%) of respondents reported motives for dishonesty relating to treatment strategy (e.g., “Being less-than-honest was deliberately part of the treatment for this patient; this lack of honesty was strategic and necessary for treatment; this includes the ‘blank slate,’ ‘analytic abstinence,’ or ‘transference’ aspect in which a therapist believes it would break the frame to be honest about this. I wanted to encourage the patient to progress”).

Harmful to Patient. The second most common (18.8%) reported reason for dishonesty was related to concerns about potential harm to the client (e.g., “I wanted to protect the patient’s feelings. Being honest about this would result in more harm than good for the patient or for the treatment”). Meaning units which suggested that an expression of honesty in the given therapeutic context would not warrant the risk of harming the patient’s feelings or safety were attributed to this category.

Self-Protection. The third most common reason (15.8%) was related to self-protection on the part of the therapist (e.g., “I wanted to protect myself and my capacity as a therapist in this situation”). Meaning units were attributed to this category if they suggested that being less than completely honest with a patient was justified in order for the therapist to protect his or her own wellbeing, safety, and/or livelihood.

Bond. The fourth most common reason (13.2%) was related to concerns about compromising the bond or therapeutic alliance (e.g., “I did not want to compromise the bond or the nature of the therapeutic alliance”). This category and the aforementioned category (i.e., “harmful to patient”) may be understood as two sides of the same coin, with the central focus of this category being the preservation or strengthening of rapport.

Legal/Ethical. The fifth most common reason (9.4%) had to do with concerns about legal or ethical issues related to the client or the client’s confidentiality (e.g., “I was concerned about legal or ethical issues related to this patient, or the patient’s confidentiality”).

Focus on Patient. The sixth most common reason (9.1%) was about wanting to keep the focus of the treatment on the client (e.g., “I wanted to keep the focus of the treatment on the patient. In order to keep the focus on the patient, I redirected conversation back to the patient”).

Unbeneficial to Patient. The seventh most common reason (8.2%) was related to a belief that the truth was not relevant to treatment or would not benefit the client’s progress at that time (e.g., “This was not relevant to treatment. Being truthful about this would not benefit the patient’s progress at this time”).

Impression Management. The least common reason (5%) was about wanting to protect the client’s image of the therapist (“I wanted to protect the patient’s image of me”). Although not as frequent a category assigned, the diversity of circumstances encapsulated by this code was notable. While some respondents felt that an expression of honesty might call their expertise into question (e.g., “I felt that he would doubt me as a clinician if I were honest”), others felt that being less than completely honest was a means of controlling a given patient’s view of them on a more personal level (e.g., “Sometimes to seem a little cooler to teens…”).

Results of a Grounded Theory Analysis for Research Question 5

Lastly, this study sought to answer the following question: According to therapists, what consequences, if any, does therapist dishonesty have on the delivery and outcome of the therapy itself?

Structure of the qualitative data. As above, all 341 therapists (85% of the sample) who completed the qualitative section of the survey (i.e., provided a response to the prompt to recall and describe the most recent time when they were less than completely honest with a client in session) provided a response to the prompt to describe the immediate and later consequences of this decision. Responses to these questions were coded into one of five content categories for both immediate and later consequences. The number of respondents endorsing each of these five immediate consequences is presented in Table 8 and the same for later consequences is presented in Table 9. Sample quotations drawn from text entered by respondents are provided for each immediate and later consequence.

Code and Category Descriptions for Immediate Consequences. The following sections describe each of the five mutually exclusive content codes, including language provided to coders in the codebook. The coding scheme for these data was identical to the process described for the analysis of data pertaining to reasons for being less than completely honest (i.e., research question 4). Five categories emerged from the data: none; positive consequences; negative consequences; unsure; and too soon to tell. A particularly salient point became apparent during the coding of this variable: the distinction between the categories “unsure” and “too soon to tell.” Although conceptually similar, differentiation between these categories was ultimately made because of a discernible trend in language among raw data that emphasized the

temporal relationship between being less than completely honest to a patient and its effects on a therapeutic relationship.

None. The most common response from therapists (46%) was that there was no immediate consequence of their dishonesty in session (e.g., “This did not lead to any interruption in session; the patient kept moving on and continued to speak (also: there were no immediate consequences to this moment of less-than-complete honesty)”).

Positive Consequences. The second most common reported immediate consequence (33.5%) was that the consequence was a positive one (e.g., “This disclosure led to a stronger patient-therapist bond or a better treatment outcome”).

Negative Consequences. The third most common reported immediate consequence (14.3%) was that the consequence was a negative one (e.g., “This disclosure led to termination, defensiveness, a rupture, or any general negative response to treatment on the side of the patient”).

Unsure. The fourth most common reported immediate consequence (5.5%) was that they were unsure about the immediate consequences (e.g., “It is unclear what the consequences were, or generally, therapist is unclear about the consequence”).

Too Soon to Tell. The least common reported immediate consequence (1.1%) was that it was too soon to tell (e.g., “It is too soon to tell the immediate consequences of this disclosure”).

Category Descriptions for Later Consequences. The following sections describe each of the five mutually exclusive categories, including language provided to coders in the codebook. The coding scheme for these data was identical to the process described for the analysis of data pertaining to reasons for and immediate consequences of being less than completely honest. Five

categories emerged from the data: none; unsure; positive consequences; negative consequences; and negative feeling/discomfort.

None. The most common response from therapists (46%) was that there were no later consequences of their dishonesty in session (e.g., “This did not lead to any interruption in session; there were no distal consequences to this moment of less-than-honest disclosure”).

Unsure. The second most common response from therapists (23%) was that they were unsure about the later consequences (e.g., “It is unclear what the consequences were, or generally, therapist is unclear about the consequences”).

Positive Consequences. The third most common response (15.6%) was that the consequence was positive (e.g., “this disclosure led to a stronger patient-therapist bond or a better treatment outcome; also applies to amicable termination or strengthening of bond”).

Negative Consequences. The fourth most common response (12.6%) was that the consequence was negative (e.g., “this disclosure led to termination, defensiveness, a rupture, or any general negative response to treatment on the side of the patient, loss of clients”).

Negative Feeling/Discomfort. The least common response (6.6%) was that the consequence resulted in negative feelings or discomfort for either the patient or the therapist (e.g., “led to the therapist’s feeling of discomfort”). This category is differentiated from “Negative Consequences” via its emphasis on the affective state of the patient or therapist.

Discussion

The purpose of this study was to make methodological improvements to the previous research to better explore the prevalence, motivations, and consequences of therapist dishonesty as perceived by therapists themselves. A sample of 401 therapists provided Likert-style

responses reporting how often and about what they had ever been less than completely honest with clients in therapy. Among this sample, 341 (85%) additionally provided open-ended responses describing an event and their reason(s) for and perceived consequence(s) of being less than completely honest with their clients in session.

Therapist dishonesty is a present and likely consequential phenomenon in psychotherapy, and one which has remained virtually unexamined. Identifying the presence of and extent to which therapists report being less than completely honest with their clients in session is critical to developing a more complete picture of the process of psychotherapy. Similarly, identifying the topics about which therapists report being most frequently dishonest (and, conversely, those about which they are almost never dishonest) is critical to understanding the times in therapy when therapists feel uncomfortable being completely candid, or even times when they feel inclined to deliberately mislead their clients. Identifying and appreciating the reasons behind therapists' decisions to be less than completely honest with certain clients or in certain situations is critical to developing effective interventions and guiding clinical training. And importantly, understanding the impact of these decisions is essential to understanding the process and outcome of psychotherapy itself. To that end, this study examined the topics about which therapists are more and less likely to be less than completely honest with their clients, looked for factors affecting the likelihood of the use of therapist dishonesty, and asked therapists to describe their reasoning and perceived consequences of these decisions.

Most therapists have been dishonest with their clients

The first major finding of this study is that most psychotherapists reported having been dishonest with their clients about a variety of topics at least once. As indicated in Table 10, a vast majority of therapists reported having been *covertly* dishonest with their clients at some

point: 91.5% of therapists reported having given a client the impression that they were paying attention when they were not, 88% of therapists reported having given a client the impression that they were not available for a session when in fact they were, and 84.5% of therapists reported having given a client the impression that they were making clinical progress when they did not think that was true. Fewer, yet still a majority, of therapists reported having ever been *overtly* dishonest with their clients. As indicated in Table 11, 65.6% of therapists reported having explicitly told a client something untrue about their own mental health history, 63.6% of therapists reported having explicitly told a client that they were not available for a session when in fact they were, 59.4% of therapists reported having explicitly told a client something untrue about his or her diagnosis, and 55.4% of therapists reported having been explicitly dishonest with a client about his or her reasons for being late to session. The reported ubiquity of the use of dishonesty by therapists in session speaks to the importance of understanding therapist dishonesty as a fairly commonplace occurrence in the process of psychotherapy.

The reported majority of therapists who have been dishonest with their clients about whether they were paying attention (i.e., who led their clients to believe they were paying attention when they were not) echoes findings from research on fatigue and burnout in psychotherapists. Burnout is widely regarded as a significant work-related problem for psychotherapists (Baker, 2003; Bearse, McMinn, Seegobin, & Free, 2013; Lee, Lim, Yang, & Lee, 2011). Research by Simionato & Simpson (2017) found that over half of the psychotherapists they surveyed reported moderate to high levels of work-related burnout, with the related risk-factors being younger age, having less work experience, and “being overinvolved in client problems” (p. 1431), which again align with the findings of the present study.

However, regardless of a therapist's general level of burnout, occasional lapses in attention are a perfectly normal part of therapeutic practice, especially when considering current trends in therapists' increasingly busy daily schedules. Norcross and Guy (2007) describe the often-jam-packed days of the average therapist in their book *Leaving it at the Office: A guide to psychotherapist self-care*, "All [psychotherapists] are working overscheduled lives. Skimping on breakfast, probably skipping lunch, existing on snack foods during the day on the run. Running nearly on empty, subclinically exhausted. Little time for self or loved ones. In a success-driven culture hostile to rest and self-care, many psychotherapists have lost the balance, priorities, and mission they once treasured. *Quis custodiet ipsos custodiet?* (Who will guard the guards?)" (p. 15). Despite existing research emphasizing the importance of periodic breaks throughout the day to optimize one's quality of work and wellbeing (Carroll et al., 1999; Kottler, 1993; Shoyer, 1999), many therapists have opted to maximize their workdays and billable hours by seeing clients back-to-back, without even 10-minute breaks between their sessions (Norcross & Guy, 2007). The commonness of overscheduling and related fatigue in the field of psychotherapy aligns with the current finding that many therapists find themselves losing focus in sessions with clients and feeling inclined to cover up or deny their lapses in attention.

On the other hand, a lack of attention with a client in session may be attributable to more than just the therapist's fatigue, and in fact may serve as a defense on the part of the therapist, which deserves consideration of its own. In their book *What Therapists Don't Talk About and Why*, Pope et al. (2006) identify therapist "boredom and drowsiness as protective factors," or "a possible clue to unacknowledged feelings or issues" on the part of the therapist. In some situations, they explain:

The therapist finds it hard, if not impossible, to pay attention to what a patient is saying. The patient's words seem to deflect the therapists' awareness to the physical aspects of the consulting room, to memories of the day's events, to anticipation of patients scheduled for later in the day or week, or to daydreams and fantasies that seem completely unrelated to the patient. Sometimes a patient seems to induce a drowsiness that falls over the therapist session after session. Each session seems interminable. The clock face is frozen. No matter how alert and engaged the therapist was during the previous patient's session or will be during the subsequent patient's session, the therapist feels drugged, comatose, daunted by the seemingly impossible tasks of concentrating and keeping his or her eyes open. The emotional numbness associated with sustained boredom or drowsiness that recurs from session to session with a particular patient may be a clue that the therapist is on some level fighting against awareness of taboo topics or acutely uncomfortable feelings or impulses. Picking up the clue for careful examination, of course, may be difficult in light of the dulled nature of the therapist's customary alertness and by the prospect that examination will lead to direct awareness of uncomfortable feelings or impulses (pp. 81-82).

This observation highlights the importance of honest introspection on the part of the therapist to consider the possible reasons behind his or her distraction for the sake of improving the therapy itself. Honest self-reflection and communication in therapy with clients about what may be going on dynamically is likely to be an important part of effective therapeutic intervention and clinical progress.

The high percentage of therapists who reported having been dishonest with their clients about their clinical progress brings up questions about what therapists believe their fundamental

roles in therapy to be: stewards of complete honesty, purveyors of hope, or a delicate balance between the two. Hope has been acknowledged as an important contributory factor to effective psychotherapy (Babits, 2001; Bergin & Walsh, 2005; Duncan, Hubble & Miller, 1997; Shabad, 2001; Yalom, 1989). While the ethics of instilling false hope in non-psychiatric medical settings has been addressed by extant literature and largely regarded as unethical, the ethics of instilling hope in psychotherapy remains largely unvisited. In fact, the instillation of hope has been established as a critical and common tenet in most—if not all—modalities of psychotherapy (Frank, 1961, 1968, 1971, 1973, 1989). Dembo and Clemens (2013) reflected on this dilemma, explaining:

Clinical psychological studies on depressive realism and optimistic bias indicate that some degree of positive bias, referred to by some authors as “the optimal margin of illusion,” is in fact necessary to promote what we define as “good mental health;” conversely, stark realism is correlated with mild to moderate depression. An examination of the existential literature, including Ernest Becker’s work, *The Denial of Death*, indicates that without the defense mechanism of denial, human beings tend to experience paralytic despair as a result of being fallible, mortal creatures in a frightening world. The combination of these diverse bodies of literature, along with the surprising outcomes of our case examples, leads to an unexpected conclusion: it may occasionally be ethical to encourage some degree of optimistic bias, and perhaps even positive illusion, when treating patients in psychotherapy (p. 316).

Hope serves to help clients identify their goals and understand their feelings related to achieving those goals (Snyder and Taylor, 2000). With this in mind, Snyder and Taylor (2000) recommend:

As such, perhaps students who are learning psychotherapy could profit by first learning the hope-based common foundation and thereafter proceeding to in-depth training in the particular empirically validated form of treatment that matches their personal style. After all, when it comes to imparting hope, everyone—therapists and, more importantly, clients—can share in the success (p. 103).

Therapist dishonesty exists, but is not especially common

The second major finding of this study is that psychotherapists report only occasional, relatively infrequent, use of dishonesty with their clients in session. Specifically, although most therapists reported having been dishonest with their clients at least once, even the topics with the highest mean frequencies for both covert dishonesty (“Feeling Emotionally Unwell” $M = 3.60$, $SD = 1.66$) and overt dishonesty (“Availability,” $M = 2.57$, $SD = 1.51$) scored below the midpoint (i.e., 4 = “Sometimes”). In other words, even the most frequent topics for both covert and overt therapist dishonesty are not terribly frequent. It is worth noting that it is possible that the therapists who participated in the survey underreported the frequency of their use of dishonesty in session, as self-reports, particularly ones assessing behaviors that are socially undesirable or illegal, often result in underreporting of these behaviors (Chan, 2009). However, a meta-analysis by Gnambs and Kaspar (2014) indicated that anonymous computerized surveys, such as the survey used in this study, elicit significantly more reporting of “socially undesirable behaviors” (such as lying) when compared to anonymous paper surveys. Thus, although it is possible that these numbers reflect a minimization in reporting by the therapists in this study, it is likely that these results provide a relatively accurate view of therapists’ use of dishonesty with their clients.

Therapists report more covert lies than overt ones

As noted above, the mean frequency reported by therapists for the most common topic of covert dishonesty (“Feeling Emotionally Unwell”) was 3.60 ($SD = 1.66$), on a 7-point Likert scale (where 1 = Never; 4 = Sometimes; 7 = Frequently), while the mean frequency for the most common topic of overt dishonesty (“Availability”) was only 2.57 ($SD = 1.51$), on the same scale. In other words, therapists reported being more likely to be covertly dishonest with their clients (e.g., to passively allow a client to believe something that is not true) than to be overtly dishonest with them (e.g., to actively say something that is not true). As previously mentioned, a paired-samples t-test found that, overall, therapists reported being significantly more likely to be covertly dishonest with their clients than to be overtly dishonest. These results are not surprising: it is understandable that the practice of being *covertly* dishonest with a client, such as choosing not to correct a client’s erroneous assumption about something, would feel less shameful than *overtly* saying something untrue to a client in session. Most therapists (91.5%) reported having given a client the impression that they were paying attention when they were not, while significantly fewer (32.9%) reported having explicitly told a client that they were paying attention when they were not. In other words, not surprisingly, therapists appear to be much more comfortable allowing a client to believe something untrue than they are telling a client an explicit lie.

Basescu (1987) offered reflections on the kind of covert dishonesty that can often take place in analysis:

I think that too often, with the intention of allowing the patient’s fantasies and projections free reign, analysts avoid the kind of self-disclosure that can have far greater therapeutic value. Getting direct, open, forthright feedback about the impact one has on others may

be one of the most important aspects of the therapeutic experience—for both participants. Of course, one has to be ready to hear it. The whole issue of the analyst’s self-disclosure has become a focal point in recent years. Judgments about its appropriateness and therapeutic consequences must take into account the context in which it occurs, and the conscious and unconscious intentions motivating its use (p. 260).

Basescu’s reflections again highlight not only the importance of context in therapists’ decisions around honesty (or dishonesty), but also emphasize the ways in which even covert dishonesty can stymie the therapeutic process. This further reiterates the importance of therapists’ reflections and awareness regarding their motivations behind even their more “benign” acts of covert dishonesty with their clients.

Most therapist dishonesty is reportedly in service of the client and/or therapy

Another major finding of this study is that most therapists believe that their dishonesty is motivated primarily by consideration of their clients’ best interests. As reported in Table 7, 20.5% of therapists described their dishonesty as being motivated by their treatment strategy, such as “playing dumb” for the sake of engendering conversation or making it easier for the client to speak freely without concerns about judgment. Similarly, 18.8% of therapists reported that their dishonesty was motivated by a desire to shield the client from harm, such as being less than completely honest about his or her reaction in order to avoid hurting the client’s feelings or making him or her feel unfavorably judged. Another 13.2% of therapists described their dishonesty as being in the service of the therapeutic alliance, or bond, such as keeping negative feelings to oneself to avoid a rupture, and 9.1% of dishonesty reported by therapists was described as serving a purpose of maintaining focus on the client, rather than the therapist, such as choosing to cover up not feeling well to avoid diverting the focus of the session onto the

therapist, instead of the client. Another 8.2% of dishonesty described by therapists in this study was identified as being motivated by avoiding something that the therapist believed to be unbeneficial to the patient, such as admitting one's sexual attraction to a client.

These findings about the client-centered motivations behind therapist dishonesty are highly consistent with clinical perspectives and previous research on the related topic of therapist self-disclosure. Research by Miller and McNaught (2016) found that cognitive behavioral therapists employed use of self-disclosure that had a clear clinical purpose and was related to the client's goals for therapy. Humanistic, client-centered, and existential psychotherapists also report utilization of therapist self-disclosure when it serves the purpose of modeling and encouraging honesty and humanizing the therapist (Audet, 2011; Bottrill et al., 2010; Henretty & Levitt, 2010; Satterly 2006). Despite, a historically more conservative approach to therapist self-disclosure in the psychodynamic modality, research by Henretty and Levitt (2010) indicated that psychodynamic psychotherapists disclose almost as frequently as therapists practicing in other modalities. Regarding the question of therapists' use of self-disclosure, Wachtel (1993) suggested an individualized approach, in line with the considerations about honesty described by therapists in the present study, keeping in mind the needs and wellbeing of each client when considering what and when to disclose:

The approach to partial self-disclosure by the therapist [...] enables the therapist to approach the question with flexibility and sensitivity to the differing needs of different patients. If, for example, you sense that a patient needs at some point in the work to maintain an idealized view of you, or needs to feel he is in strong hands and would be uncomfortable to see you as a three-dimensional (and hence inevitably flawed) human being, you can be very sparing in your revelations. For such patients—or better, at such

points in the work, for patients' needs change if the process is working as it should—considerable discretion is required to develop the sense of safety that is the foundation of effective therapeutic work (p. 286).

The present findings are similarly consistent with clinical perspectives on the role of clinical tact in psychotherapeutic practice. Poland (1975) explained, "The goal of tact is to protect the other's self-esteem. Tact and analytic progress are mutually interdependent. Interpretations can never be successful if they violate the fundamental integrity of the patient's sense of himself, i.e. they must not be disintegrative. Nonetheless, the need for tact cannot serve as a rationalization for avoiding difficult interpretations" (p. 155). Clinical tact relies on the therapist's keen awareness of and attentiveness to the client's progress and his or her readiness to receive certain information, thereby making it a critical skill for therapists to conduct effective psychotherapy. Geller (2005) described the degree of attunement required for optimally tactful clinical interventions and noted the particular challenge this presents to novice therapists:

Tact implies a keen sense of what a patient is ready to hear. Tact is a feeling for how much pain and frustration a patient can tolerate. To paraphrase Cocteau (1981), tactful therapists are capable of "knowing how far to go in going too far" (p. 51). In these various respects, therapeutic tact is comparable to Kohut's (1984) conceptualization of the empathic mode of knowing. Acquiring these refined sensitivities requires combining tough-minded curiosity and candidness with receptiveness and softness. Synthesizing these often competing inclinations into an efficacious and personally viable investigatory style is inherently difficult. This task is particularly difficult for student therapists who have unresolved conflicts about their aggressive impulses, especially if they view the

resistant patient as struggling against them, or as not cooperating in the therapy in a way that they would wish or expect” (p. 479).

Therapists’ attempts at clinical tact likely account for much of therapist dishonesty, which is described by most therapists as being in the service of the client and his or her therapy.

Therapists appear to become more adroit at clinical tactfulness over time; while novice therapists are more likely to turn to dishonesty, more experienced therapists are likely better able to employ tactfulness without straying from truthful interactions with their clients in sessions.

Self-preservation motivates some therapist dishonesty

Another important finding of this study is that the dishonesty reported by therapists that was not described as being in the client’s best interest was described as being in the service of maintaining the therapist’s own boundaries. Of the dishonesty described by therapists, 15.8% was reported as being motivated by self-preservation, such as working to create better work/life balance or making up an excuse to cancel a session when one is not feeling emotionally well. Similarly, another 5% of therapists reported that their dishonesty was motivated by personal impression management, such as a concern that being completely honest would make the therapist appear inexperienced or less capable of providing service. Pope et al. (2006) illustrated one example of such self-preservation, specifically, avoiding addressing a stagnation in progress due to the therapist’s fear that such an acknowledgement would reflect poorly on him or her.

If there is a powerful factor or taboo topic that the therapist alone or the therapist and client are working to avoid noticing, identifying, or addressing, the therapy may drift aimlessly. Therapist and client continue to meet and discuss topics that seem important, but there is no movement toward the client’s stated goals, developmental progress, or increased understanding. There tends to be no discussion of the degree to which the

client is—or is not—making progress on what lead him or her to seek therapy in the first place, no evaluation of what is and is not working. Therapy seems to just float without direction, as if it were resting atop the water somewhere in the middle of an ocean. One therapist noticed that therapy had drifted for the first 6 months of treatment. On reflection, and with the help of consultation, it became clear to her that the client had sought therapy for his self-destructive impulses, but the prospect that if they discussed self-destructiveness the client might become suicidal and take his own life terrified the therapist. She had lost a client to suicide the previous year and found it almost impossible to admit to herself that she no longer felt competent to work with suicidal clients (p. 67).

This example highlights the ways in which avoidance of truthful communication between therapists and clients in therapy can exacerbate a lack of clinical progress and emphasizes the importance of carefully considering one's reasons for being less than completely honest with clients about a lack of progress in therapy. On the one hand, providing a more favorable view of progress being made may imbue necessary hope for improvement for the client; on the other hand, avoidance of discussing a stagnation in the therapy may represent the therapist's unexamined fears about his or her own competence to help, which, in turn, further stalls progress in therapy.

With such scenarios in mind, Pope et al. (2006) provided a list of 17 possible signs that “taboo topics and uncomfortable feelings” may be driving a therapist to be less than completely honest for reasons related to his or her own self-preservation, rather than the client's best interest (pp. 65-66). Among these helpful “clues,” Pope et al. (2006) include noticing that the therapy has gone “adrift: (i.e., the therapist and/or client seek to avoid a certain topic and the therapy

appears to “drift aimlessly”), repetitive therapy (i.e., the therapy tends to circle around the same topics, due to the therapist’s and/or client’s desires to avoid a particular topic), a discrepant record (i.e., the notes that the therapist includes in the client’s paper record are not an honest reflection of what he or she knows to be the actual content of the therapy), and avoidance (e.g., the therapist looks for reasons to cancel sessions or reduce the frequency with which he or she sees a certain client). These indications, among the others, encourage therapist self-reflection and provide therapists with a helpful guide with which to consider their acts of dishonesty, when they (inevitably) come up.

A minority of therapist dishonesty is motivated by legal or ethical issues

The remaining 9.4% of therapists described their reasons for being less than completely honest as having to do with legal or ethical issues, such as maintaining another client’s confidentiality or choosing not to take on a client in order to avoid getting involved in legal matters themselves. This particular motivation combines both concerns about the therapy or client (e.g., behaving ethically for the sake of the client’s wellbeing) and efforts at self-preservation on the part of the therapist (e.g., avoiding cases that are likely to involve legal involvement as a part of the work). This finding also brings up the matter of safety, which is an important consideration for psychotherapists when managing their caseload. A survey by Corder and Whiteside (1996) found that psychotherapy cases that were related to certain kinds of legal issues were more likely to be associated with stalking, threats, and attacks on the therapist by clients. A study by Guy et al. (1992) inquired about psychotherapists’ efforts at increasing their own workplace safety, which included refusing to treat certain patients (50%), choosing not to disclose certain personal information (41%), not allowing clients to be seen in their home (41%), choosing a safe building for their practice (39%), and identifying certain patient behaviors as

unacceptable (35%). Effective management of such safety concerns requires therapists to draw clear boundaries in their clinical practice. Importantly, the results of the present study indicate that therapists often feel the need to resort to dishonesty for the sake of drawing such boundaries for their personal wellbeing, including making decisions about not treating certain clients and choosing not to honestly disclose personal information.

As previously referenced, the APA's ethics code includes a brief mention of the use of dishonesty by psychologists, stating succinctly, although perhaps vaguely, that "Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat or engage in fraud, subterfuge, or intentional misrepresentation of fact. [...] In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques" (American Psychological Association, 2017). This code leaves much open to interpretation on the part of the therapist, including identifying the kinds of situations in which deception may be "ethically justifiable to maximize benefits and minimize harm." This, partnered with the dearth of previous research on this topic and the apparent lack of discussion about therapist dishonesty in clinical training programs, highlights the overwhelming absence of guidance on this issue. While there is little, if any, literature on the ethical considerations related to therapist dishonesty, contemporary clinical perspectives on the ethics of therapist self-disclosure are a helpful point of reference to the matter of therapist dishonesty. Danzer (2019) describes:

It is common for proponents [of therapist self-disclosure] to argue (in a language reminiscent of *beneficence*) that [therapist self-disclosure] frequently conveys the

humanity of the therapist, helps to develop rapport with clients, and permits a level of authenticity that may contribute to the formation of a positive relationship, roundly understood to be central to therapeutic healing and growth. Opponents often counter (in a language reminiscent of *maleficence*) that [therapist self-disclosure] crosses professional boundaries, suggests the possibility of a dual relationship, and therefore should be substituted for any number of alternative interventions that competent therapists should be able to call upon in service of building professional and not personal relationships with clients. Neither perspective is mutually exclusive, as [therapist self-disclosure] can be ethically appropriate and helpful to clients, unethical and unhelpful to clients, or both positive *and* negative (p. 9).

Covert dishonesty is used to conceal negative feelings

The four most common topics of covert dishonesty (i.e., “Feeling Emotionally Unwell,” “Feeling Physically Unwell,” “Feeling Frustrated/Disappointed,” and “Feeling Bored”) appear to be motivated by a common desire: to conceal the therapist’s negative feelings from the client. Taken together with the finding that therapists report believing that their dishonesty is most often in service of the patient and his or her therapy, this suggests that therapists choose to disguise their negative feelings from their clients in session due to a belief that the therapy itself, or the client’s wellbeing, would be worse off were they to be truthful. Of course, the therapist’s disclosure of even unpleasant feelings—be they the therapist’s negative feelings *unrelated* to the therapy (e.g., “I have a bit of a headache.”) or *related* to the therapy (e.g., “I’m feeling frustrated by how this is going.”)—has the potential to deepen the therapy in a number of ways. As previously mentioned, research has found that clients felt more comfortable disclosing information to their therapists if the therapist had self-disclosed to them previously. In

particular, the most impactful therapist self-disclosures reportedly included those which engendered a similarity between the therapist and the client (perhaps, including vulnerability to headaches and the like) and those which discussed negative thoughts or feelings related to the client or the therapy, such as expressing sadness about something a client said in session (Henretty et al., 2014). As such, the reported inclination of therapists to put on a false front with their clients about feeling physically or emotionally unwell, as well as their own frustration or boredom in session, highlights the importance of further examining this topic and including it as a core part of clinical training and continuing education programs in psychology.

McWilliams (2004) acknowledged the temptation to conceal such negative feelings in psychotherapy and suggested the following guiding principles for making decisions about communicating honestly with clients about such difficult topics:

The guidelines I have developed for myself in this vexed area are to admit to feelings that are obvious to the client in any way, to try to respond honestly to direct questions about my feelings whether or not I explicitly disclose, to bring up my emotional state when I am pretty certain it will further rather than complicate the client's work, and, when I do reveal my feelings, to do so in ways that run the least risk of making the patient feel either blamed for my reactions or impelled to take care of me (p. 185).

She added:

It seems to me that it is subtly dishonest to act as if one is "blank" when one in fact is full of feeling, and that a more candid reaction than putative neutrality often deepens the work. For example, when a chronically self-destructive woman reports that she has again put herself in harm's way, despite weeks of work on understanding why she does that, I am likely to feel rage, and my best poker face is not good enough to hide this. If she then

asks if I'm angry, it feels evasive to say something like "What's your fantasy about that?," or "What comes to mind about your question?" I would rather say, "Well, it doesn't thrill me to hear that you've had unprotected sex again with a stranger. If you want to get a therapist upset, one of the best ways to do it is to keep demonstrating that her efforts to make you less self-destructive are in vain. What's your reaction to having gotten this reaction from me?" (p. 185).

McWilliams's description of addressing her own negative feelings in session is a wonderful example of the ways in which therapists may feel caught off guard by their own emotional reactions to the content of sessions. Novice therapists in particular are likely to fall victim to the desire to conceal such feelings and avoid delving into uncomfortable dynamics, although even experienced therapists are likely to be similarly tempted. Gold (2005) described:

Novice therapists work under scrutiny that often is intense and critical. They treat persons whose lives are marked by pain and dysfunction, and these therapists newly are using techniques and processes that are less well defined and understood than any of us would wish. Few realize until they begin doing clinical work just how difficult, frustrating, and mysterious it often is. The difficulties that more experienced therapists take for granted and have come to expect can threaten the novice therapist's sense of well-being, self-esteem, and self-confidence. Therefore, novice therapists are easy prey to uncertainty, self-doubt, and confusion (p. 378).

These considerations further highlight the greater likelihood that novice psychotherapists may turn to dishonesty when trying to navigate difficult client interactions or to protect their self-esteem, their wellbeing, and their relationships with clients.

Overt dishonesty is used to maintain personal boundaries

Although overt dishonesty was overall less common among psychotherapists than covert dishonesty, examination of the topics about which therapists reported most commonly being overtly dishonest sheds light on the reasons behind this behavior. The four most common topics about which therapists reported being *overtly* dishonest (i.e., “Availability,” “Feeling Emotionally Unwell,” “Feeling Physically Unwell,” “Reasons for Not Taking on a New Client”) appear to serve a common purpose of maintaining the therapist’s personal boundaries. In particular, therapists appear to be more comfortable being overtly dishonest with clients specifically about matters that affect their schedule and client load (e.g., turning down certain clients and certain appointment times and providing a less than completely honest explanation) and to keep their internal experiences internal (e.g., having a bad day or a stomach ache without needing to acknowledge it to a client who asks, “How are you?”). This aligns with the finding that some therapist dishonesty is motivated by self-preservation, including a desire to create some distance between one’s personal life and work life, or to create boundaries in support of a better work/life balance.

The creation of personal boundaries, which serve to separate therapists’ work lives from their home lives and their inner worlds from their outer worlds, is essential to therapists’ self-care. Norcross and Guy (2007) suggest keeping one’s caseload manageable by limiting the number of “high-risk and high-demand patients,” deliberately making time between sessions to walk, stretch, review notes, and have a moment to oneself, and avoiding scheduling more difficult cases at the end of the work day. The reported inclination for therapists to turn to dishonesty to create such limits suggests a critical need to enhance clinical training to better

support therapists' abilities to draw personal boundaries in support of their own wellbeing, while maintaining honest communication with their clients.

Novice therapists are more likely to be dishonest with clients

Another major finding of this study is that therapists with less experience are significantly more likely to utilize dishonesty in sessions with their clients than therapists with more years of experience. This is consistent with previous research on therapists' responses to personal questions from their clients: while even experienced therapists are often flummoxed by personal questions (Chakraborti, 2006), therapy trainees are particularly likely to feel caught off guard and unsure how to respond (Edelstein and Waehler, 2011).

This finding suggests that much of the learning related to the use of honesty (or dishonesty) with clients happens on-the-job and by way of experience, rather than in clinical training programs. It is possible that learning to negotiate the use of complete honesty with clients is, as Freud described in his writings on the use of clinical tact, not something that can be taught; rather, "the analyst's experience and normality will have to be the decisive factors" (Freud & Ferenczi, 2000). Of course, while the nuances of clinical tact may be hard to teach in a classroom, there are likely ways in which clinical training programs can better provide trainees with skills to support them in maintaining honest communication with clients, with particular attention on effectively creating personal boundaries (as described previously). In fact, a study of psychology graduate students by Munsey (2006) found that 83% of participants reported having never been provided with written materials on self-care. Norcross and Guy (2007) posit that, "Most practitioners are simply underprepared by graduate programs for the emotional demands of practice" (p. 163). It is possible, even likely, that novice psychotherapists, when put on the spot, will resort to the use of dishonesty for self-preservation, protection, and to avoid

making a mistake. In her book *Maybe You Should Talk to Someone*, author Lori Gottlieb described a moment of conflict in session when a client asked her whether she was wearing a pajama shirt (which she was, having absentmindedly forgotten to change it when getting dressed that morning). Gottlieb explained, “Whenever I’m not sure what to say in the therapy room—which happens to therapists more often than patients realize—I have a choice: I can say nothing until I understand the moment better, or I can attempt an answer, but whatever I do, I must tell the truth” (p. 29). Gottlieb later reflected on the experience of a colleague in her clinical training internship, who found himself faced with whether to provide the details of his reason for being away from the clinic for three weeks (i.e., his wedding). She recalled:

“That’s a long vacation,” the patient remarked, and the intern, believing that sharing the news of his wedding would be too personal, decided instead to focus on the patient’s comment. What would it be like for her to miss three weeks of sessions? What did her feelings about his absence remind her of? Both of which might be fruitful avenues to explore, but so would the patient’s indirect question: *Since it’s neither summer nor a holiday season, why are you really taking three weeks off?* And sure enough, when the intern returned to work, the patient noticed his wedding ring and felt betrayed: “Why didn’t you just tell me the truth?” In retrospect, the intern wished that he had. So what if a patient learned that he was getting married? Therapists get married and patients have reactions to that. Those can be worked through. Loss of trust is harder to repair (p. 29).

The temptation to resort to less-than-complete honesty with clients is especially understandable among novice therapists such as the one described by Gottlieb above, and further emphasizes the need for psychology programs to include such interactions as part of clinical training.

Gottlieb also acknowledged an important issue related to the use of dishonesty by therapists: namely, what should occur when a therapist's dishonesty is recognized by the client and impairs the relationship? Research by Safran et al. (2011) provided suggestions for successful repairs to ruptures in the therapeutic alliance, such as ruptures related to a client's observation that the therapist has been dishonest with him or her. Their suggestions include the importance that clients "assert their perspective on what is going on when it differs from the therapist's" and that "it is important for therapists to attempt to respond in an open and nondefensive fashion, and to accept responsibility for their contribution to the interaction as opposed to blaming the patient for misunderstanding or distorting" (p. 86). Taking ownership of one's dishonesty in a nondefensive way is likely to be difficult for therapists, especially if the client's observation is unexpected. However, acknowledgement of the event is critical to repairing a loss of trust that is likely to have taken place as a result. The reported ubiquity of therapist dishonesty, together with its potential for damaging the therapeutic relationship, further highlights the need to incorporate the topic in clinical training.

Most therapists perceive no consequences of their dishonesty with clients

Of the therapists who described an instance in which they were less than completely honest with their clients in session, nearly half (46%) reported no immediate or later consequences of their decision to be dishonest. Specifically, many participants described the therapy and relationship as "continuing as usual" or described that they were unable to identify any consequences of their use of dishonesty. Of note, this perceived lack of consequences per therapists' self-report, is in contrast with the notion that honest discourse is a critical element of good psychotherapy. As McWilliams (2004) explained:

As Michael Guy Thompson (2002) and others [sic] inheritors of Rieff's perspective have argued, psychoanalysis as a field has [...] embraced an ethic of honesty that takes precedence over other aims and regards therapeutic goals, including symptom relief, as by-products of the achievement of honest discourse. Thomas Szasz (2003) has gone so far as to as to [sic] define psychoanalysis as "*a moral dialogue, not a medical treatment*" (p. 46). For many decades, the ethic of honesty was personified in the image of a therapist who had presumably attained unflinching self-awareness in a personal analysis and who bore the responsibility for fostering the same achievement in the patient. In current analytic writing, there is more acknowledgement that participation in a therapeutic partnership requires *both* analyst and patient to become progressively more honest with themselves in the context of that relationship (pp. 2-3).

Many (33.5%) therapists reported only positive consequences of being less than completely honest. For example, participants described the dishonesty as providing a more optimistic view that helped the client feel motivated about their work or making it easier for the client so speak openly in the therapy about difficult topics—in other words, therapists described using dishonesty in the service of clinical tact, as discussed previously. Notably, most responses that therapists provided to the two questions in this survey about consequences of their dishonesty (i.e., immediate consequences and later consequences) pertained only to consequences *to the client* and/or his or her therapy. In other words, virtually no therapists reported potentially positive (or negative) consequences related to him or herself, such as the creation or maintenance of personal boundaries or avoiding working with a client with whom he or she did not want to work. Respondents to this survey appeared to consider this question primarily in terms of their client's experience and related positive or negative consequences,

rather than his or her own, suggesting that the question of possible positive effects of therapist dishonesty on *therapists* themselves may require further research.

A minority (14.3%) of therapists reported negative consequences of their decision to be dishonest with their clients, such as feelings of regret, getting caught in a lie, and stagnation in therapy from allowing a client to believe that progress was being made when it was not. Just as the positive consequences of dishonesty deserve attention, the possible negative consequences of therapist dishonesty require further exploration to better understand the impact of these decisions on clients and the process of psychotherapy. Importantly, without knowing clients' perspectives on perceived acts of dishonesty by their therapists, it is impossible to determine with certainty what the consequences might have been. Research by Thompson and Hill (1991) found that therapists were able to correctly identify their clients' reactions to clinical interventions only 50% of the time, indicating that therapists may frequently misinterpret their clients' reactions to interactions in session and supporting the need for future research in this area.

Limitations and Future Directions

A primary limitation inherent to the methods used in this study is that this methodology relied only on the perceptions of the psychotherapists themselves regarding the consequences of therapist dishonesty. Although therapists may do their best to identify and appreciate the consequences of their dishonesty, this picture remains incomplete without their clients' perspectives of the impact on their therapy. Another limitation is the use of online surveys and recruitment of therapists through email lists and online communities. Although the demographics of this study's participants reflect a very similar demographic distribution to the population of psychotherapists in the United States, without the use of random sampling, the

sample of psychotherapists used in this study cannot be identified as representative of the therapist population. There is a sampling bias inherent to the use of online surveys, namely, representation of therapists who are more plugged in to online therapist communities. However, as previously mentioned, use of anonymous computerized surveys is associated with greater likelihood of honest reporting by participants, which is particularly important when inquiring about potentially shameful topics, such as lying (Gnambs and Kaspar, 2014).

Another important limitation of the present study is that its data have not been assessed in terms of diversity and multicultural considerations. Although the present study found no significant differences in the uses of dishonesty based on therapists' gender, ethnicity, or sexual orientation, it is possible, in fact likely, that decisions around dishonesty (including clinical tact) vary as a function of the gender, ethnic, and sexual orientation *pairing* between the therapist and client. Indeed, multiple participants in the present study described instances in which they chose to deliberately mislead their clients about their own sexual orientation due to concerns that their clients would not respond well to knowing the truth (e.g., that the therapist was gay). In the instances described by therapists in the present study, the therapists reportedly chose to be less than completely honest because they felt that the identification of this difference between the client and the therapist would negatively affect their rapport and, thereby, the course of the therapy. It is likely that other similar circumstances arise which compel therapists to be less than completely honest with their clients, as a function of perceived personal differences between the therapist and client. With racial relations being an issue of particular currency, understanding the ways in which differences between the therapist and client may impact honesty in therapy is especially important. Future research should explore the ways in which such interpersonal

differences impact the use of therapist dishonesty to understand its role and the impact on the therapy itself.

The findings of the present study revealed many consistent themes as well as some notable differences when compared to the results of the original PATCH survey. Regarding covert dishonesty, feeling frustrated or disappointed and finding a client likable (or dislikable) remained in the top five most common topics of dishonesty. However, the topics of feeling emotionally unwell and physically unwell (new items in this survey, created from a previously combined “feeling physically or emotionally unwell” item in the original PATCH survey) moved to the top two most common topics in the present study. Similarly, the topic of feeling bored (another new item in the present study) moved to the top of the list for covert dishonesty. The therapist’s personal beliefs or values, forgetting something a client said, and information about the therapist’s personal life moved down the list. The least common topics of covert dishonesty were slightly more consistent between the two surveys: three of the five least common topics of covert dishonesty remained the same, namely, information about one’s training or credentials, details of one’s fee structure, and romantic or sexual feelings towards one’s clients. In the present study, covert dishonesty regarding reasons for terminating and reasons for being late or absent was usurped by more frequent covert dishonesty about conversations with others about the therapy and discussing the client’s diagnosis.

Regarding overt dishonesty, a comparison between results from the original PATCH survey and the present study revealed a similar pattern of consistencies and differences. Two topics, namely, feeling frustrated or disappointed with a client and availability, remained in the top five between the two surveys. However, three new topics emerged in the top five, namely, feeling emotionally unwell, feeling physically unwell, and reasons for not taking on a new client,

bumping down the list the topics of liking or disliking a client and one's confidence in being able to help. The five least common topics of overt dishonesty were largely consistent with the results of the original PATCH survey. Specifically, one's training or credentials, details of one's fee structure, romantic or sexual feelings towards one's clients, and information about the client's diagnosis remained consistently in the bottom five topic between both surveys. However, the topic of one's professional experience bumped the topic of outside knowledge out of the bottom five.

These differences in the results between the original PATCH study and the present study are likely attributable to changes in the survey between the first and second surveys, as well as the aforementioned demographic differences between the two samples. Specifically, as described previously, the present survey consisted of 26 items (compared to the previous survey's 23 items). This change consisted of one new topic (i.e., feeling bored in session), and two previous topics split into two (i.e., knowledge of *someone* and knowledge of *something*, and feeling *physically unwell* and feeling *emotionally unwell*), one topic removed (i.e., physical or mental health) and replaced with another (i.e., mental health history). Another significant change between the two surveys was the addition of an "N/A" option (i.e., "This has not come up for me") for each item. As previously discussed, this option was added to address concerns that participants who had never encountered a particular situation (e.g., those who had never been sexually attracted to a client) were selecting "1 = Never," giving the impression that they had only ever been completely honest in that situation, when in actuality it had not come up for them before. Without this option present in the original PATCH survey, it is likely that the data contained depressed means as a result, thereby affecting the results.

The most significant and surprising difference in the results of the present study pertains to the finding about which types therapists reported being more frequently dishonest with their clients. The original PATCH study found that therapists who were not students, working in private practice, older than 30 years, and with five or more years of experience were significantly more likely to be dishonest with their clients (both overtly and covertly). Results of the present study, however, found that the only consistently significant difference in the demographics between the high and low lying classes was age, and the finding contradicted the previous results; specifically, the present study found that therapists who reported being more frequently dishonest with their clients were more likely to have *less* experience than therapists who reported being less frequently dishonest. This discrepancy is likely attributable to the differences in the samples in the original PATCH survey and this revised version. The majority of participants in the original PATCH survey reported an integrated or eclectic approach to psychotherapy, while a psychodynamic approach captured roughly 11.4% of the sample. In the current study, nearly 30% of the sample self-identified as adhering primarily to a psychodynamic approach to therapy, while eclectic approaches accounted for roughly 5% of the sample. It is possible that a psychodynamic approach in therapy may moderate the relationship between therapist age and likelihood of lying, a topic which warrants future exploration.

The most important area for future research identified by the current study relates to clients' perceptions of and reactions to their therapists' dishonesty in session. What remains unclear from the results of the current study is whether or to what extent clients perceive dishonesty on the part of their therapists, and the ways in which it affects (or does not affect) the therapy, from the perspective of the client. Do clients perceive more or less therapist dishonesty than therapists report using? How well do clients pick up on their therapists' less-than-complete

honesty, how do they make sense of it, and what impact does it have on their therapy process? A survey approach, parallel to the one used in the present study, would be helpful to examine clients' perceptions of and reactions to perceived therapist dishonesty and would allow a helpful comparison between *therapists'* reported use and perceived consequences of dishonesty in session and *clients'* experiences of the same.

Conclusions

The present study identifies therapist dishonesty—a previously unexplored element of the psychotherapy process—as a fairly commonplace occurrence in psychotherapy. In addition, it presents valuable information regarding the topics about which therapists are more likely to be *covertly* dishonest, namely, the therapist's negative feelings, and *overtly* dishonest, namely, topics that protect the therapist's personal boundaries, as well as the topics about which therapists are rarely ever dishonest (i.e., training or credentials; hourly rate; diagnosis; and romantic or sexual feelings about clients). This study also identifies therapists with less experience as being more likely to utilize dishonesty with their clients, suggesting that therapists learn to interact in a more truthful and effective way with practice and indicating a need for clinical training programs and the American Psychological Association (APA) to incorporate discussions and training about the role of honesty, tact, and occasional dishonesty in psychotherapy as part of clinical programs, ethical guidelines, and continuing education. Importantly, this study also reveals that therapist dishonesty is most often reportedly used in service of the therapy or with the client's best interests in mind, and—according to therapists—with few negative consequences.

The findings of the current study highlight, in particular, the importance of incorporating the topic of the role of honesty (and dishonesty) in psychotherapy into clinical training programs.

Not only did novice therapists report using dishonesty more frequently than more experienced therapists, but, overall, therapists reported using dishonesty for reasons directly related to the quality of psychotherapy delivered: specifically, self-care and client wellbeing. Additionally, therapists consistently reported greater use of covert dishonesty than overt dishonesty, likely reflecting greater relative comfort with covert untruths than overt ones. With this in mind, it is important to recognize that covert dishonesty is not innately less harmful than overt dishonesty. While most therapists reported positive consequences of their dishonesty (or no consequences at all), the reported occasional negative consequences of both overt and covert dishonesty further underscore the need to provide trainees with guidance in this area, for the wellbeing of both therapists and their clients.

Importantly, the results of this study also highlight another critical point: that therapist dishonesty is not always a bad thing. Therapists constantly make in-the-moment decisions regarding what to say, when, and how. The results of this study have provided a peek into the types of decisions therapists are required to make, most often in service of their clients and the therapy, and sometimes in service of their own self-care, which, arguably, is also in service of the therapy they provide. Therapists reportedly make decisions about what they believe their clients can handle, versus what might hinder or derail the therapy in some way. Jack Nicholson's famous line from Aaron Sorkin's movie *A Few Good Men* comes to mind:

Colonel Jessep: I'll answer the question. You want answers?
Lieutenant Kaffee: I think I'm entitled to them.
Colonel Jessep: You want answers?!
Lieutenant Kaffee: I want the truth!
Colonel Jessep: You can't handle the truth!

Of course, it is entirely possible, even likely, that clients are able to “handle” more than their therapists think they can, and that the therapy would actually benefit from more honesty than

from dishonesty used for the sake of avoiding certain interactions. The results of this study speak not only to the clinical consequences of the decisions about honesty and dishonesty, but to issues of personal integrity—the overlap between the demands of the role that therapists play (i.e., developing tactful interventions) and the therapist’s own identity (i.e., his or her authenticity). However, as Freud explained, knowing when and how to speak candidly is difficult to teach, and most often depends on the therapist’s individual knowledge of the client, their relationship, the therapy, their own experiential learning, and him or herself.

References

- Abend, S. M. (1982). Serious illness in the analyst: Countertransference considerations. *Journal of American Psychoanalytic Association*, 30(2), 365-79.
- American Psychological Association. (2017). *Ethical Principles of Psychologists and Code of Conduct*. Retrieved August 2018, from <https://www.apa.org/ethics/code>
- American Psychological Association. (2017, January 1). *Ethical Principles of Psychologists and Code of Conduct*. Retrieved from American Psychological Association: <https://www.apa.org/ethics/code/>
- American Psychological Association. (2018). *Demographics of the U.S. psychology workforce: Findings from the 2007-16 American Community Survey*. Washington, DC.
- Anonymous. (2013, March 3). *I caught my therapist in a lie; am I overreacting?* Retrieved June 2019, from Meta Filter: <https://ask.metafilter.com/258062/I-caught-my-therapist-in-a-lie-am-I-overreacting>
- Arlow, J. A. (1990). Psychoanalysis and character development. *Psychoanalytic Review*, 77(1), 1-10.
- Audet, C. T. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers?. *Counselling Psychology Quarterly*, 24(2), 85-100.
- Babits, M. (2001). The Phoenix juncture: Exploring the dimension of hope in psychotherapy. *Clinical Social Work Journal*, 29 (4), 341–350.
- Baker, E. K. (2003). Professional challenges. *Caring for ourselves: A therapist's guide to personal and professional well-being* (1st ed., Vol. 8, 99–125). Washington, DC: American Psychological Association.

- Basescu, S. (1987). Behind the "seens": The inner experience of at least one psychoanalyst. *Psychoanalytic Psychology*, 4(3), 255–265. <https://doi-org.tc.idm.oclc.org/10.1037/h0079134>
- Bearse, J. L., McMinn, M. R., Seegobin, W., & Free, K. (2013). Barriers to psychologists seeking mental health care. *Professional Psychology: Research and Practice*, 44, 150–157. <https://doi.org/10.1037/a0031182>
- Beck, A. T. (2015). *Cognitive therapy of personality disorders*. New York, NY: Guilford Publications.
- Bergin L, & Walsh S. (2005). The role of hope in psychotherapy with older adults. *Aging & Mental Health*, 9(1), 7–15.
- Bishop, J., & Lane, R. C. (2001). Self-disclosure and the therapeutic frame:. *Journal of Contemporary Psychotherapy*, 31(4), 245-56.
- Blanchard, M., & Farber, B. A. (2016, 2016). Lying in psychotherapy: Why and what clients don't tell their therapist about therapy and their relationship. *Counseling Psychology Quarterly*, 29(1), 90-112.
- Bottrill, S., Pistrang, N., Barker, C., & Worrell, M. (2010). The use of therapist self-disclosure: Clinical psychology trainees' experiences. *Psychotherapy Research*, 20(2), 165-180.
- Burgo, J. (2013, April 12). *Lying to our clients*. Retrieved September 2017, from After Psychotherapy: <http://www.afterpsychotherapy.com/lying-to-our-clients>
- Carroll, L., Gilroy, P. J., & Murra, J. (1999). The moral imperative: Self-care for women psychotherapists. *Women & Therapy*, 22(2), 133-143.
- Chakraborti, A. (2006). Did you ever suffer from any mental illness?. *British Medical Journal*, 333(7570), 709.

- Chan, D. (2009). So why ask me? Are self-report data really that bad? In C. E. Lance & R. J. Vandenberg (Eds.), *Statistical and methodological myths and urban legends* (pp. 309–336). New York, NY: Routledge.
- Cocteau, J. (1981). Quoted in W. H. Auden & L. Kronberger (Eds.). *Aphorisms: A personal selection*. New York: The Viking Press.
- Corder, B. F., & Whiteside, R. (1996). A survey of psychologists' safety issues and concerns. *American Journal of Forensic Psychology*, 14(3), 65–72.
- Curtis, D. A., & Hart, C. L. (2015). Pinocchio's nose in therapy: Therapists' beliefs and attitudes toward client deception. *International Journal for the Advancement of Counselling*, 37(3), 297-92.
- Danzer, G. S. (2018). *Therapist self-disclosure: An evidence-based guide for practitioners*. New York, NY: Routledge.
- Dembo, J. S., & Clemens, N. A. (2013). The ethics of providing hope in psychotherapy. *Journal of Psychiatric Practice*®, 19(4), 316-322.
- Denzin, N. K., & Lincoln, Y. S. (1994). *Handbook of qualitative research*. Thousand Oaks, CA: Sage Publications, Inc.
- Duncan, B., Hubble, A., & Miller, D. (1997). *Psychotherapy with 'impossible' cases*. New York: Norton & Co.
- Edelstein, L. N., & Waehler, C. A. (2011). *What do I say?: The therapist's guide to answering client questions*. Hoboken, NJ: John Wiley & Sons.
- Elliott, R., Shapiro, D. A., Firth-Cozens, J., Stiles, W. B., Hardy, G. E., Llewelyn, S. P., & Margison, F. R. (1994). *Comprehensive process analysis of insight events in cognitive-*

- behavioral and psychodynamic-interpersonal psychotherapies. *Journal of Counseling Psychology*, 41(4), 449-463. doi:10.1037/0022-0167.41.4.449
- Epstein, R. S. (1994). *Keeping boundaries: Maintaining safety and integrity in the psychotherapeutic process*. Washington, DC: American Psychoatric Press.
- Farber, B. A. (2006). *Self-disclosure in psychotherapy*. New York: Guilford Press.
- Farber, B. A., & Hall, D. (2002). Disclosure to therapists: What is and is not discussed in psychotherapy. *Journal of Clinical Psychology*, 58(4), 359-370.
- Farber, B. A., Berano, K. C., & Capobianco, J. A. (2004). Clients' perceptions of the process and consequences of self-disclosure in psychotherapy. *Journal of Counseling Psychology*, 51(3), 340.
- Farber, B. A., Blanchard, M., & Love, M. (2019). *Secrets and lies in psychotherapy*. Washington, DC: American Psychological Association.
- Ferenczi, S. (1928). The elasticity of psycho-analytic technique. In *Final contributions to the problems and methods of psycho-analysis* (pp. 87-101). London: Karnac Books.
- Frank, J. D. (1961). *Persuasion and healing*. Baltimore, MD: Johns Hopkins University Press.
- Frank, J. D. (1968). The role of hope in psychotherapy. *International Journal of Psychiatry*, 5, 383-395.
- Frank, J. D. (1971). Therapeutic factors in psychotherapy. *American Journal of Psychotherapy*, 25, 350- 361.
- Frank, J. D. (1973). *Persuasion and healing: A comparative study of psychotherapy* (rev. ed.). Baltimore, MD: Johns Hopkins University Press.

- Frank, J. D. (1989). Non-specific aspects of treatment: The view of a psychotherapist. In M. Sheppherd and N. Sartorius (Eds.), *Non-specific aspects of treatment* (pp. 95-114). Toronto: Hans Huber.
- Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing*. Baltimore, MD: Johns Hopkins University Press.
- Frank, J. D., Nash, E. H., Stone, A. 1L., & Imber, S. D. (1963). Immediate and long-term symptomatic course of psychiatric outpatients. *American Journal of Psychiatry*, 120, 429-439.
- Freud, S. (1904). Freud's psychoanalytic procedure. *Standard Edition*, 7, 249-254.
- Freud, S. (1915). *Freud, Sigmund. "Observations on transference-love (Further recommendations on the technique of psycho-analysis III).*
- Freud, S. (1923). Two encyclopedia articles. *Standard Edition*, 18, 233-60.
- Freud, S. (1925). An autobiographical study. *Standard Edition*, 20, 1-74.
- Freud, S., & Ferenczi, S. (2000). *The correspondence of Sigmund Freud and Sándor Ferenczi. Volume 3: 1920-1933.* (E. Falzeder, E. Brabant, P. Giampieri-Deutsch, P. T. Hoffer, & A. E. Haynal, Eds.) Cambridge, MA: The Belknap Press of Harvard University Press.
- Frost, J. C. (1998). Counter-transference considerations for the gay make when leading psychotherapy groups for gay men. *International Journal of Group Psychotherapy*, 48, 3-24.
- Gallucci, A. M. (2002). Therapists' use of self-disclosure: A quantitative study. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 63(5-B), 2582.
- Garrett, N., Lazzaro, S. C., Ariely, D., & Sharot, T. (2016). The brain adapts to dishonesty. *Nature neuroscience*, 19(12), 1727.

- Geller, J. D. (2003). Self-disclosure in psychoanalytic-existential therapy. *Journal of Clinical Psychology, 59*(5), 541-54.
- Geller, J. D. (2005). Style and its contribution to a patient-specific model of therapeutic technique. *Psychotherapy: Theory, Research, Practice, Training, 42*(4), 429-482.
- Gerson, B. (1996). *The therapist as a person: Life crises, life choices, life experiences, and their effects on treatment*. Hillsdale, NJ: Analytic Press, Inc.
- Gnambs, T., Kaspar, K. (2014). Disclosure of sensitive behaviors across self-administered survey modes: a meta-analysis. *Behavior Research Methods, 47*, 1237–1259 (2015).
- Gold, J. (2005). Anxiety, conflict, and resistance in learning an integrative perspective on psychotherapy. *Journal of psychotherapy integration, 15*(4), 374.
- Goldstein, E. G. (1994). Self-disclosure in treatment: What therapists do and don't talk about. *Clinical Social Work Journal, 22*(4), 417-33.
- Gottlieb, L. (2019). *Maybe you should talk to someone: A therapist, her therapist, and our lives revealed*. Boston: Houghton Mifflin Harcourt.
- Guy, J. D., Brown, C. K., & Poelstra, P. L. (1992). Safety concerns and protective measures used by psychotherapists. *Professional Psychology: Research and Practice, 23*(5), 421.
- Heath, H., & Cowley, S. (2004). Developing a grounded theory approach: a comparison of Glaser and Strauss. *International Journal of Nursing Studies, 41*(2), 141-50.
- Henretty, J. R., & Levitt, H. M. (2010). The role of therapist self-disclosure in psychotherapy: A qualitative review. *Clinical Psychology Review, 30*(1), 63-77.
- Henretty, J. R., Currier, J. M., Berman, J. S., & Levitt, H. M. (2014). The impact of counselor self-disclosure on clients: A meta-analytic review of experimental and quasi-experimental research. *Journal of Counseling Psychology, 6*(2), 191.

- Hill, C. E., Gelso, C. J., & Mohr, J. J. (2000). Client concealment and self-presentation in therapy: Comment on Kelly. *Psychological Bulletin*, 126(4), 495-500.
- Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A Guide to Conducting Consensual Qualitative Research. *The Counseling Psychologist*, 25(4), 517-572. <https://doi.org/10.1177/0011000097254001>
- Hook, A., & Andrews, B. (2005). The relationship of non-disclosure in therapy to shame and depression. *British Journal of Clinical Psychology*, 44(3), 425-438.
- Howe, E. (2008). Ethical considerations when treating patients with schizophrenia. *Psychiatry (Edgmont)*, 5(4), 59-64.
- Hurd, M. (2011, November 26). *Therapists who lie to their clients and the clients who pay them*. Retrieved June 2018, from Dr.Hurd.com: <https://drhurd.com/2011/11/26/therapists-who-lie-to-their-clients-and-the-clients-who-pay-them>
- Jackson, D., & Farber, B. A. (2018). *Therapist dishonesty*. Amsterdam: Paper presented at the annual conference, Society for Psychological Research.
- Johnson, G. (2013, July 29). *Re: Lying to our clients [Blog comment]*. Retrieved from <http://www.afterpsychotherapy.com/lying-to-our-clients/>
- Jones, P. (2018, February 24). *When a therapist lies, can I trust her ever again?* Retrieved June 2019, from Quora: <https://www.quora.com/When-a-therapist-lies-can-I-trust-her-ever-again>
- Kelly, A. E., & Yuan, K. H. (2009). Clients' secret keeping and the working alliance in adult out. *Psychotherapy: Theory, Research, Practice, Training*, 46(2), 193.
- Knox, S., & Hill, C. E. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of Clinical Psychology*, 59(5), 529-539.

- Kohut, H. (1984). *How does psychoanalysis cure?* Chicago: University of Chicago Press.
- Kottler, J. A. (1993). *On being a therapist* (2nd ed.). San Francisco: Jossey-Bass.
- Kranzberg, M. B. (1998). Comments on “counter-transference considerations.”. *International Journal of Group Psychotherapy*, 48, 25-30.
- Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross, & M. R. Goldfried, *Handbook of psychotherapy integration* (pp. 94-129). New York: Basic Books.
- Lee, J., Lim, N., Yang, E., & Lee, S. M. (2011). Antecedents and consequences of three dimensions of burnout in psychotherapists: A meta-analysis. *Professional Psychology: Research and Practice*, 42, 252–258. <https://doi.org/10.1037/a0023319>
- Lee, J. J., Hardin, A. E., Parmar, B., & Gino, F. (2019). The interpersonal costs of dishonesty: How dishonest behavior reduces individuals’ ability to read others’ emotions. *Journal of Experimental Psychology: General*, 148(9), 1557.
- Levitt, H. M. (2015). Qualitative psychotherapy research: The journey so far and future directions. *Psychotherapy*, 52(1), 31-37. doi:10.1037/a0037076
- Livingston, G. (2015, January 15). *Pew Research Center*. Retrieved June 2019, from For most highly educated women, motherhood doesn’t start until the 30s : <https://www.pewresearch.org/fact-tank/2015/01/15/for-most-highly-educated-women-motherhood-doesnt-start-until-the-30s/>
- Love, M., & Farber, B. A. (2018). Honesty in Psychotherapy: Results of an online survey comparing high vs. low self-concealers. *Psychotherapy Research*.
- Lupoli, M., Jampol, L., & Oveis, C. (2017). Lying because we care: Compassion increases prosocial lying. *Journal of Experimental Psychology: General*, 146(7), 1026-1042.

- MacFarquhar, L. (2018, October 8). The comforting fictions of dementia care. *The New Yorker*, pp. 42-55.
- Matthews, B. (1988). The role of therapist self-disclosure in psychotherapy: A survey of therapists. *American Journal of Psychotherapy*, 42(4), 521-31.
- McWilliams, N. (2004). *Psychoanalytic psychotherapy: A practitioner's guide*. New York, NY: Guilford Press.
- Miller, E., & McNaught, A. (2018). Exploring decision making around therapist self-disclosure in cognitive behavioural therapy. *Australian Psychologist*, 53(1), 33-39.
- Miller, J. B., & Stiver, I. (1997). *The healing connection*. Boston: Beacon.
- Myers, D., & Hayes, J. (2006). Effects of therapist general self-disclosure and countertransference disclosure on ratings of the therapist and session. *Psychotherapy: Theory, Research, Practice, Training*, 43(2), 173-85.
- Norcross, J. C., & Guy, J. D. (2007). *Leaving it at the office: A guide to therapist selfcare*. New York, NY: Guilford Press.
- Oberg, B. (2013, April 30). *Should mental health professionals ever lie?* Retrieved January 2018, from Healthy Place: <https://www.healthyplace.com/blogs/borderline/2013/04/should-mental-health-professionals-ever-lie>
- Poland, W. S. (1975). Tact as a psychoanalytic function. *International Journal of Psycho-Analysis*, 56, 155-162.
- Robinson, K. (2014). Empathy, tact and the freedom to be natural. *The American Journal of Psychoanalysis*, 74, 332-9.
- Safran, Jeremy D., J. Christopher Muran, and Catherine Eubanks-Carter. "Repairing alliance ruptures." *Psychotherapy* 48.1 (2011): 80.

- Satterly, B. A. (2006). Therapist self-disclosure from a gay male perspective. *Families in Society*, 87(2), 240-7.
- Shabad, P. (2001). Despair and the return of hope: Echoes of mourning in psychotherapy. Northvale, NJ, US: Jason Aronson, Inc.
- Shoyer, B. G. (February, 1999). Psychotherapist self-care: Beliefs, practices, and outcomes. *Dissertation Abstracts International: Section B*, 59, 4485.
- Simionato, G., Simpson, S., & Reid, C. (2019). Burnout as an ethical issue in psychotherapy. *Psychotherapy*, 56(4), 470.
- Simone, D. H., McCarthy, P., & Skay, C. L. (1998). An investigation of client and counselor variables that influence likelihood of counselor self-disclosure. *Journal of Counseling & Development*, 76(2), 174-82.
- Sledge, W. (1989). The psychoanalyst's use of tact. *The Psychoanalytic Study of the Child*, 44(1), 137-47.
- Slepian, M. L., Halevy, N., & Galinsky, A. D. (2019). The Solitude of Secrecy: Thinking About Secrets Evokes Goal Conflict and Feelings of Fatigue. *Personality and Social Psychology Bulletin*, 45(7), 1129-1151.
- Snyder, C. R., & Taylor, J. D. (2000). Hope as a common factor across psychotherapy approaches: A lesson from the dodo's verdict. In *Handbook of hope* (pp. 89-108). Academic press.
- Solomon, A. (1994, March). I'm okay, but my shrink isn't: How to find a homo-friendly psychotherapist. *Au Courant*, 1, 11-12.
- Sprinks, J. (2013). Therapeutic lying should be avoided. *Nursing Older People*, 25(8), 7.

- Stiles, W. B. (1995). Disclosure as a speech act: Is it psychotherapeutic to disclose? In J. W. Pennebaker, *Emotion, disclosure, & health* (pp. 71–91). American Psychological Association.
- Thompson, B. J., & Hill, C. E. (1991). Therapist perceptions of client reactions. *Journal of Counseling & Development*, 69(3), 261-265.
- Vrij, A. (2000). *Detecting lies and deceit: The psychology of lying and implications for professional practice*. West Sussex, England: John Wiley & Sons, Ltd.
- Yalom, I. D. (1989). *Love's Executioner and other tales of psychotherapy*. London: Penguin.

Tables

Table 1

Participant Demographics: Quantitative Section (N = 401)

	M	SD
Age		
Mean	46.25	15.59
Median = 45		
Years in Practice		
Mean	16.48	12.67
Median = 13		
Number of Clients per Week		
Mean	22.19	23.50
Median = 20		
	n	%
Gender		
Female	292	72.8
Male	107	26.7
Other/Undisclosed	2	0.5
Race/Ethnicity		
African American/ Black	10	2.5
American Indian/Alaska Native	2	0.5
Asian/Asian-American	16	4
Hispanic/Latino/a	17	4.2
White/Caucasian	334	83.3
Other	18	4.5
Undisclosed	4	1
Sexual Orientation		
Heterosexual	329	82
Gay/Lesbian	24	6
Bisexual	37	9.2
Other	11	2.7
Relationship Status		
Single	78	19.5
Married	254	63.3
In Relationship	68	17
Undisclosed	1	0.2

Highest Degree of Education

Ph.D.	120	29.9
Psy.D.	38	9.5
M.D.	23	5.7
M.S.W.	61	15.2
Licensable M.A.	85	21.2
Graduate Student	43	10.7
Other	31	7.7

Enrolled/Received Post-degree Training

Yes	119	29.7
No	282	70.3

Country of Practice

United States	357	89
Others	44	11

State of Practice

New York	50	12.5
California	44	11
Illinois	23	5.7
Arizona	17	4.2
Texas	14	3.5
Oregon	12	3
Colorado	12	3
Pennsylvania	10	2.5
North Carolina	10	2.5
Washington	10	2.5
Others	155	38.7
Undisclosed	44	11

Theoretical Orientation

Psychodynamic	120	29.9
CBT	117	29.2
DBT	17	4.2
Interpersonal	8	2
Humanistic	85	21.2
Eclectic	22	5.5
Other	32	8

Primary Clinical Specialty

Addiction	21	5.3
Anxiety	26	6.7
Borderline Personality	4	1
Children/Adolescents	31	7.7
Depression	9	2.2

Relationships/Couples Counseling	18	4.5
Trauma	57	14.2
Other	58	14.5
No Primary Specialty	177	44.1
Currently in Own Psychotherapy		
Yes	146	36.4
No	255	63.6
Currently in Supervision		
Yes	173	43.1
No	228	56.9

Table 2*Participant Demographics, Qualitative Section (N = 341)*

	M	SD
Age		
Mean	46.63	15.74
Median = 45		
Years in Practice		
Mean	16.76	12.94
Median = 14		
Number of Clients per Week		
Mean	21.68	14.15
Median = 20		
	n	%
Gender		
Female	248	72.7
Male	91	26.7
Other/Undisclosed	2	0.6
Race/Ethnicity		
African American/ Black	7	2.1
American Indian/Alaska Native	2	2
Asian/Asian-American	13	3.8
Hispanic/Latino/a	14	4.1
White/Caucasian	286	83.9
Other	16	4.7
Undisclosed	3	0.9
Sexual Orientation		
Heterosexual	278	81.5
Gay/Lesbian	19	5.6
Bisexual	33	9.7
Other	11	3.2
Relationship Status		
Single	65	19.1
Married	221	64.8
In Relationship	55	16.1
Highest Degree of Education		
Ph.D.	106	31.1

Psy.D.	28	8.2
M.D.	20	5.9
M.S.W.	51	15
Licensable M.A.	75	22
Graduate Student	35	10.3
Other	26	7.6
Enrolled/Received Post-degree Training		
Yes	103	30.2
No	238	69.8
Country of Practice		
United States	308	90.3
Others	33	9.7
State of Practice		
New York	44	18.8
California	39	16.7
Illinois	18	7.7
Arizona	13	5.6
Texas	13	5.6
Oregon	10	4.3
Colorado	9	3.9
Pennsylvania	9	3.9
North Carolina	9	3.9
Washington	8	3.4
Others	136	39.9
Undisclosed	33	9.7
Theoretical Orientation		
Psychodynamic	100	29.3
CBT	102	29.9
DBT	16	4.7
Interpersonal	6	1.8
Humanistic	69	20.2
Eclectic	19	5.6
Other	29	8.5
Primary Clinical Specialty		
Addiction	18	5.3
Anxiety	23	6.7
Borderline Personality	22	6.5
Children/Adolescents	14	4.1
Depression	53	15.5
Relationships/Couples Counseling	63	18.5
Trauma	148	43.4

Other	18	5.3
No Primary Specialty	23	6.7
Currently in Own Psychotherapy		
Yes	126	37
No	215	63
Currently in Supervision		
Yes	148	43.4
No	193	56.6

Table 3*Therapist perceptions of the frequency of topics about which they have been covertly dishonest (N = 401)*

Item		N	Mean	SD
Feeling Emotionally Unwell	Have you ever given a client the impression that you felt emotionally well when in fact you didn't?	378	3.60	1.66
Feeling Physically Unwell	Have you ever given a client the impression that you felt physically well when in fact you didn't?	386	3.54	1.65
Feeling Frustrated/Disappointed	Have you ever given a client the impression that you weren't feeling frustrated or disappointed when in fact you were?	392	3.35	1.44
Feeling Bored	Have you ever given a client the impression that you weren't bored in session when in fact you were?	377	3.34	1.42
Finding Client Likable	Have you ever given a client the impression that you found him or her likeable when in fact you didn't?	377	3.10	1.57
Remembering Something	Have you ever given a client the impression that you remembered something when in fact you didn't?	396	3.04	1.52
Paying Attention	Have you ever given a client the impression that you were paying attention when in fact you weren't?	391	3.04	1.22
Availability	Have you ever given a client the impression that you were not available for a session when in fact you were?	386	2.68	1.56

Feeling Confident	Have you ever given a client the impression that you felt confident you could help him or her when in fact you didn't feel that way?	396	2.61	1.47
Reasons for Not Taking Client	Have you ever given a client a false impression about your reasons for not taking him or her on as a client?	316	2.57	1.57
Knowing Someone	Have you ever given a client a false impression about whether you knew, or didn't know, a person that he or she asked you about?	328	2.43	1.57
Outside Knowledge	Have you ever given a client a false impression about whether you knew about something that happened to him or her outside of session?	326	2.25	1.37
Reasons for Canceling/Rescheduling	Have you ever given a client a false impression about your reason for canceling or rescheduling a session?	387	2.25	1.40
Knowing About Something	Have you ever given a client a false impression about whether you had heard of, or hadn't heard of, something that he or she asked you about?	386	2.21	1.33
Own Personal Beliefs/Values	Have you ever given a client a false impression about your personal beliefs or values?	382	2.19	1.30
Own Personal Life	Have you ever given a client a false impression about aspects of your personal life?	386	2.11	1.40
Reasons for Being Late/Not Showing Up	Have you ever given a client a false impression about your reason for being late or failing to show up to a session?	338	1.92	1.35

Making Clinical Progress	Have you ever given a client the impression that you thought he or she was making clinical progress when in fact you didn't think so?	392	1.86	1.05
Professional Experience	Have you ever given a client the impression that you had experience in a particular area when in fact you didn't?	394	1.74	0.98
Own Mental Health	Have you ever given a client a false impression about your own mental health history?	329	1.74	1.34
Reasons for Terminating	Have you ever given a client a false impression about your reasons for terminating with him or her?	351	1.72	1.13
Conversations with Others	Have you ever given a client a false impression about the nature or content of your conversations with others (e.g., providers, employers, referrals, etc.) about his or her therapy?	367	1.69	1.01
Romantic/Sexual Feelings	Have you ever given a client a false impression about your romantic or sexual feelings towards him or her?	280	1.68	1.18
Diagnosis	Have you ever given a client a false impression about his or her diagnosis?	385	1.58	0.92
Hourly Rate	Have you ever given a client a false impression about your hourly rate?	332	1.20	0.65
Training or Credentials	Have you ever given a client a false impression about your training or credentials?	394	1.14	0.47

Note. Means are based on scores on a Likert scale where 1 = Never, 4 = Sometimes, 7 = Frequently

Table 4*Therapist perceptions of the frequency of topics about which they have been overtly dishonest (N = 401)*

Item		N	M	SD
Availability	Have you ever explicitly told a client that you were not available for a session when in fact you were?	386	2.57	1.51
Feeling Emotionally Unwell	Have you ever explicitly told a client that you felt emotionally well when in fact you didn't?	362	2.41	1.67
Feeling Physically Unwell	Have you ever explicitly told a client that you felt physically well when in fact you didn't?	377	2.40	1.58
Reasons for Not Taking Client	Have you ever explicitly told a potential client something untrue about your reasons for not taking him or her on as a client?	315	2.30	1.53
Feeling Frustrated/Disappointed	Have you ever explicitly told a client you weren't feeling frustrated or disappointed when in fact you were?	378	2.29	1.34
Remembering Something	Have you ever explicitly told a client that you remembered something when in fact you didn't?	394	2.15	1.26
Reasons for Canceling/Rescheduling	Have you ever explicitly told a client something untrue about your reason for canceling or rescheduling a session?	389	2.06	1.33
Feeling Confident	Have you ever explicitly told a client that you felt confident you could help him or her when in fact you didn't feel that way?	393	1.97	1.31
Knowing Someone	Have you ever explicitly told a client you knew, or didn't know, a person that he or she asked you about?	328	1.87	1.44

Finding Client Likable	Have you ever explicitly told a client that you found him or her likeable when in fact you didn't?	357	1.80	1.25
Reasons for Being Late/Not Showing Up	Have you ever explicitly told a client something untrue about your reason for being late or failing to show up to a session?	338	1.79	1.26
Knowing About Something	Have you ever explicitly told a client something untrue about whether you had heard of, or hadn't heard of, something that he or she asked you about?	387	1.72	1.10
Outside Knowledge	Have you ever explicitly told a client something untrue about whether you knew about something that happened to him or her outside of session?	324	1.70	1.13
Feeling Bored	Have you ever explicitly told a client that you weren't bored in session when in fact you were?	313	1.64	1.11
Making Clinical Progress	Have you ever explicitly told a client that you thought he or she was making clinical progress when in fact you didn't think so?	385	1.58	0.93
Own Personal Life	Have you ever explicitly told a client something untrue about aspects of your personal life?	387	1.58	1.16
Reasons for Terminating	Have you ever explicitly told a client something untrue about your reasons for terminating with him or her?	352	1.56	0.99
Paying Attention	Have you ever explicitly told a client that you were paying attention when in fact you weren't?	348	1.55	0.85

Own Personal Beliefs/Values	Have you ever explicitly told a client something untrue about your personal beliefs or values?	377	1.51	1.06
Conversations with Others	Have you ever explicitly told a client something untrue about the nature or content of your conversations with others (e.g., providers, employers, referrals, etc.) about his or her therapy?	362	1.40	0.81
Own Mental Health	Have you ever explicitly told a client something untrue about your own mental health history?	323	1.37	1.01
Professional Experience	Have you ever explicitly told a client that you had experience in a particular area when in fact you didn't?	390	1.29	0.70
Romantic/Sexual Feelings	Have you ever explicitly told a client something untrue about your romantic or sexual feelings towards him or her?	261	1.26	0.85
Diagnosis	Have you ever explicitly told a client something untrue about his or her diagnosis?	384	1.26	0.64
Hourly Rate	Have you ever explicitly told a client something untrue about your hourly rate?	332	1.16	0.58
Training or Credentials	Have you ever explicitly told a client something untrue about your training or credentials?	394	1.04	0.26

Note. Means are based on scores on a Likert scale where 1 = Never, 4 = Sometimes, 7 = Frequently

Table 5*Fit indices for one-to-three-class latent classes of therapists (covert dishonesty) (N = 401)**Covert Model Fit*

Statistics	1 Class	2 Classes	3 Classes
Akaike Information Criteria	31355.52	29929.24	29435.16
Bayesian Information Criteria	31563.21	30244.76	29858.52
Entropy	-	0.90	0.90
Lo-Mendell-Rubin Adjusted			
LRT	-	1471.19	544.72
<i>P-value</i>	-	0.06	0.19
Bootstrapped LRT <i>P-value</i>	-	0	0

Table 6*Fit indices for one-to-three-class latent classes of therapists (overt dishonesty) (N = 401)*

Statistics	1 Class	2 Classes	3 Classes
Akaike Information Criteria	27183.79	25551.99	24970.58
Bayesian Information Criteria	27391.48	25867.52	25393.94
Entropy	-	0.98	0.94
Lo-Mendell-Rubin Adjusted			
LRT	-	1675.44	631.52
<i>P-value</i>	-	0.054	0.49
Bootstrapped LRT <i>P-value</i>	-	0	0

Table 7*Reported motives (with examples) for therapist dishonesty in psychotherapy (N = 341)*

Reported Reasons	n	Percent
Treatment Strategy	70	20.5
“I find it can be helpful to play stupid about certain things in order to build empathy with clients.”		
“Being completely honest, if that meant giving her [the client] a direct answer to her question, I felt would have foreclosed the analytic process.”		
“I wanted to give the [client] space to express themselves without judgment.”		
Harmful to Patient	64	18.8
“I was less than honest because I felt the truth would be hurtful or damaging to the patient.”		
“The patient’s ego and self-esteem is fragile and I thought that sharing my most honest feelings would be damaging to them.”		
“[...] I didn’t want this person struggling with acceptance and abandonment to feel rejected by me.”		
“[...] to protect the veteran from unnecessary, potentially traumatizing details.”		
Self-Preservation	54	15.8
“A desire to create better boundaries for work/life balance.”		
“[I] often feel unsure about disclosing my sexuality, in part because I fear anger or complaints from parents [...]”		
“It is easier for me to say that I am single than to explain polyamory and my decisions regarding relationships and relationship configurations.”		
“Usually if I am too emotionally distraught, I will cancel on my client and report ‘an emergency came up,’ and leave it at that. I will also use the excuse of traffic if I need to take some time to myself, finish a phone call or use the restroom [...]”		
Bond	45	13.2
“I wish I could tell them how small minded and bigoted they are but that does not serve our therapeutic relationship.”		

<p>“I did not want to disrupt the therapeutic alliance by making the client feel uncomfortable [...]”</p> <p>“I wasn’t sure how to divulge something personal about myself without disrupting the relationship.”</p>		
Legal/Ethical	32	9.4
<p>“I wanted to respect the client’s right to privacy.”</p> <p>“I feel that this was more related to ethics and limits of confidentiality.”</p> <p>“I felt she [the client] was a liability and if I took her back, the chances of her suing me were increased. Plus, the sessions with her were not enjoyable and I experienced them as very stressful, having to watch every single word [...] that I said (or didn’t say).”</p>		
Focus on Patient	31	9.1
<p>“[I] didn’t want to disclose something that would put the focus of the session on me.”</p> <p>“[I] didn’t think it was in his [the client’s] best interest to spend 15 minutes of the session talking about me.”</p> <p>“[...] I feared that if she knew I was not feeling good, she would focus on my needs rather than her own [...]”</p>		
Unbeneficial to Patient	28	8.2
<p>“Saying I was upset would put my own feelings before the client’s and would likely prevent their honesty moving forward.”</p> <p>“Admitting sexual attraction is not productive.”</p> <p>“Sharing details of my healing was not relevant to the client’s growth.”</p>		
Impression Management	17	5
<p>“I felt that he would doubt me as a clinician if I were honest.”</p> <p>“[I] didn’t want to seem like I was inexperienced.”</p> <p>“My practice is new and thus relatively small and I do have a fear that being honest about when I’ve had little to no other clients may lead them to believe I do not provide quality services.”</p>		

Table 8*Reported perceived immediate consequences (with examples) for therapist dishonesty (N = 341)*

Reported Perceived Consequences	n	Percent
None	157	46
“[...] our relationship continued as usual.”		
“Can’t think of any.”		
“Nothing specific or notable.”		
Positive Consequences	114	33.5
“He [the client] continued to bring up other fantasies of violent ideation and we were able to discuss them.”		
“She [the client] has begun to moderate her anger in more appropriate ways other than lashing out at me when she is frustrated with herself.”		
“Client seemed to feel more hopeful and motivated to do the homework.”		
Negative Consequences	48	14.3
“I continue to feel regret.”		
“They have recently told me that they aren’t sure which direction we’re going in therapy. They’ve made statements that imply they’re wanting therapy that is noticeably DBT. They seem to have picked up on that I’m not doing DBT.”		
“Client has gained minimal insight into her personal issues and is seeing progress where there most likely isn’t any.”		
Unsure	18	5.5
“I don’t know. The patient moved to another city for financial concerns.”		
“Unsure. I want to say none but perhaps my reaction made the [client] less likely to revisit the topic.”		
“It appeared that my story did help the client to feel I understood, but I’m not so sure that it helped the client therapeutically.”		
Too Soon to Tell	4	1.1
“Not sure. I will see him [the client] tomorrow.”		
“Don’t know yet.”		
“Only time will tell!”		

Table 9*Reported perceived later consequences (with examples) for therapist dishonesty (N = 341)*

Reported Perceived Consequences	n	Percent
None “None that I can think of.”	157	46
Unsure “Don’t know.” “Not sure.”	78	23
Positive Consequences “More long-term trust in the therapist and the client’s own progress in trusting herself.” “The client has been working harder to resolve her issues.” “[The client] shows more self-esteem.”	53	15.6
Negative Consequences “The client may still not be able to accept the truth herself.” “Client relapsed again two weeks later, unclear if changing my reaction would have influenced this in any way.” “The client continued to miss sessions and ended up terminating.”	43	12.6
Negative Feeling / Discomfort “I don’t know the implications of this yet, but it makes me uncomfortable and also a bit disappointed in myself.” “There remains some degree of regret.” “I was more exhausted by the end of the session than I would normally have been” “My own guilt and shame for indulging in what felt like ‘gossip’.” “I am awaiting to hear whether or not the Board will open up a complaint against me.”	23	6.6

Table 10

Percent of therapists who reported having been covertly dishonest at least once, by topic (N = 401)

Item		Percent
Paying Attention	Have you ever given a client the impression that you were paying attention when in fact you weren't?	91.5
Availability	Have you ever given a client the impression that you were not available for a session when in fact you were?	88.0
Clinical Progress	Have you ever given a client the impression that you thought he or she was making clinical progress when in fact you didn't think so?	84.5
Reason for Being Late	Have you ever given a client a false impression about your reason for being late or failing to show up to a session?	84.0
Conversations with Others	Have you ever given a client a false impression about the nature or content of your conversations with others (e.g., providers, employers, referrals, etc.) about his or her therapy?	84.0
Diagnosis	Have you ever given a client a false impression about his or her diagnosis?	82.3
Reason for Canceling	Have you ever given a client a false impression about your reason for canceling or rescheduling a session?	75.6
Training or Credentials	Have you ever given a client a false impression about your training or credentials?	70.8
Own Mental Health	Have you ever given a client a false impression about your own mental health history?	63.3
Feeling Emotionally Unwell	Have you ever given a client the impression that you felt emotionally well when in fact you didn't?	60.8
Being Bored	Have you ever given a client the impression that you weren't bored in session when in fact you were?	57.6

Feeling Frustrated/Disappointed	Have you ever given a client the impression that you weren't feeling frustrated or disappointed when in fact you were?	52.9
Professional Experience	Have you ever given a client the impression that you had experience in a particular area when in fact you didn't?	52.1
Outside Knowledge	Have you ever given a client a false impression about whether you knew about something that happened to him or her outside of session?	51.1
Reasons for Not Taking Client	Have you ever given a client a false impression about your reasons for not taking him or her on as a client?	49.4
Finding Client Likable	Have you ever given a client the impression that you found him or her likeable when in fact you didn't?	49.1
Hourly Rate	Have you ever given a client a false impression about your hourly rate?	44.6
Own Personal Life	Have you ever given a client a false impression about aspects of your personal life?	38.9
Personal Beliefs/Values	Have you ever given a client a false impression about your personal beliefs or values?	38.7
Knowing Someone	Have you ever given a client a false impression about whether you knew, or didn't know, a person that he or she asked you about?	37.7
Feeling Confident	Have you ever given a client the impression that you felt confident you could help him or her when in fact you didn't feel that way?	33.7
Feeling Physically Unwell	Have you ever given a client the impression that you felt physically well when in fact you didn't?	30.9
Reasons for Terminating	Have you ever given a client a false impression about your reasons for terminating with him or her?	29.4

Remembering Something	Have you ever given a client the impression that you remembered something when in fact you didn't?	24.2
Knowing Something	Have you ever given a client a false impression about whether you had heard of, or hadn't heard of, something that he or she asked you about?	9.7
Romantic/Sexual Feelings	Have you ever given a client a false impression about your romantic or sexual feelings towards him or her?	9.7

Table 11

Percent of therapists who reported having been overtly dishonest at least once, by topic (N = 401)

Item		Percent
Own Mental Health	Have you ever explicitly told a client something untrue about your own mental health history?	65.6
Availability	Have you ever explicitly told a client that you were not available for a session when in fact you were?	63.6
Diagnosis	Have you ever explicitly told a client something untrue about his or her diagnosis?	59.4
Reason for Being Late	Have you ever explicitly told a client something untrue about your reason for being late or failing to show up to a session?	55.4
Being Bored	Have you ever explicitly told a client that you weren't bored in session when in fact you were?	52.4
Conversations with Others	Have you ever explicitly told a client something untrue about the nature or content of your conversations with others (e.g., providers, employers, referrals, etc.) about his or her therapy?	51.6
Training or Credentials	Have you ever explicitly told a client something untrue about your training or credentials?	48.6
Professional Experience	Have you ever explicitly told a client that you had experience in a particular area when in fact you didn't?	45.1
Feeling Emotionally Unwell	Have you ever explicitly told a client that you felt emotionally well when in fact you didn't?	42.9
Own Personal Life	Have you ever explicitly told a client something untrue about aspects of your personal life?	35.4
Outside Knowledge	Have you ever explicitly told a client something untrue about whether you knew about something that happened to him or her outside of session?	35.2

Reason for Canceling	Have you ever explicitly told a client something untrue about your reason for canceling or rescheduling a session?	34.9
Paying Attention	Have you ever explicitly told a client that you were paying attention when in fact you weren't?	32.9
Reasons for Not Taking Client	Have you ever explicitly told a potential client something untrue about your reasons for not taking him or her on as a client?	31.9
Feeling Physically Unwell	Have you ever explicitly told a client that you felt physically well when in fact you didn't?	30.9
Feeling Confident	Have you ever explicitly told a client that you felt confident you could help him or her when in fact you didn't feel that way?	28.7
Feeling Frustrated/Disappointed	Have you ever explicitly told a client you weren't feeling frustrated or disappointed when in fact you were?	28.2
Clinical Progress	Have you ever explicitly told a client that you thought he or she was making clinical progress when in fact you didn't think so?	27.2
Finding Client Likable	Have you ever explicitly told a client that you found him or her likeable when in fact you didn't?	26.9
Personal Beliefs/Values	Have you ever explicitly told a client something untrue about your personal beliefs or values?	23.7
Hourly Rate	Have you ever explicitly told a client something untrue about your hourly rate?	18.7
Knowing Someone	Have you ever explicitly told a client you knew, or didn't know, a person that he or she asked you about?	18.2
Reasons for Terminating	Have you ever explicitly told a client something untrue about your reasons for terminating with him or her?	15.0

Remembering Something	Have you ever explicitly told a client that you remembered something when in fact you didn't?	8.7
Knowing Something	Have you ever explicitly told a client something untrue about whether you had heard of, or hadn't heard of, something that he or she asked you about?	8.0
Romantic/Sexual Feelings	Have you ever explicitly told a client something untrue about your romantic or sexual feelings towards him or her?	2.7

Figures

Figure 1

Latent class analysis results for covert dishonesty, by topic

Figure 2

Latent class analysis results for overt dishonesty, by topic

Appendix A: PATCH2 Recruitment Email

Subject: Psychotherapist Study

I am writing from Columbia University Teachers College seeking participants for a study on therapist honesty. This research comes out of a research lab, overseen by Dr. Barry Farber, that has been investigating various aspects of client, therapist, and supervisee disclosure in psychotherapy. Our study seeks to learn more about an under-researched but seemingly common phenomenon in psychotherapeutic practice: the extent to which therapists, like individuals in any interpersonal situation, occasionally conceal certain feelings, are less than fully honest, and/or are not entirely disclosing.

The survey is online, completely confidential, and should take **about 15 minutes to complete**. Our study has been approved by the Teachers College, Columbia University Institutional Review Board (Protocol ID: 19-237).

To learn more about the study, or to begin the survey, please click here: [INSERT LINK HERE]

We greatly appreciate your time and participation. If you have any questions or concerns, please feel free to contact me at this email address.

Sincerely,
Devlin Jackson

Devlin Jackson, Ed.M., M.A.

Clinical Psychology Doctoral Candidate | [PATCH Lab](#)

Department of Clinical Psychology, Teachers College, Columbia University

Appendix B: PATCH2 Informed Consent

Teachers College, Columbia University
525 West 120th Street
New York NY 10027
212-678-3000

INFORMED CONSENT

Protocol Title:

Psychotherapists' Assessments of Tact, Concealment, and Honesty (PATCH2)

Principal Investigator:

Devlin A. Jackson, Ed.M., M.A., Teachers College, Columbia University
617-820-8105, dah2178@tc.edu

INTRODUCTION

You are being invited to participate in a research study called “Psychotherapists' Assessments of Tact, Concealment, and Honesty.” You may qualify to take part in this research study because you are currently practicing psychotherapy as either a trainee or licensed clinician. Approximately two hundred people will participate in this study and it will take about 15 minutes of your time to complete.

WHY IS THIS STUDY BEING DONE?

Our research seeks to learn more about an under-researched but seemingly common phenomenon in psychotherapeutic practice: the extent to which therapists, like individuals in any interpersonal situation, occasionally conceal certain feelings, are less than fully honest, and/or are not entirely disclosing.

WHAT WILL I BE ASKED TO DO IF I AGREE TO TAKE PART IN THIS STUDY?

If you decide to participate, you will complete a self-report electronic survey of questions including demographic data (e.g., age, gender, sexual orientation, ethnicity, relationship status, work setting, degree type, primary modality) and questions about the extent to which you have been less than completely honest about common topics in psychotherapy (e.g., diagnosis, remembering something a client mentioned previously in session, reasons for being late or missing a session). Your participation is voluntary, and you may withdraw from the survey at any point. All responses are completely confidential.

WHAT POSSIBLE RISKS OR DISCOMFORTS CAN I EXPECT FROM TAKING PART

IN THIS STUDY?

This is a minimal risk study, which means the harms or discomforts that you may experience are not greater than you would ordinarily encounter in daily life while taking routine physical or psychological examinations or tests. However, there are some risks to consider. You might feel discomfort at recalling instances when you were less than completely honest from your clinical practice. However, you can stop participating in the study at any time without penalty. The principal investigator is taking precautions to keep your information confidential (all responses are entirely anonymous and unlinked to any identifying information) and prevent anyone from discovering or guessing your identity, including keeping all information on a password protected computer and locked in a file drawer.

WHAT POSSIBLE BENEFITS CAN I EXPECT FROM TAKING PART IN THIS STUDY?

There is no direct benefit to you for participating in this study. Participation may benefit the field of psychology by helping us better understand the ways in which clinical tact, sometimes in the form of less than complete honesty, is utilized in clinical practice.

WILL I BE PAID FOR BEING IN THIS STUDY?

You will not be paid to participate. There are no costs to you for taking part in this study.

WHEN IS THE STUDY OVER? CAN I LEAVE THE STUDY BEFORE IT ENDS?

The study is over when you have completed the survey. However, you can leave the study at any time even if you haven't finished.

PROTECTION OF YOUR CONFIDENTIALITY

All information is collected anonymously and aggregated on a group basis. The principal investigator will keep all electronic or digital information on a computer that is password protected. Regulations require that research data be kept for at least three years. For quality assurance, the study team, the study sponsor (grant agency), and/or members of the Teachers College Institutional Review Board (IRB) may review the data collected from you as part of this study. Otherwise, all information obtained from your participation in this study will be held strictly confidential and will be disclosed only with your permission or as required by U.S. or State law.

HOW WILL THE RESULTS BE USED?

The results of this study may be published in journals and/or presented at academic conferences. Your name or any identifying information about you will not be collected nor published. This study is being conducted as part of the dissertation of the principal investigator.

WHO CAN ANSWER MY QUESTIONS ABOUT THIS STUDY?

If you have any questions about taking part in this research study, you should contact the principal investigator, Devlin Jackson, at 617-820-8105 or at dah2178@tc.columbia.edu. You can also contact the faculty advisor, Dr. Barry Farber at 212-678-3125 or at farber@tc.columbia.edu.

If you have questions or concerns about your rights as a research subject, you should contact the Institutional Review Board (IRB) (the human research ethics committee) at 212-678-4105 or email IRB@tc.edu. Or you can write to the IRB at Teachers College, Columbia University, 525 W. 120th Street, New York, NY 1002. The IRB is the committee that oversees human research protection for Teachers College, Columbia University.

PARTICIPANT'S RIGHTS

- I have read and discussed the informed consent with the researcher. I have had ample opportunity to ask questions about the purposes, procedures, risks and benefits regarding this research study.
- I understand that my participation is voluntary. I may refuse to participate or withdraw participation at any time without penalty.
- The researcher may withdraw me from the research at his or her professional discretion, such as not meeting inclusion criteria (i.e., status as a training or practicing therapist) or an incomplete survey.
- If, during the course of the study, significant new information that has been developed becomes available which may relate to my willingness to continue my participation, the investigator will provide this information to me.
- Any information derived from the research study that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- I should receive a copy of the Informed Consent document.

By clicking "I agree" below you are indicating that you are at least 18 years old, have read and understood this consent form, and agree to participate in this research study. You may print a copy of this page for your records.

I do not agree

I agree

Appendix C: PATCH2 Survey

Introduction

Our study seeks to learn about an under-researched but seemingly common phenomenon in psychotherapeutic practice: the extent to which therapists, like individuals in any interpersonal situation, occasionally conceal certain feelings, are less than fully honest, and/or are not entirely disclosing. We anticipate that the results of this survey will benefit clinical practice; although we anticipate no risks, some items might engender some discomfort or anxiety. As a reminder, your participation is voluntary, and you may withdraw from the survey at any point. All responses are completely confidential; all data will be aggregated on a group basis. The survey should take approximately 15 minutes. We thank you in advance for your time and participation.

About the questions

This survey consists of three parts:

- (1) Demographic information
- (2) Rating how often, if ever, you have been less than completely honest with clients on a variety of topics
- (3) Describing a memorable time when you were less than completely honest with a client

Part 1: Demographic information

What is your age? _____

What is your gender?

- Male
- Female
- Other

What is your sexual orientation?

- Heterosexual
- Gay/Lesbian
- Bisexual
- Other

What is your relationship status?

- Single
- Married
- In a relationship
- Widowed

What is your ethnicity?

- White
- Black or African American
- Hispanic/Latino
- American Indian or Alaska Native
- Asian/Asian American
- Native Hawaiian or Pacific Islander
- Other
- Prefer not to say

What is the nature of your clinical work setting?

- Private practice
- Clinic/Hospital
- Both

What is your highest degree type?

- Ph.D.
- Psy.D.
- M.D.
- M.S.W.
- Licensable M.A. (e.g., LHMC, LPC, LMFT)
- Graduate in a mental health program (e.g., Ph.D., Psy.D., M.S.W., Licensable M.A.)
- Other _____

Approximately how many total clients do you currently see per week (including group patients, assessments, etc.)? _____

How many years have you been seeing clients (please include pre-licensing training)? _____

Where do you practice primarily?

- In the United States
- Outside of the United States

[If “In the United States” is selected] Where do you primarily practice (check all that apply)?

● Alabama	● Nebraska
● Alaska	● Nevada
● Arizona	● New Hampshire
● Arkansas	● New Jersey
● California	● New Mexico
● Colorado	● New York
● Connecticut	● North Carolina
● Delaware	● North Dakota
● Florida	● Ohio
● Georgia	● Oklahoma
● Hawaii	● Oregon
● Idaho	● Pennsylvania
● Illinois	● Puerto Rico
● Indiana	● Rhode Island
● Iowa	● South Carolina
● Kansas	● South Dakota
● Kentucky	● Tennessee
● Louisiana	● Texas
● Maine	● Utah
● Maryland	● Vermont
● Massachusetts	● Virginia
● Michigan	● Washington
● Minnesota	● West Virginia
● Mississippi	● Wisconsin
● Missouri	● Wyoming
● Montana	

[If “Outside of the United States” is selected] In what country/countries do you currently practice? _____

Which of the following is your *primary* modality or theoretical orientation?

- Psychodynamic Psychotherapy
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Interpersonal Therapy (IPT)
- Integrated/Eclectic Psychotherapy
- Humanistic Therapy
- Other _____

If you have a *primary* clinical specialty, please note it here.

- Addiction
- Anxiety
- Borderline Personality
- Children/Adolescents
- Depression
- Relationships/Couples Counseling
- Trauma
- Other _____

Are you currently in your own psychotherapy?

- Yes
- No

Are you currently in supervision?

- Yes
- No

Part 2: Specific situations

*Therapists cite many situations in which they have been less than completely honest with a client in session. Below are 26 examples. For each example, you will be asked about how many times you have been less than completely honest **by giving a client a false impression about something or by being explicitly untruthful**. Please indicate on the scale below each of these situations how many times have you have been less than completely honest about each topic in your clinical work. If you have not encountered the situation in your practice, please indicate so on the scale.*

1. Being alert or paying attention

Have you ever given a client the impression that you were paying attention when in fact you weren't?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client that you were paying attention when in fact you weren't?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

2. Feeling bored in session

Have you ever given a client the impression that you weren't bored in session when in fact you were?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client that you weren't bored in session when in fact you were?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

3. Feeling frustrated or disappointed

Have you ever given a client the impression that you weren't feeling frustrated or disappointed when in fact you were?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client you weren't feeling frustrated or disappointed when in fact you were?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

4. Disliking a client

Have you ever given a client the impression that you found him or her likeable when in fact you didn't?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client that you found him or her likeable when in fact you didn't?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

5. Feeling physically unwell

Have you ever given a client the impression that you felt physically well when in fact you didn't?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client that you felt physically well when in fact you didn't?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

6. Feeling emotionally unwell

Have you ever given a client the impression that you felt emotionally well when in fact you didn't?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client that you felt emotionally well when in fact you didn't?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

7. Forgetting something a client said

Have you ever given a client the impression that you remembered something when in fact you didn't?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client that you remembered something when in fact you didn't?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

8. Claiming experience

Have you ever given a client the impression that you had experience in a particular area when in fact you didn't?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client that you had experience in a particular area when in fact you didn't?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

9. Claiming confidence that you'll be able to help

Have you ever given a client the impression that you felt confident you could help him or her when in fact you didn't feel that way?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client that you felt confident you could help him or her when in fact you didn't feel that way?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

10. Claiming clinical progress

Have you ever given a client the impression that you thought he or she was making clinical progress when in fact you didn't think so?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client that you thought he or she was making clinical progress when in fact you didn't think so?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

11. Clarifying your availability

Have you ever given a client the impression that you were not available for a session when in fact you were?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client that you were not available for a session when in fact you were?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

12. Giving reasons for canceling or rescheduling

Have you ever given a client a false impression about your reason for canceling or rescheduling a session?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client something untrue about your reason for canceling or rescheduling a session?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

13. Giving reasons for being late or failing to show up

Have you ever given a client a false impression about your reason for being late or failing to show up to a session?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client something untrue about your reason for being late or failing to show up to a session?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

14. Describing your conversations with providers, employers, referrals, etc.

Have you ever given a client a false impression about the nature or content of your conversations with others (e.g., providers, employers, referrals, etc.) about his or her therapy?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client something untrue about the nature or content of your conversations with others (e.g., providers, employers, referrals, etc.) about his or her therapy?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

15. Discussing diagnosis

Have you ever given a client a false impression about his or her diagnosis?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client something untrue about his or her diagnosis?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

16. Discussing your hourly rate

Have you ever given a client a false impression about your hourly rate?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client something untrue about your hourly rate?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

17. Representing your training or credentials

Have you ever given a client a false impression about your training or credentials?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client something untrue about your training or credentials?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

18. Knowing about things that happened outside of session

Have you ever given a client a false impression about whether you knew about something that happened to him or her outside of session?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client something untrue about whether you knew about something that happened to him or her outside of session?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

19. Sharing your own mental health history

Have you ever given a client a false impression about your own mental health history?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client something untrue about your own mental health history?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

20. Sharing aspects of your personal life, such as marital status, children, sexual orientation, ethnicity, etc.

Have you ever given a client a false impression about aspects of your personal life?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client something untrue about aspects of your personal life?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

21. Sharing your personal beliefs or values, such as political views, moral beliefs, lifestyle preferences, etc.

Have you ever given a client a false impression about your personal beliefs or values?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client something untrue about your personal beliefs or values?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

22. Knowing someone, such as a mutual acquaintance between you and your client

Have you ever given a client a false impression about whether you knew, or didn't know, a person that he or she asked you about?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client you knew, or didn't know, a person that he or she asked you about?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

23. Being familiar with something, such as a movie, a book, a musician, etc.

Have you ever given a client a false impression about whether you had heard of, or hadn't heard of, something that he or she asked you about?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client something untrue about whether you had heard of, or hadn't heard of, something that he or she asked you about?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

24. Discussing your romantic or sexual feelings towards clients

Have you ever given a client a false impression about your romantic or sexual feelings towards him or her?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client something untrue about your romantic or sexual feelings towards him or her?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

25. Taking on new clients

Have you ever given a client a false impression about your reasons for not taking him or her on as a client?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a potential client something untrue about your reasons for not taking him or her on as a client?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

26. Terminating with a client

Have you ever given a client a false impression about your reasons for terminating with him or her?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Have you ever explicitly told a client something untrue about your reasons for terminating with him or her?

Never 1	2	3	Sometimes 4	5	6	Frequently 7	This has not come up for me N/A
------------	---	---	----------------	---	---	-----------------	--

Follow up questions

In general, how self-disclosing are you with clients in session?

Not very self-disclosing 1	2	3	Somewhat self-disclosing 4	5	6	Very self-disclosing 7
-------------------------------	---	---	-------------------------------	---	---	---------------------------

How honest do you feel you have been in completing this survey?

Not very honest 1	2	3	Somewhat honest 4	5	6	Very honest 7
----------------------	---	---	----------------------	---	---	------------------

Part 3: A recent example

Being less than completely honest with clients in session is a seemingly common phenomenon in psychotherapeutic practice. A therapist's motives for being less than completely honest with a client can reflect his or her own needs, the client's needs, or some combination.

Take a moment to recall the most recent time when you were less than completely honest with a client in session and describe the situation as you remember it. A reminder: your responses on this survey are *completely anonymous*.

If you haven't already noted this above, please tell us about the following:

What were your reasons for being less than completely honest?

What feelings did you experience?

What were the immediate consequences of this decision?

What, if any, were the later consequences?

Would you handle this any differently today?

Thank you for completing our survey.

If you are interested in participating in a 30-45 minute phone interview as part of a subsequent study on the topic of therapist honesty, please click **here** to provide your contact information to be contacted by a member of our lab at a later time. Your contact information will remain completely separate from your survey answers to maintain the complete anonymity of your responses.

By entering your contact information below you are indicating that you agree to be contacted by a member of our lab at a later time with the opportunity to participate in a 30-45 minute phone interview as part of a subsequent research study on the topic of therapist honesty. If you decide to participate, you will complete a 30-45 minute phone interview including demographic data (e.g., age, gender, sexual orientation, ethnicity, relationship status, work setting, degree type, primary modality) and questions about the extent to which you have been less than completely honest about common topics in psychotherapy (e.g., diagnosis, remembering something a client mentioned previously in session, reasons for being late or missing a session). Your contact information will remain completely separate from your survey answers to maintain the complete anonymity of your responses.

Name: _____

Email: _____

Phone Number: ____ - ____ - _____