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When Clients Are Untruthful: Implications for the Therapeutic Alliance, Case Conceptualization, and Intervention

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Therapists endeavor to be genuine and trustworthy with clients, thus facilitating the establishment and maintenance of a positive therapeutic relationship. Unfortunately, clients sometimes knowingly give false or misleading information, maintain counter therapeutic hidden agendas, and deliberately obscure clinically relevant facts. Such factors likely will obstruct the process of case conceptualization, strain the therapeutic relationship, and result in disagreements about proper interventions. We discuss some of the telltale signs of clients' untruthfulness, and suggest ways in such cases for therapists to draw upon clients' behaviors in session to construct useful case formulations. Additionally, we describe a number of interventions that increase the chances of pursuing healthy, appropriate, therapeutic goals, irrespective of clients' degree of sincerity.

Keywords: client-therapist relationship; trust; truthfulness; psychiatry

We as therapists typically believe that our clients choose to enter therapy for legitimate reasons, that clients' emotional pain and suffering have a basis in fact, and that clients recognize that it is in their best interest to give us truthful information. We say "truthful" in the sense that the clients' personal constructions of their realities—as they understand them—are in fact what they present to their therapists. However, this is not always the case. There are times when clients offer their therapists information about themselves and their situations that can be described as significantly misrepresentative. While this may (in part) involve clients' clinically relevant perceptual distortions, clients sometimes are well aware that what they are saying

in session is not really what they know to be the case. In other words, clients sometimes deliberately distort their self-presentation for unwarranted personal gain, avoidance of anticipated consequences, or some other patently inappropriate use of therapy.

CLINICAL EXAMPLES

The following are brief examples of clients who are being less than honest with their therapists:

1. A client in an outpatient drug-abuse rehabilitation program fails to show up for two consecutive sessions. The therapist subsequently learns that two of the client's mandated urine samples recently turned up positive for cocaine. Nonetheless, when the client suddenly shows up for a therapy session, she maintains steadfastly that she has not used drugs, and becomes indignant when the therapist nicely, humbly offers to talk about dealing with the client's relapse.
2. A new client answers "no" to all of the therapist's standard assessment questions about the client's history of suicidality or hospitalization. Later, a clinical supervisor warns the therapist that this client was seen in the clinic many years ago, and has had repeated suicide attempts and hospitalizations.
3. A client presents with an unusually wide range of symptoms that do not seem to fit together conceptually. Further, the client does not seem to be interested in forming an alliance with the therapist, or in attending sessions as scheduled. Later, the therapist receives a subpoena from the client's attorney, referring to a lawsuit (that the therapist never heard about) in which the client is the plaintiff, asking the therapist to submit clinical records that will prove the client's "considerable pain and suffering."

Although clients sometimes lie to their therapists, this does not necessarily mean that therapy cannot proceed. By conceptualizing the client's untruthful presentation, therapists can offer interventions that make therapy viable, even when the therapeutic relationship is something less than optimally genuine.

THE THERAPIST'S VULNERABILITY TO CLIENT DECEPTION

There are times when a therapist may be primed and alerted to the possibility that a new client is likely to be dishonest in his or her self-reported presentation. For example, a therapist may receive a court-mandated referral, where the client's previous records indicate an Axis II diagnosis of antisocial personality disorder.

Unfortunately, it is not often the case that therapists have such clear advance notice. When clients enter treatment, the therapist is likely to assume that they are doing so out of a genuine desire to deal with their psychological problems, and that they are prepared to state the nature of their problems as accurately as their subjective perspective will allow. This assumption may be faulty. Pankratz (1998) offers examples of therapists' beliefs that can make them vulnerable to client deception. To paraphrase, these beliefs include:

1. If I show my client that I have good intentions and that I am honest, the client will want to act the same way toward me.
2. If I show that I value the therapeutic relationship, the client will be motivated to interact with me in a genuine way.
3. If I am treating a client who has a problem in my particular area of professional expertise, I will be especially adept at assessing hidden agendas or other complicating issues that the client may be obscuring.

Pankratz (1998) also makes the observation that being empathic can cause therapists to lose a little bit of the critical edge needed to ascertain when clients are not being forthcoming in their self-report. Unlike police detectives who interrogate suspects, or trial attorneys who cross-examine witnesses, therapists generally search for relevant information in a more collaborative fashion with their clients. To be cynical or intimidating would damage the therapeutic alliance. Thus, therapists will often choose to err on the side of accepting their clients' self-report in good faith.

IMPLICATIONS FOR THE CASE CONCEPTUALIZATION

Therapists gather information on each client to formulate an individualized case conceptualization (Needleman, 1999), a process that is highly dependent on the reliability of the data. How can therapists detect when clients may be deliberately falsifying or hiding salient facts?

Red Flags

There are some telltale signs that may signal client dishonesty. One such red flag is when clients offer historical background information that seems difficult to reconcile with their presenting problems, or (similarly) when their presenting problems create an oddly inconsistent profile (Pankratz, 1998). Another indicator that clients may be using therapy in an insincere manner is when their goals for treatment are poorly defined or run counter to what most would consider to be a "healthy" outcome. For example, a client who presents with "test anxiety" does not want to work on time-management skills, relaxation, self-coaching, or graded-task exercises, but instead wants a "doctor's note that confirms that [the client] should be excused from taking final exams."

Cunnien (1988) advises therapists to be on guard whenever clients present for treatment while engaged in any sort of legal action. As clients may not necessarily volunteer such information, it is recommended that therapists inquire about clients' current legal involvements as a routine part of the initial screening or intake procedure. Some clients may be far more interested in using their therapists as "expert witnesses" in court than in making personal changes or engaging in honest self-assessments. In a related vein, Cunnien (1988) also warns therapists to be suspicious whenever new clients refuse to cooperate with the standard intake and evaluation procedures. For example, it is a red flag when clients refuse to reveal the details of previous treatments and/or will not give consent for the current therapist to communicate with or receive records from former treatment providers (Bryant

& Harvey, 2000). Of course, as illustrated by a previous example, some clients simply lie about their treatment history. In such cases, the therapist will need to rely more heavily on in-session observations to inform a conceptualization of the case.

Another indicator of client deception is when therapists notice a pattern whereby clients' symptoms worsen when they are more closely observed (Cunnien, 1988). Examples include clients whose functioning seems to worsen in the context of formal testing, and those who show a surprisingly improved condition when they mistakenly think that nobody relevant is present (e.g., when the therapist sees the client in passing, in public). Similarly, some clients demonstrate symptom patterns that shift in accordance with situational changes, such that they always seem to serve the clients in some advantageous way. For example, one of our clients would evidence worsening agoraphobic symptoms when his wife expected him to go out and look for a job, but would become remarkably mobile when his buddies invited him along for the 60-mile drive to the casinos. The therapist on this case knew nothing of this phenomenon until the client's wife revealed it in a conjoint session.

One of the more immediate signs of potential client dishonesty occurs when the therapists themselves feel invalidated by their clients, and thus feel either a rift in the therapeutic relationship and/or an inability to proceed without ignoring their own perceptions. In an earlier example we described a client who denied using drugs between sessions, yet had produced two urine samples that were positive for cocaine, and had mysteriously dropped out of sight for 2 weeks. The therapist in this instance felt stymied. If he confronted the client directly, he risked precipitating a breach in the alliance. If he did not confront the client, he would have to proceed as if in denial himself, and in the process tacitly endorse a mutual conspiracy of avoiding the incontrovertible evidence of the client's relapse. Of course, this case was simplified by the independent data of the urinalyses. The trickier occurrences are those in which therapists have only their clinical impressions and judgment on which to go, all of which point to hypotheses that run counter to that which the client insists to be true.

Similarly, therapists can use their own internal responses as indicators that "something is not quite right." Reactions may range from a feeling of helplessness in conducting a fruitful session, perhaps coupled with a more general sense of self-doubt, to frustration, anger, and even fear in the presence of the client. Despite this felt discomfort, therapists who are aware of their own "bad feelings" about a case are in the best position to systematically articulate their thoughts about their interactions with these clients (perhaps on paper, and/or to a supervisor or consultant), and to look at the data in a critical (hopefully elucidating) way.

Revising the Case Conceptualization in Light of Clients' Dishonest Report

Clearly, when therapists gather bogus data from their clients, the process of case conceptualization will be hindered. By extension, the change process will bog down as well. Signs that the client may be thwarting an accurate formulation of the case include:

- The therapist adjusts the case formulation in light of the client's unexpected behavior, yet the client continues to reject the therapist's revised hypotheses at every turn, unless they match the client's views exactly, at that moment.

- The therapist tries to gather more information to understand the client better, but the client does not take kindly to this process and tries to sidestep it.
- The client does not want to explore personal issues, but rather to simply be believed at face value, and obeyed (e.g., "Here is my story, and this is what you need to do for me!"). They may simply tell their story, again and again, as their chief mode of engaging with the therapist. They respond to the therapist's further questioning with annoyance, as if all further evaluation is unnecessary.
- The client seems never to answer the question the therapist is asking, and instead slips away onto other topics and/or gives rote, repetitive answers and comments.
- The therapist feels hesitant to speak openly, and anticipates a rift in the therapeutic relationship if he or she verbalizes observations about the client, and about what is happening in session.

Each scenario described above is characterized by the therapist's legitimate efforts to understand the client and willingness to be flexible in doing so. In response, the client tries to block this process, wanting his or her own stated formulation of the problem to be the finished product, and rejecting the idea of delving into the related issues more completely. One may hypothesize that the client in this scenario views the therapist's inquiries (tactful though they may be) as a waste of time—or worse—evoking a threatening process that could trip up the client and expose the lies. In either case, the client will not engage the therapist in a good faith effort to flesh out the facts, and/or to consider alternative hypotheses.

Rather than feel stymied, therapists who find themselves mired in the above problems can try to incorporate those difficulties into the case formulation. For starters, therapists who conclude that clients' week-to-week reports are of dubious accuracy can turn their attention primarily to what is happening in the therapy session proper. Even if the therapist is unable to gain a clear, credible mental picture of what the client is actually doing during the week, he or she certainly has a front row view of the client's behavior in the context of the therapeutic relationship. These data are very valuable when trying to understand a client's modus operandi.

For example, a client who had been seen for over a year of weekly sessions suddenly reported experiencing command hallucinations, a symptom that had never appeared before. This incident occurred in the context of an otherwise congenial, routine session in which the therapist wondered aloud which educational and employment goals the client would now pursue, given her marked improvements in treatment. The client's sudden, precipitous decline in functioning in session, coupled with the fact that hallucinations had never been mentioned before, led the therapist to hypothesize that the client was frightened by the therapist's comments. However, rather than stating that she was hesitant to pursue goals that required greater competency and maturity, the client feigned a severe problem to stymie the pursuit of a more ambitious agenda. Nevertheless, the therapist cautiously followed through with an assessment of the client's stated symptoms, complete with a safety check for suicidality.

Therapists at times may choose *not* to share their hypotheses about the client's suspected deceitfulness, particularly if there is a strong likelihood that doing so would precipitate potentially destructive in-session conflicts. This is obviously not an ideal situation, as therapy works best when therapists and their clients can freely exchange

ideas and feedback without fear of discord in the relationship. Therapists may choose to silently formulate and eventually test viable explanations for the marked lack of common ground they perceive in the therapeutic relationship and agenda.

Why Is the Client Lying?

A complete answer to the above question is beyond the scope of this article (for more comprehensive reviews of the field's approaches to understanding client malingering, see Morey & Lanier, 1998; Rogers, 1988; Rogers, Sewell, & Salekin, 1994). For our purposes, this query can be distilled to two components:

1. Is the client's lying largely a result of feeling *ashamed* or *afraid* of the truth?
2. Is it more likely that the client has a calculated ulterior motive (e.g., to escape responsibilities; gain monetary rewards from an outside party)?

In cases in which clients' lies are predominantly fear- or shame-based, we may hypothesize that if therapists express sufficient care and tact, and if they challenge clients' disingenuous reports in a manner that allows the clients to "save face," the therapists may be able to break through the clients' dissimulation. Conversely, it follows that clients who have more calculated motives will be considerably less interested in gaining therapists' warmth and acceptance than in achieving their self-serving ends. Thus, they may be much less amenable—indeed, they may even become hostile in response—to a therapist's caring, benevolent attempts to gather heretofore hidden clinical data from the client (cf., Gediman & Lieberman, 1996).

Truth, Honesty, and Trust Are Not All-or-None

We should add that clients rarely act in an all-or-none fashion in terms of honesty. At times, clients will combine honest, accurate comments with others that are more misleading or false. Additionally, when clients lie to their therapists at a given point in the therapy process (e.g., at intake, or when a particularly difficult topic arises in the therapeutic agenda), it does not necessarily imply that engaging in deception is, and will continue to be the client's standard mode of interacting in therapy. Thus, it is very important that therapists try to assess the frequency and scope of their clients' falsehoods. If the deception is circumscribed, it may be possible to circumvent that issue while other, more fruitful topics are discussed sincerely and—it is hoped—in a productive manner that engenders therapeutic change. Later, the therapist may attempt to use the cachet built on treatment gains to encourage the client to be more forthcoming about the sensitive area that was bypassed earlier.

Some clients will engage in a tactic called the "plea-bargain" maneuver—a method of avoiding responsibility that they may have learned from their exposure to the U.S. criminal justice system (Beck, Wright, Newman, & Liese, 1993). Here, clients "plead guilty" to a minor transgression to avoid being held accountable for their *actual, more serious* misdeeds. A euphemistic way to describe such behavior is to say that the client is underreporting. Therapists do not have to grill their clients to elicit further information beyond the plea bargain. A therapist can benignly ask for additional information about the problem in question, noting that sometimes there is more than meets the eye, and nicely adding that further admissions by the client would be neither unexpected nor unwelcome.

Multiple Sources of Data

One of the most effective ways to improve the accuracy of the case conceptualization is to obtain clinical data from a number of sources. In addition to information verbally provided by the clients during a clinical interview, therapists also may ask their clients to fill out written inventories. This practice allows therapists a means of assessing the consistency of clients' information by cross-checking data obtained in verbal and written form. In addition, some self-reported inventories include scales that may cue the therapist to a client's propensity for being evasive or deceptive (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989; Butcher & Williams, 1993; Greene, 1991; Morey, 1991; Morey & Lanier, 1998). Additionally, it is good clinical practice to secure a client's signed consent to obtain past clinical records, which will provide the therapist with the benefits of previous professionals' observations of the client, and the nature of the care that was provided. While there is no guarantee that data from other sources will be free of the effects of client deception, they can help the current therapist gain a broader and more longitudinal picture of the client.

As noted earlier, it is a red flag whenever clients refuse their therapists' request for previous records. Many therapists choose not to enter into a therapeutic relationship with clients who are not forthcoming about prior mental health assessments and care, preferring to avoid the risk of commencing therapy when potentially vital data are being denied. Other therapists may try to initiate a discussion about the client's hesitancy in order to ascertain whether the client's concerns are out of fear and shame (e.g., a case in which the client had been sexually involved with her previous therapist), or are instead motivated by a desire to disguise his or her countertherapeutic agenda.

Another source of outside information is the client's family. It can be extremely useful to have one or more of the client's family members attend at least one session (with the client's consent) to hear their viewpoints on the nature of the client's difficulties. Assuming the client's family relationships are not unduly strained, the client's flat refusal even to consider the involvement and input of those who arguably know him or her best may sound a warning bell for the therapist that the client may have something to hide.

INTERVENTIONS

The following are some general guidelines that therapists can follow to improve the level of authenticity of the therapeutic enterprise.

Acknowledge the Impasse

Sometimes a client will make statements that are so implausible that the therapist becomes dumbfounded. That was certainly the case when (as mentioned in an earlier example) a woman denied using drugs even though she had disappeared for two previous sessions and had tested positive for drugs in two separate urinalyses. The therapist did not know how to proceed. If he simply contradicted the client, the result could be a destructive power struggle, and the client might bolt from treatment altogether.

Yet to simply go along with the client, nodding politely as she ignored the compelling facts of her relapse, might turn the treatment into a farce. All the therapist's suggested interventions for staying clean and sober would become, ostensibly, irrelevant.

The "solution" (at first) was for the therapist to admit that he was at a complete loss for words, and unsure about how to proceed. He explained that he was prepared to help the client with her relapse, but now found his session plan marginalized by the client's denials. The therapist added that in order to believe that the client had not used drugs, he would have to ignore his own perceptions and hypotheses—in other words, to invalidate his own clinical judgment. He implored the client to help him, saying, "I really don't know what to say . . . I'm stuck."

Ask the Clients to Review and Restate Their Treatment Goals

An elegant way to get back into a productive discussion is to review the client's goals for therapy. This simple method accomplishes many useful things. First, it reminds the client that therapy has a purpose, and that this purpose needs to be stated openly. Second, it implies that the therapist and client are working together toward common ends. Third, it puts the client in the position of having to take some responsibility for the direction of therapy. If the client claims to have appropriate goals (e.g., return to work, improve relationships, reduce addictive behaviors), then the therapist can entreat the client to pursue these goals actively, and can point out ways that the client's actions may be running counter to these goals. If clients protest, it can be noted in session that they are arguing against achieving *their own* goals. This conceptualization opens a door for clients to make self-corrections without feeling controlled or shamed by an outside party.

Give Clients a Face-Saving Way Out

Therapists should bear in mind that some clients may be ambivalent about their dissimulation. However, once they have made a false statement (e.g., "I swear to you that I haven't used drugs this week") they may feel too ashamed to change their story, lest they look especially foolish. Thus, even if they have a change of heart, they may opt to stick with their original, insincere report to save face. The key then is to formulate a way to give the clients a way out of their falsehoods without shaming them. The therapist can offer that perhaps there are "missing data" that might clear up the difficulties that therapist and client alike are having in making sense of the latter's reported experience between sessions. The therapist then entreats the client to go on a collaborative search for this elusive information that would otherwise clear things up.

Similarly, therapists may openly hypothesize that the issue is one of *memory*, such that if the therapeutic dialogue can jog the client's more complete recollection of what has occurred during the week (or in the past in general), perhaps the client will be able to give an account that begins to "hang together" in a more understandable way. Alternatively, therapists may choose to opine that the client may have mixed feelings about opening up to the therapist, such as by saying, "I know that there is a lot that you have chosen *not* to tell me, and I understand that you may have good reasons for not wanting to share certain things with me." Such a statement gives the message that the therapist both empathizes with the client's hesitancy in being up front, and also knows that what the client is saying is less than complete.

Be Willing to Work Things Out to Regain Trust

The question, "Can I trust this client or can I not?" is all-or-none. It is perhaps more realistic to view the issue of trust on a continuum. Feelings of trust between two people may strengthen or weaken over time, depending on their ongoing experiences with each other. Thus, it is not necessary for a therapist to decide *whether or not* to trust a client. As clients' trustworthiness may be situation-dependent and/or transient, therapists' evaluations also should remain open and flexible. If trust is lost, it can always be regained if both parties are committed to the process of reparation. This is a constructive perspective that may be shared with clients to fortify both parties' hope, morale, and investment in creative problem-solving.

In the case of the woman who denied her drug abuse, the therapist emphasized that he felt their therapeutic relationship was quite solid and secure, even though there may have been times when they were not sure what to make of each other's comments. He stated that, "One moment of doubt does not have to destroy the trust between two people who are trying their best to communicate, under difficult circumstances." He added examples of how they worked well together leading up to the controversial episode in question, and expressed confidence that they would find a way to work through the current disagreement. Further, the therapist shared his own ambivalence with the client, saying that he was afraid that if he believed her without challenging the veracity of her report, he would risk shortchanging her by not giving her the full benefits of his clinical judgment and skills. This approach lowers the stakes by communicating to clients that an admission of false report will not cause their therapists to distrust them entirely.

Develop Nonthreatening Ways to Say "I Think You're Being Untruthful"

The following are some examples of caring, respectful, diplomatic ways to say, "I think you're lying to me" (adapted from Beck et al., 1993):

- "Usually the things you say to me make sense, and I have come to expect a high level of clarity of communication from you. That's why I'm puzzled now. What you're saying right now doesn't make sense to me, and this is so different."
- "I have to assume that you have a good reason for not leveling with me. I don't think you would do this lightly. I'm very interested in understanding what's getting in the way of our honest communication right now."
- "I have a favor to ask of you. If there's something you would rather not tell me, please tell me so, and I'll respect that and back off. That's much better than having you tell me what you think I want to hear, because that will send me down the wrong path and render me less helpful to you."

As may be gleaned from the examples above, therapists can make it clear that they know they're not getting the true story, but don't want to engage in a power struggle over the issue. In response, the clients may feel relieved and accepted, and the therapeutic relationship may actually grow stronger. On the other hand, if clients have little interest in maintaining good rapport with their therapists, they are likely to react negatively to even the most tactful of such therapist comments (Gediman & Lieberman, 1996).

Stay True to a Therapeutic Agenda

The clinician increases the chances of staying on safe ground if he or she sticks to an agenda that facilitates therapeutic ends. What are such therapeutic ends? We contend that they consist of some of the following values, many of which are derived from an existential approach to psychotherapy (Yalom, 1980). Here, clients are expected to pursue goals in therapy that:

- Maximize their ability to cope with stressors while minimizing avoiding or aggressing.
- Emphasize their responsibility for, and ownership of the symptoms, and in enacting the solutions.
- Promote self-efficacy, rather than helplessness and victimhood.
- Improve self-awareness, along with the ability to self-correct.
- Enhance their sense of freedom of choice, while simultaneously growing more mindful of how such choices affect themselves and others.
- Develop skills for healthy relating, rather than simply competing or avoiding.
- Recognize and accept the notion that the clients must change themselves, rather than working to change other people exclusively.

If therapists endeavor to steer therapy in the direction of achieving these general goals, there is less likelihood that clients' hidden agendas will guide the treatment unduly. If clinicians can remain well-grounded in the principles, rationale, goals, and ethics of therapy, the worst that may happen is that the client may leave therapy feeling annoyed at the therapist who didn't "bite." Sometimes a premature termination of this sort may be the best outcome possible at that time, in that simply refraining from reinforcing a countertherapeutic agenda may be all that can be done.

Raise the Bar

Some clients engage in falsehoods of self-aggrandizement. This may be an aspect of their grandiose self-presentation style and/or an attempt to bypass the parts of therapy that are irrelevant to their countertherapeutic agendas. In either case, these clients often expect that by making exaggerated claims of achievement, wellness, and insight, they will be "exempt" from the nuts and bolts work of therapy, thus making the process as undemanding as possible. Therapists can confound this strategy by moving such clients "to the head of the class," meaning that they will now expect *more* from the clients than is typically required in therapy. An earnest client who is legitimately coping and navigating life's demands very well may welcome the chance to demonstrate his or her heightened ceiling of functioning. The client who is disingenuously looking for a free pass through therapy will not be so pleased. This is an important distinction.

For example, one of our clients apparently wanted to be relieved of his employer-mandated treatment by asserting that he was "completely cured" after three sessions. In the therapist's clinical judgment, this client had yet to even acknowledge that he needed to control his anger, reduce his aggressive behavior, and modify his belief that "if I do what others want me to do, they are defeating me." Instead of engaging the

client in a debate over whether or not he was ready to terminate treatment, the therapist expressed an eagerness to witness demonstrations of the client's new psychological skills. He humbly suggested that the client design a behavioral homework assignment that would illustrate his new, more congenial and collaborative strategies at work. The client rejected the idea, got visibly angry, and fumed that "shrinks always try to drag things out." The therapist responded by allowing for a prolonged silence, and then thoughtfully replied, "I didn't expect you to become angry, or to think that I was trying to accomplish something at your expense. I was hoping you had grown past that sort of reaction, as you led me to believe just a few minutes ago."

Consult With a Colleague

When therapists are confounded by their client's behaviors, it can be quite helpful to review the case with a senior colleague or with another clinician who has previously treated the client (provided that the release of information has been properly secured). Not only can this process generate useful, new hypotheses, it can also provide much-needed support for therapists who are laboring mightily to help clients who are not behaving in good faith, and who may be trying to convince the therapists to doubt their own sense of reality.

Consulting is especially important when there is reason to believe that the client's lack of forthrightness is obscuring a dangerous situation, either for the client or for someone else. In such instances, it may be decided that emergency measures (e.g., breaking confidentiality to inform family members of a significant clinical problem, arranging for hospitalization) must be taken, with or without the client's consent or knowledge.

HOW THERAPISTS CAN COPE WITH CLIENTS WHO ARE UNTRUTHFUL

When therapists discover that their clients have lied to them, they may be apt to chastise themselves, thinking, "How could I have been so easily fooled?" or wondering if there was something they failed to do to facilitate the client's behaving in a more trustworthy fashion. This sort of self-examination—in contrast to a knee-jerk reaction of blaming the client—can be a very productive and admirable thing to do. However, overly conscientious therapists must guard against taking this sense of ownership for interpersonal problems too far, such that they criticize themselves essentially for being decent, caring, open-minded, forgiving, and for having faith in their clients.

Therapists who fall prey to client deception in the course of engaging in a good faith effort to form a healthy therapeutic bond do not merit self-derogation. Rather, such an event should serve as a sobering reminder that clients are a diverse lot, that therapists cannot assume that their efforts at being genuine and trustworthy will be reciprocated, and that there is no parallel code of ethics for clients. We trust our clients because it is therapeutic to do so in *most* situations, with *most* clients, and also because this stance reflects our general worldview, but *not* because we are foolhardy, naïve, or blind.

Clients' lying can be viewed as a circumscribed part of the therapeutic endeavor—a hazard of the business, if you will. Its occurrence should not lead therapists to become cynical about clients in general, nor about their own professional skills. In order for therapists to remain effective, it is very important that they maintain an overriding faith in themselves as clinicians, and in their clients as individuals who are trying their best to cope and obtain help for their problems. Within this context, the phenomenon of clients' lying can be reframed as an interesting, albeit befuddling and bemusing exception to the rule, inspiring curiosity and intrigue more so than disillusionment and dread.

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