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Peer Reviewed

Lies, Deception, and Denial in the Counseling Profession: An Inconvenient Truth

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Abstract

Most professional ethics codes for therapists counsel clinicians to be honest and truthful, yet therapists and other practitioners of the helping professions routinely engage in various forms of deceit and deception as part of their therapeutic practices. It is my contention that not all forms of lying are harmful or unethical and that professional codes should be updated to reflect this. This article examines the role of deception in clinical settings, including its potential benefits and harms. I then provide a classification of five different modes of deception: whoppers, fibs, omissions, deflections, and denials. I conclude with a suggestion for research that could guide clinicians in their practice while also indicating how professional codes should be revised to account for deception's occasionally helpful role in therapy.

Keywords: deception, lying, denial, counseling, ethics, honesty

Lying is a part of human nature and is a prevalent aspect of everyday conversation (Ariely, 2012; DePaulo & Kashy, 1998; DePaulo, Kashy, Kirkendol, Wyer, & Epstein, 1996; Feldman, 2009; Jacobsen, Fosgaard & Pascual-Ezama, 2017; Patterson & Kim, 1992), especially at work (Blanton, 2005). In fact, Serban (2001) estimates that 91% of the population lies on a daily basis (p. 77); the prevalence figures vary widely (Serota & Levine, 2015). Codes of professional ethics,[1] however, are in tension with this aspect of daily human life since they instruct practitioners to be accurate, sincere, truthful, and factual in virtually every aspect of practice (see Table 1) (Curtis, Perez, Johnson, & Kelley, 2016).

[1] See, for instance, those published by the American Counseling Association (ACA, 2014), American Association for Marriage and Family Therapy (AAMFT, 2015), National Association of Social Workers (NASW, 2008), American Psychological Association (APA, 2017), and the Association for Addiction Professionals (NAADAC, 2016).

Table 1. *Deception: Profession, ethics, code*

Profession	Professional Value (PV) Ethical Principle (EP)	Code: Statement/Definition
ACA (2014)	Veracity (EP)	"…Dealing truthfully with individuals with whom counselors come into professional contact" (p. 3)
	Integrity (PV)	" . . . Safeguarding the integrity of the counselor– client relationship" (p. 3)
AAMFT (2015)	Integrity (PV)	"…Evidenced by a high threshold of ethical and honest behavior within Association governance and by members" (p. 2)
NASW (2008)	Integrity (PV) Behave in a trustworthy manner (EP)	"Social workers are continually aware of the profession's mission, values, ethical principles, and ethical standards and practice in a manner consistent with them. Social workers act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated" (p. 6).
APA (2017)	Integrity (EP)	"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" (pp. 3-4).
	Honesty and Candor (PV)	"Tell the truth in all dealing with clients, colleagues, business associates and the community" (p. 1).
NAADAC/ NCC AP (2016)	Integrity (EP)	"Addiction Professionals shall conduct themselves with integrity. Providers aspire to maintain integrity in their professional and personal relationships and activities. Regardless of medium, Providers shall communicate to clients, peers, and the public honestly, accurately, and appropriately" (p. 7).

Note. Core values or general principles are intended to provide both a framework for ethical practice and basis to inspire professionals to pursue the highest ethical ideals or goals of professional practice (AAMFT, 2015; ACA, 2014; APA, 2017). (AAMFT, 2015; ACA, 2014; APA, 2017).

Professional codes of ethics appear to presuppose that: a) good, noble or virtuous counselors don't lie; b) deception carries a corrupting influence on moral standards that might produce unintended outcomes; c) no benefit deriving from counselor deception is superior to the value of retaining honesty in professional communications; and d) dishonesty is a serious breach of professional conduct or ethic. Yet, despite these ethical codes, counselors are human and nearly all of them have lied or will lie at some point in their career (Kottler, 2010; Kottler & Carlson, 2011). Although deception is pervasive, most studies of deception in clinical settings have focused on deception by the patient, not the clinician (e.g., Carrillo, 2016; Curtis, 2013; Curtis & Hart, 2015; Doll, 2016, Love & Farber, 2018; Miller, 1992). The literature, then, provides us with little guidance on what to do about the mismatch between ethical codes and the actual tendencies of practitioners.

The main purpose of this article is to call attention to the types of deception used in counseling practice and to argue that, far from being unprofessional, deception is part and parcel of clinical professionalism. I will also argue that deception is an important tool for gaining the trust of the patient and constructing a helper identity. To achieve these aims, I will begin by complicating the notion that truth-telling is always a positive act in counseling contexts. Following this, I will provide a definition of deception on which to anchor my subsequent arguments. I will then explain how deception is a mechanism that undergirds professionalism and why a total prohibition on lying can have ethically questionable consequences. Finally, I will make a case for the link between the careful and judicious deployment of deception and better treatment outcomes.

Truth-Telling Can Be Problematic

We need a realistic definition of truth-telling, one that acknowledges the fact that perfect and total truth ("Truth with a capital T") is unattainable. We should, instead, focus on "telling the truth, where the intention is all important" (Higgs, 1985, p. 191). Telling the truth requires honestly stating facts (and falsities) as they are understood in a clear and impartial way, and despite the impracticality of telling all the facts of a story, potentially partial information, and possible personal biases, every effort should be made to transcend such limitations by even-handedly conveying relevant facts (Mearsheimer, 2011).

Even with this somewhat looser definition, however, some issues remain. Blanket declarations about the importance of truth-telling assume that truth has intrinsic moral value, which is not necessarily the case (Nyberg, 1993; Solomon, 1993). For example, if a counselor believes that

the results of a suicidal patient's psychological tests could disturb them, it may be reasonable to withhold that information from them (Cohen & Cohen, 1999), particularly when lying respects that person's autonomy (Strudler, 2016). Truth-telling might also oblige the counselor to express sincere but unflattering feelings of dislike when, for instance, a client asks, "Do you like me?" or, conversely, may result in the disclosure of sexual attraction during the session (Koocher & Keith-Spiegel, 2016; Pope, Sonne & Holroyd, 1993). Honesty, then, can cause harm, humiliation, or distress (Nyberg, 1993). These are unnecessary costs and potential hindrances to a successful clinical outcome, and they are avoided by telling a so-called white lie, which may be a more moral act than truth-telling (e.g. Levine, & Schweitzer, 2014). In light of this, it should be evident that a strict commitment to telling the truth can work against the best interests of the client (e.g., Levine, 2017). This is not mere speculation, but an assertion backed by empirical evidence. For instance, one study showed that "the clients of therapists with higher honesty scores improved less than those of therapists with lower honesty scores" (Yonatan-Leus, Tishby, Shefler, & Wiseman, 2017, p. 7). Further, "Lieberman's study of encounter groups demonstrates that total honesty with patients is not a virtue" (Weiner, 1978, p. 89-90; citing Lieberman, Yalom, & Miles, 1973).

One compelling reason to advocate for truth-telling in counseling is that therapist honesty is an integral part of establishing trust in counseling with clients (Ackerman & Hilsenroth, 2003). While honesty is certainly one of the core features of any relationship built in trust, other values come into play as well. While honesty is essential, complete truth-telling can erode the trust or prevent it from forming if, for example, it is practiced at the expense of civility or support (Bok, 1978). Likewise, Solomon (2009) notes that indiscriminate truth-telling can "inflict [ ] non-redeeming and unnecessary hurt in others, complicat[e] social arrangements… destroy[ ] relationships, and incit[e] violence and vengeance" (p. 22).

A milder version of the duty to tell the truth is the obligation to "not say what you believe to be false" (Barnes, 1994, p. 9). Adhering to this injunction would allow practitioners to sidestep some of the negative consequences of truth-telling by allowing them to avoid certain subjects or keep silent about certain facts. If a patient asks their clinician whether they find them attractive, the practitioner could say "I don't believe it is appropriate to discuss this topic in a clinical setting," allowing them to evade the question without uttering anything they believe to be false. While this is certainly an improvement, it nevertheless prohibits acts of deception that could be necessary to help a patient through a serious crisis or to help a patient who suffers from delusions refrain from engaging in self-

harm (Ryan, de Moore, & Patfield, 1995). More generally, many clients surely have an overriding interest in alleviating their problems. Solutions should take precedence over strictly adhering to norms of truth and accuracy.

There are, of course, levels of deception which clients can tolerate, while some deceptions may be seen as "crossing the line" and considered unforgivable (Ekman, 2001). There is, therefore, some degree of judgment involved in deciding whether to employ deception in a therapeutic setting. While taking the decision out of the hands of clinicians by prohibiting all forms of deception may seem less risky than permitting it (Shulman, 2007), truth-telling for its own sake may represent a failure to privilege other more contextually important values (Lynch, 2009; Smith, 2009).

Framing Deception (on a Spectrum)

Given that there is no intrinsic value to truth-telling and, moreover, that it may result in worse clinical outcomes when deployed indiscriminately, counselors and the professional codes of ethics that guide their practice should allow room for deception. However, it is important to note that deception can be difficult to use judiciously (Gell-Mann, 2009), and while a strict prohibition against it may not be beneficial to patients, a blanket permission to deceive could cause just as much (if not more) harm (Grayling, 2009). We need, therefore, a classification of different forms of deception so that we may map out which types of deception should be permitted and which ones should be regarded as a breach of ethics (Saul, 2012).

On the broadest definition, deception involves knowingly and intentionally providing a false account by explicit spoken or non-verbal communication (Krauss, 2017), imparting a false impression by implicit demeanor, or using true facts to mislead (Rogers et al., 2017; Schauer & Zeckhauser, 2009). In counseling contexts, we can expand our classification of deception according to five different types: whoppers, fibs, omissions, deflections, and denials. Although these types of dishonesty are not mutually exclusive (Carson, 2009), as these categories share overlapping contours and features (Mahon, 2015; Harris, 2013; Stokke, 2013), they are nevertheless distinct phenomena (Dynel, 2018). In this section, I will define each of these modes of dishonesty and discuss the role they can play in a counseling context.

Whoppers

A whopper, as I define it, is a form of dishonesty in which what is known or understood is

actively suppressed or communicated with intent to deceive, mislead, or induce false belief. This is the most active form of deception discussed in this section and comes closest to what we might call a "bold-faced lie."

Whoppers appear to have little clinical utility and few (if any) instances in which uttering one would help the patient (Burgo, 2013). It is, moreover, the type of deception that comes closest to violating the client or third-party's right to know based on their right to informed consent and the treatment contract. (See Table 2 for examples.)

Table 2. *Whoppers in the counseling profession*.

Falsely certifying treatment compliance (e.g., Department of Health and Human Services medical documents).	Behind client's back and potential objection, seeking information in violation of agreed explicit and implied terms of the treatment contract.	"Extending the duration of treatment beyond what the counselor believes to be beneficial to the client to continue to receive payment" (Cohen & Cohen, 1999, p. 75).
Lie about what happened or occurred in session in face of a client complaint, alleged ethics violation, or malpractice lawsuit.	Up-charging and overutilization (e.g., UA testing) (The National Association of Addiction Treatment Providers [NAATP, 2016]).	Unwarranted reassurance (Keyes, 2004) or optimism expressed about medical condition or "palliative lies" (Fallowfield, Jenkins, & Beveridge, 2002).
Billing for services not rendered or Medicaid, Medicare, TRICARE Fraud.	Misrepresent health and information, assessment results, prognosis, treatment intervention, or risks and benefits (Taleff, 2010).	Exploit client's right to privacy for the purpose of promoting or marketing the provider or treating agency.

Fabricate progress and encounter notes (Hantoot, 2000).	Disguised "treatment" billing (NAATP, 2016).	Conducting a particular test or engaging in a treatment intervention inferred to be against the wish or will of the client.
Exaggerate outcomes (Hantoot, 2000) and advertise false testimonials (e.g., "agency claims a 90% success rate") including online (NAATP, 2016).	Using truthful facts or shreds of truth to deceive people about the services offered, products, or treatment effects and outcomes.	Affirm that a future deed or behavior will be done (e.g., to provide information or help a client, colleague, provider, insurance carrier, client family member) with no actual intent of fidelity.
Licensing and accreditation misrepresentations (NAAPT, 2016), and failing to disclose financial conflicts of interest.	Failing to reveal serious or irreversible side-effects associated with antipsychotic medication (Ryan et al., 1995).	Failing to inform client of psychiatric diagnosis (Green & Gantt, 1987; Ryan et al., 1995).

Fibs

Unlike whoppers, fibs are falsehoods that are used for the sake of the counseling relationship or therapeutic treatment process. They may, for instance, be used to gain and preserve the trust of the client by concealing how the clinician truly feels about certain subjects or about the client. Fibs commonly told to clients include, "I know I can help you" and "of course I like you" (Kottler & Carlson, 2011, p. 274) (for further examples, see Table 3). Fibs can also be used by practitioners when rejecting accurate observations made by clients such as "you seem stressed" or "you looked tired."

Table 3. *Fibs in the counseling profession*

Telling untruths in the name of lubricating social interaction or improving the function of interpersonal discussion (Ford, 1996).	Agreeing with client, or stating affirmatively, that which is unknown because it is thought it is what the client wants to hear.	Embellishing information reported on insurance authorizations to ensure continued insurance coverage for the client.
Denying boredom or drowsiness in session but giving credit to an innocuous or therapeutic-sounding reason.	Accepting a gift, such as a baked cookie the client made and throwing it away out of distrust or disgust, but telling the client how wonderful tasting the cookie was.	Untruthfully telling the client you've experienced the same situation or felt the same way in order to relate to the client.
Lying to get client connected to much needed help or emergency treatment services, or other necessary resources.	Exaggerating the dangerousness of a mentally ill person's behavior to obtain a judicial order for civil commitment to a mental institution (Szasz, 1979).	When asked by the client, lie about not having any money to give.
Feigning compassion and empathy when no such sentiment is felt, or pretending to show interest in a client's story.	Telling the client, "It's for your own good" when that statement is not entirely believed.	Inflating recommendation letters on behalf of the client to the courts, DHS, or other provider or agency.
Stating that 42CFR, HIPPA, code of ethics, or agency policy forbids a certain action as a convenient	Not telling the client the real reason for terminating treatment therapy.	Not telling the client the truth about cancelling a session.

excuse for not doing something or saying no.		
Assuring the client that what is discussed in session will not reach other staff or the treatment team.	Dissembling over the real reasons for failing to return calls, fax documents, or respond to phone messages and emails.	Salving conscience as a helping professional by depriving client of honest opinion with insincere praise and flattering lies that gloss over client flaws (Bok, 1978).
Paying client compliment not genuinely meant.	Giving paradoxical directions (Cohen & Cohen, 1999).	Laughing when not sincerely amused by the client's joke, story, or effort to be funny.

Omission

A further type of falsification takes the form of bluff, concealment, or omission that hides or fails to disclose information that might have special significance to the client in the context of the therapeutic process (Burgo, 2013). This is distinct from simply not telling the full truth, since the information is withheld specifically for the purposes of misleading or giving a false impression (DePaulo et al., 2003; Peterson, 1996). For example, a therapist may mask their disgust with a client who does not bathe and has a repugnant odor, even if expressing that disgust might be calling attention to an impediment to the client's quality of life (on the assumption that it may improve the way others react to the client in social settings). (See Table 4 for further examples.)

Table 4. *Omission in the counseling profession*

Failing to disclose to the client information germane to the therapeutic process (e.g., lack of training and credentialed education relating to a certain topic/subject/issue/problem).	Hiding behind the façade of counseling for the client's own good when deeper motives are self-serving and indulge the client's idealization of the counselor as beautiful, wise, powerful.	Not telling client's side of a negative situation involving a counseling incident in which regressive behavior or poor attitude was displayed.
Looking up patient information online or looking at the patient's social media account without the client knowing.	Refusing to acknowledge a client's accurate perceptions.	Pretending to know what to do (when in reality one really doesn't) and engendering a sense of false hope.
"Significant discrepancies between what is recorded in the client's chart and what is actually happening in therapy" (Hantoot, 2000; Pope et al., 2006, p. 68) (e.g., highlighting achievement rather than setbacks and failures) (Kottler & Carlson, 2011, p. 274).	Consciously concealing counseling material (Yourman & Farber, 1996) (e.g., covering up mistakes, shortcomings, imperfections) (Kottler, 2010; Kottler & Carlson, 2011, p. 274; Pope et al., 2006).	In case conferencing, treatment planning, or supervision, not providing a fully accurate account reflecting the reality of counseling work with the client and the nature of what is known about the client (Hantoot, 2000).
Not revealing fears and frustrations when expressing such sentiments	Not informing the insurance carrier, employer, collateral contact, or outside agency/stakeholder of, for	Maintaining the client's idealized image of the professional helper by not disclosing shortcomings

can advance rapport building and open therapeutic inroads.	example, the reduced sensitivity of urinalysis drug panel testing threshold/cutoff or removing certain substances from being tested.	and flaws or revealing other details that would demystify.

Deflection

Deflection is another type of misleading prevarication: a form of reality distortion that "tends to bend the truth rather than contradicting it" (Peterson, 1996, p. 280; citing Metts, 1989). An example is speech that deliberately makes use of vague, figurative, or metaphorical language in order to emphasize false or partial truth for the purposes of deflecting attention from the facts of the matter. Burgo (2013) noted the following example:

> "In my early years as a therapist, if a client accurately observed that I looked sleepy or stressed, rather than acknowledging the truth, I'd usually address their anxiety concerning what they perceived about my health or state of mind. In one sense, this is a perfectly valid therapeutic approach because it is the client's feelings, after all that is [*sic*] the focus of the work. On the other hand, such interpretations can subtly imply that what the client accurately perceives is "only" a projection; sometimes, it can feel crazy-making, not to have your perceptions validated." (para. 4; see Table 5 for further examples.)

Table 5. *Deflection in the counseling profession*

To seem intelligent, crafty, consistent, blameless via parrying and equivocation when truth is expected, and answering or responding with no affirmative sense of truth.	To present a clinical narrative in case conferencing that reflects one side of the real truth.	Encounter notes show linear progression or accentuate client statements creating a narrative that makes the counselor appear expert demonstrating high skills and ability.

Distort reports (Hantoot, 2000) by overstating facts, extent of help delivered, and therapeutic impact made.	Manipulate vocal pitch to seem sincerely happy to see a client or genuinely eager to help when not entirely feeling that way.	To make people believe that the counselor is honest by partially revealing, or making a calculated illumination of certain "bungled interventions" (Kottler & Carlson, 2011, p. 274).
Manipulating body language, words, or tone of voice to give effective impression of discrediting or ignoring client symptoms without actually saying so.	Not exploring certain areas or avoiding certain topics relevant to helping client (e.g., failure to keep awareness of client's partner for potential violence within the scope of consultation and clinical supervision) (Pope et al., 2006).	Exaggeration of emotional responses for therapeutic purposes (e.g., look sad, surprised, upset, extremely distraught when client recounts story or experiences).
Referring to person as a diagnosis, disorder, dysfunction, symptom, or label as convenient scapegoating or avoidance of addressing material that is threatening to the therapist's sense of self. (Pope et al., 2006).	Use speech repetition as a means of making what one says more believable or not providing full and honest feedback to an inquiry but stating "I'd rather not say."	Blame the client for lack of progress and use terms such as 'resistance', 'in denial', or 'unmotivated' to justify continuing to charge client (Zur, 2005, p. 273).
Passing time in counseling rather than the honest hard work of therapeutic intervention so as to escape a	Deflect blame or distorting truth by being intentionally vague or using metaphorical language, figurative speech,	Deflecting attention to cover up poor quality job performance in counseling and documentation.

role for which the counselor feels inadequate. (Pope et al., 2006).	or words with softening connotations.

Denial

Denial is the conscious rejection of reality or believing that something false is true (Shibles, 1985). It is accomplished by means of faulty thinking, uncritical acceptance, or "suppression of reason" (Shibles, 1985, p. 46). In a counseling context, denial may take the form of communicating optimism to a client with substance use disorder despite the client showing a very poor prognosis, thereby denying the reality of the situation (Varki, & Brower, 2013). In this case, denial would likely be counterproductive to the patient's treatment, since being overoptimistic may deprive the client of information about their current state and potentially rob them of the opportunity to self-correct or change certain behaviors (Harris, 2013) (see Table 6 for further examples).

Table 6. *Denial in the counseling profession*

Invalidating accurately sensitive perceptions and interpretations by rejecting such possibilities and not acknowledging the client's validity or claim (Burgo, 2013).	Deny failures (Kottler, 2010; Kottler & Carlson, 2011; Pope et al., 2006).	Denying responsibility in contributing to less than therapeutic outcome.
No acknowledgement of (sexual) transference/counter-transference and attempt to reject such feelings via dissimulation, sublimation, transmutation, stance of	Denying reality by not appreciating the client's likely chances of failure or the iatrogenic effects of participating in treatment.	Counselor contrives to hide real state of affairs for remaining in the helping profession under the guise of, "I love helping people" and "Am not in this for the money".

neutrality or objectivity (Burgo, 2013).		
Denial in the form of over-optimism (Varki & Brower, 2013) about producing positive treatment effects; exaggerating the odds of counseling success.	Rationalizing and denying (e.g., looking away and blocking negative or rejecting reactions).	Continuing to render services and defy objective acknowledgment of compassion fatigue empathy or burnout.
Rationalize holding clients in counseling absent of any real therapy via methods, concepts, techniques (e.g., building therapeutic rapport) when treatment need is questionable (Lippmann, 2017)	Minimizing or discounting the influence of client characteristics (e.g., race, attractiveness, sex) on intake screening, mental status examination, psychological assessment, or a course of therapy (Pope et al., 2006, p. 95).	Denying incompetence in supervision or treatment intervention to appear competent or infallible by presenting oneself in the best possible light (Kottler & Carlson, 2011, p. 274).

Deception on a Spectrum

This spectrum framework is intended to avoid the extremes of all-or-nothing, binary thinking on the issue of truth-telling and deception (Pope et al., 2006; Taleff, 2006; 2010). By laying deception on a continuum, whose segments vary in terms of clinical functionality and therapeutic value to counseling processes and outcome, we have complicated the notion that honesty is to be upheld strictly in counseling contexts. Now that I have delineated the (practical) use of certain forms of deception in clinical practice, I will now turn to a discussion of professionalism and how deception can form a part of it.

Professionalism as Deceptive Image Management

"*At times, we are much like the Wizard of Oz, trying to make an impressive presentation while hoping that the curtain we hide behind won't be pulled aside to reveal more vulnerable parts of ourselves."* (Gina Arons and Ronald D. Siegel, 1995, p. 125)

"*Self-presentation is always deception, but whether or not it counts as deception or whether or not it is blameworthy depends on the context, the performance, the expectations.*"
(Robert C. Solomon, 2009, p. 32)

The ethical codes that guide the profession take an uneasy stance toward deception. On the one hand, they admonish practitioners to remain truthful and honest in all their dealings with patients. On the other hand, they also promote a notion of professionalism that, at least for many therapeutic professionals, is suffused with and can only be sustained by deception (Malin, 2000a, 2000b).

Professionalism is a manifold construct that is demarcated by clinical standards and professional ethical codes of the respective practice discipline (Witt, 2013). It involves dignified, competent, caring, and compassionate practice that is manifested in part by civility and maintaining a respectable image (Clickner & Shirey, 2013; Deverell & Sharma, 2000; Witt, 2013). It may also involve a certain detachment and impartiality (Brown & McCartney, 2000). In essence, the multifaceted nature of professionalism makes it a professional practice competency in its own right (Kaslow et al., 2018) (see Table 7).

Although it has widespread acceptance, the construct of professionalism has also been linked to discrimination, a politics of respectability, and a socio-cultural ideology that can marginalize some clients (Brown and McCartney, 2000; Deverell & Sharma, 2000; Grus et al., 2017). Professionalism requires some practitioners to suppress key aspects of their personality or value system in order to conform to the expectations of professional conduct and comportment (Jenkins & Delbridge, 2017). This inauthenticity can encroach on a clinician's personal agency and discourage their natural emotional and moral responses, including empathy, which could be useful in therapeutic practice (Greenspan, 1993). It is, in this sense, a form of deception, since it encourages a certain amount of dissimulation (Sussman, 1992).

Table 7. *Elements of Professionalism*

Characteristics of a Professional Persona	Characteristics of a Professional Persona	Characteristics of a Professional Persona
"Recognising and respecting the boundary between the professional relationship and the personal relationship" (Amis, 2017, p. 23).	Relied or depended on for counsel, advice, guidance, instruction, good judgement (Martin et al., 2017).	Integrity (e.g., doesn't participate in water cooler gossip or purveying rumor) (Martin et al., 2017).
Good leadership skills including social intelligence and emotional competence (Ciulla, 2017).	Attempt to uphold and role model ethical conduct and practice standards of the profession (VanZandt, 1990).	Serve as the collective conscience for the general lay audience (e.g., provide education to the broader public) (Martin et al., 2017).
Moral and affective neutrality, imperturbability—"displaying the right mixture of empathy and control (Craciun, 2016, p. 376)	Respected face or representative of the agency or organization (Martin et al., 2017).	Called upon to lead others in everyday work environment (Martin et al., 2017).
Responsible documentation and record keeping.	Valuing, respecting, and working within the framework of ethical codes (e.g., maintaining confidentiality).	Worthy of trust (Evetts, 2013).
"Awareness and adherence to organisational policies and procedures" (Amis, 2007, p. 41).	Following the rules and not violating federal regulations, legal statutes or provisions of credentialing/licensure	Provides reasonable care within the accepted standard of practice.

laws (Davis, 2017).

In the counseling and therapy field, it would be considered of some importance for the psychiatrist to “look the part,” which might entail donning attire (suit, vest, and matching tie) befitting a professional manner of presentation. In somewhat the same fashion, professional counselors may put on a certain air before walking into a session. This may involve adopting a formal greeting, modulating pitch of voice, changing body language, or other conscious acts; all of which could metaphorically be thought of as donning a three-piece suit. Some therapists have made the case that such dressing up (so to speak) is inauthentic. They advise colleagues to act in a way that is more congruent with how the client and counselor really think and feel in order to arrive at a more genuine representation of truth. Nevertheless, the practice of presenting a distinctly professional air or demeanor towards clients persists. The question that therefore arises is whether this professional attitude is a form of deception itself. Furthermore, might the very fact of being "professional" be to some degree an invitation to such deception? Is such deception inevitably embedded in professional practice?

While some counselors will feel at home in formal attire and formal modes of presentation, it will require a kind of deception for others, to the point where the practitioner may feel like they are acting whenever they are in a counseling session. The superficial behavior reflecting professional values and etiquette reflecting those embedded in the code of ethics, then, can be seen for some as adaptive in so far as it disguises unfavorable (i.e. unprofessional) traits (Saarni & Lewis, 1993). Professionalism, then, can be understood as a tool that therapists can use to screen off their subjective judgments and responses in favor of those more in line with standard practice (Sussman, 1995b). Deception is therefore vital for some counselors to contain counter-therapeutic behavior and sustain the appearance of intimacy, compassion, social relatedness, and competence in the therapeutic alliance (e.g., Feldman, Forrest, & Happ, 2002), and thus achieve therapeutic rapport (e.g., Lupoli, Jampol, & Oveis, 2017).

Professionalism puts a premium on compassion and therapeutic alliance building to promote therapeutic outcomes (Duncan, 2014; Duncan, Miller, Wampold, & Hubble, 2010). For any therapist who doesn’t fit neatly and intuitively into their professional role, developing this sense of compassion will likely require some measure of deception. To put it colloquially, the clinician will need to “fake it

until they make it" by, perhaps, "presenting as considerate and concerned to help" clients (Martin, 2000, p. 70), falsely displaying personal conviction in political correctness, and feigning certain modes of address (Cummings & O' Donohue, 2005). Professionalism also encourages deception in the form of omission (Goleman, 1985), since it "circumscribe[s] what [is] acceptable to experience in the clinical setting and what could be shared with colleagues" (Sussman, 1995a, p.6). This can constrict counselor disclosure and limit what counselors express to their patients.

It would seem, then, that the very same professional codes that admonish us to adhere strictly to truth-telling also counsel us to maintain a professional disposition that is (at least for many practitioners) propped up by a scaffolding built of various forms of deception, ranging from the miniscule to the substantial (Provis, 2010). We can suppose that what professional codes should really require of us is a kind of "balanced" truth-telling, one that observes tact, involves a certain amount of dissimulation (e.g. masking our true feelings and making mock displays of other more therapeutically productive emotions), and may require fibbing to elicit desirable reactions from the patient, while not veering into excessive or damaging forms of deception (Stokke, 2017).

Conclusion

Although it is justified – when justification is given – as having a positive influence on patient relations and treatment, clinical deception and truth-telling are concepts that are perversely influenced by clients' perceptions and subsequent inferences of therapists' understanding of counseling norms. For one thing, the underlying assumption is that clinicians who tell the truth will not be perceived as dishonest. Far too little consideration is given to the possibility that therapists are viewed as liars despite not saying anything false (e.g., Wiegmann, Samland, & Waldmann, 2016) or fail to notice their own deception, which clients may see through (Marar, 2008). If deception is detected, it may surely have a deleterious effect on the counseling relationship and negatively impact perceptions of therapist integrity (e.g., Levine, & Schweitzer, 2015; Weissman & Terkourafi, 2018), conflicting with the client's own version of truth (Kemp & Lorentzatou, 2013) and regarded as morally wrong, irrespective of intention (as lying is generally considered morally wrong) (Rutschmann & Wiegmann, 2017).

Even if the deceptive statement uttered by the clinician is relatively minor, it may therefore lead the client to call into question other statements, raise doubts about the practitioner's credibility

or professionalism, and discourage the client from following the clinician's recommendations (Keyes, 2004). If deception is to be employed then, it must be done with more care and perhaps with more patient involvement. One possible way to mitigate the negative outcomes of deception would be to have the client accept in advance that counseling can involve some deception and encourage them to sign up for "authorized deception" (excluding whoppers) in the treatment setting. This can mitigate negative reactions due to a client's impression that their counselor is lying or practicing unwanted deception (for discussion see Frank, 2009; Harrington, 2009, p. 5).

Even without detection, however, we have to worry about the potential harms caused by imparting false information from a place of critical authority (Lupoli, Levine, & Greenberg, 2018). Will this have an impact on the client's well-being, their ability to reason properly, and their capacity for autonomous and informed decision-making (Harris, 2013, p. 4; Serban, 2001, Shibles, 1985)? Lying to clients effectively denies them the chance of participating in their treatment as informed and empowered persons (Higgs, 1985). Informed consent is one tool that might resolve some of this tension by having the client agree to looser parameters that make room for permissible deception and invited lies (Tuckett, 2004). This practice also creates a tension in counselors, who must hold to professional standards that mandate honesty while engaging in routine practices that subvert it (Perlmutter, 1998). This tension may have a corrupting influence on the practitioner's self-image as a helping professional and may constrict their honest human feelings, human empathy, and trust in the counseling relationship (Hansen, 2013; Shibles, 1985).

One thing is clear from these considerations: even when deception is potentially beneficial, clinicians who engage in it must tread carefully (Buechler, 2017). This is especially so when we consider that there is a tendency to underestimate the extent to which lying or deception is personally enacted (Smith, 2004) and overestimate the practical interests and communicative value of poorly performed dishonesty (Fingarette, 2000; Marar, 2008; Trivers, 2011;), while the one being deceived might exaggerate the harm or damage inflicted by it (Vrij, 2008). My recommendations, therefore, are threefold. The profession could benefit from: 1) more nuanced definitions of deception so that professional codes can better sort out therapeutically useful deception from unacceptable or harmful modes of deceit; 2) greater client involvement in the form of consent and agreement to the possibility of deception (required in order to obviate issues related to patient autonomy, informed consent, and the breakdown of trust between client and clinician); and 3) further research on deception in clinical settings in support of points 1) and 2).

Given that counselor deception is helpful in some situations but harmful in others (e.g., Wiltermuth, Newman, & Raj, 2015), ethical codes should neither strictly prohibit nor wholeheartedly endorse deception. Where to draw the line, however, is unclear. To gain insight into this, we require descriptive studies that reveal which situations stimulate deception from counselors and what form that deception takes. Follow-up studies should focus on the effects of different types of deceptive practices on client engagement, alliance formation, preservation of trust, empathy, client perception, and other variables correlated with positive therapeutic outcomes. For instance, researchers could inquire whether fibbing is acceptable or whether there are instances where even minor deception like fibbing can mar a therapeutic relationship or weaken the trust between client and clinician.

Until such research is available, my hope is that this paper will encourage counseling professionals to take a more honest look at their own practices and what types of deception may be involved in them. Greater self-awareness, more diligence in the deployment of deceptive statements and utterances, and taking a critical eye to our professional codes and standards can only be beneficial to the profession.

References

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, *23*, 1-33.

American Association for Marriage and Family Therapy (2015). *Code of ethics*. Retrieved from http://www.aamft.org

American Counseling Association (2014). *ACA code of ethics*. Retrieved from https://www.counseling.org/resources/aca-code-of-ethics.pdf

American Psychological Association (2017). *Ethical principles of psychologist and code of conduct*. Retrieved from http://www.apa.org/ethics/code/

Amis, K. (2017). *Boundaries, power and ethical responsibility in counselling and psychotherapy*. Thousand Oaks, CA: Sage.

Ariely, D. (2012). *The (honest) truth about dishonesty: How we lie to everyone—especially ourselves*. New York, NY: Harper.

Arons, G., & Siegel, R. D. (1995). Unexpected encounters: The Wizard of Oz exposed. In M. B. Sussman (Ed.), *A perilous calling: The hazards of psychotherapy practice* (pp. 125-138). Hoboken, NJ: Wiley.

Association for Addiction Professionals (2016). *NAADAC/NCC AP code of ethics*. Retrieved from http://www.naadac.org/code-of-ethics

Barnes, J. A. (1994). *A pack of lies: Towards a sociology of lying*. New York, NY: Cambridge University Press.

Blanton, B. (2005). *Radical honesty: How to transform your life by telling the truth* (Rev. ed.). Stanley, VA: Sparrowhawk.

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

Brown, R. B., & McCartney, S. (2000). Professionalism definitions in managing health services:

Perspectives on the differing views of clinicians and general managers in an NHS Trust. In N. Malin (Ed.), *Professionalism, boundaries and the workplace* (pp. 178-194). New York, NY: Routledge.

Buechler, S. (2017). Seducing patients into treatment: when the naked truth feels too revealing. In J. Petrucelli & S. Schoen (Eds.), *Unknowable, unspeakable, and unsprung: Psychoanalytic perspectives on truth, scandal, secrets, and lies* (pp. 181-188). New York, NY: Routledge.

Burgo, J. (2013, April 12). Lying to our clients [web log post]. Retrieved from http://www.afterpsychotherapy.com/lying-to-our-clients/

Carrillo, L. N. (2016). *Deception in therapy: Setting as a motivation* (Unpublished doctoral dissertation). Angelo State University, San Angelo, TX.

Carson, T. L. (2009). Lying, deception, and related concepts. In C. Martin (Ed.), *The philosophy of deception* (pp. 153-187). New York, NY: Oxford University Press.

Ciulla, J. B. (2017). What is good leadership? In C. Martin, W. Vaught, & R. C. Solomon (Eds.), *Ethics across the professions: A reader for professional ethics* (pp. 19-24). New York, NY: Oxford University Press.

Clickner, D. A., & Shirey, M. R. (2013). Professional comportment: The missing element in nursing practice. *Nursing Forum*, *48*, 106-113.

Cohen, E. D., & Cohen, G. S. (1999). *The virtuous therapist*: *Ethical practice of counseling and psychotherapy.* Belmont, CA: Wadsworth.

Cox, C. L., & Fritz, Z. (2016). Should non-disclosures be considered as morally equivalent to lies within the doctor–patient relationship?. *Journal of Medical Ethics*, 42, 632-635.

Craciun, M. (2016). The cultural work of office charisma: maintaining professional power in psychotherapy. *Theory and Society*, *45*, 361-383.

Cummings, N. A., & O' Donohue, W. T. (2005). Psychology's surrender to political correctness. In R. H. Wright & N. A. Cummings (Eds.), *Destructive trends in mental health: The well-intentioned path to harm* (pp. 3-27). New York, NY: Routledge.

Curtis, D. A. (2013). *Therapists' beliefs and attitudes towards client deception* (Unpublished doctoral dissertation). Texas Woman's University, Denton, TX.

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*, 279-292.

Curtis, D. A., Perez, B., Johnson, J. F., & Kelley, L. (2016, April). *The ethics of therapist deception*. Poster session presented at the Southwestern Psychological Association Conference, Dallas, TX.

Davis, M. (2017). Professional responsibility: Just following the rules? In C. Martin, W. Vaught, & R. C. Solomon (Eds.), *Ethics across the professions: A reader for professional ethics* (pp. 12-19). New York, NY: Oxford University Press.

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

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

DePaulo, B. M., Lindsay, J. J., Malone, B. E., Muhlenbruck, L., Charlton, K., & Cooper, H. (2003). Cues to deception. *Psychological Bulletin*, *129*, 74-118.

Deverell, K., & Sharma, U. (2000). Professionalism in everyday practice: Issues of trust, experience and boundaries. In N. Malin (Ed.), *Professionalism, boundaries and the workplace* (pp. 25-46). New York, NY: Routledge.

Doll, S. (2016). *Therapists' perceptions of deception in psychotherapy* (Unpublished doctoral dissertation). The Chicago School of Professional Psychology, Chicago, lL.
Duncan, B. L. (2014). *On becoming a better therapist: Evidence-based practice one client at a time* (2nd ed.). Washington, DC: American Psychological Association.
Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (Eds.). (2010). *The heart and soul of change: Delivering what works in therapy* (2nd ed.). Washington, DC: American Psychological Association.
Dynel, M. (2018). To say the least: Where deceptively withholding information ends and lying begins. *Topics in Cognitive Science.* Advance online publication. https://doi.org/10.1111/tops.12379
Ekman, P. (2001). *Telling lies: Clues to deceit in the marketplace, politics, and marriage*. New York, NY: Norton.
Evetts, J. (2013). Professionalism: Value and ideology. *Current Sociology*, *61*, 778-796.
Fallowfield, L. J., Jenkins, V. A., & Beveridge, H. A. (2002). Truth may hurt but deceit hurts more: communication in palliative care. *Palliative Medicine*, *16*, 297-303.
Feldman, R. (2009). *The liar in your life: The way to truthful relationships*. New York, NY: Twelve.
Feldman, R. S, Forrest, J. A., & Happ, B. R. (2002). Self-presentation and verbal deception: Do self-presenters lie more? *Basic and Applied Social Psychology*, *24*, 163-170.
Fingarette, H. (2000). *Self-Deception*. Berkeley: University of California Press.
Ford, C. V. (1996). *Lies! Lies! Lies!!! The psychology of deceit*. Washington, DC: American Psychiatric Press.
Frank, M. G. (2009). Thoughts, feelings, and deception. In B. Harrington (Ed), *Deception: From ancient empires to internet dating* (pp.55-73). CA: Stanford University Press.
Frankfurt, H. (2009). On truth, lies, and bullshit. In C. Martin (Ed.), *The philosophy of deception* (pp. 37-48). New York, NY: Oxford University Press.
Gell-Mann, M. (2009). Forward. In B. Harrington (Ed), *Deception: From ancient empires to internet dating* (pp. vii-xii). CA: Stanford University Press.
Goleman, D. (1985). *Vital lies, simple truths: The psychology of self deception*. New York, NY: Simon and Schuster.
Grayling, A. C. (2009). A. C. Grayling. In M. Gordon & C. Wilkinson (Eds.), *Conversations on truth* (pp. 74-88). New York, NY: Continuum.
Green, R. S., & Gantt, A. B. (1987). Telling patients and families the psychiatric diagnosis: a survey of psychiatrists. *Psychiatric Services*, *38*, 666-668.
Greenspan, M. (1993). On professionalism. In C. Heyward (Ed.), *When boundaries betray us*. (pp.193-205). San Francisco, CA: Harper Collins.
Grus, C. L., Shen-Miller, D., Lease, S. H., Jacobs, S. C., Bodner, K. E., Van Sickle, K. S., . . . Kaslow, N. J. (2017). Professionalism: A competency cluster whose time has come. *Ethics and Behavior.* Advance online publication. doi.10.1080/10508422.2017.1419133
Hansen, J. T. (2013). *Philosophical issues in counseling and psychotherapy: Encounters with four questions about knowing, effectiveness, and truth*. Plymouth, UK: Rowman and Littlefield.
Hantoot, M. S. (2000). Lying in psychotherapy and supervision. *Academic Psychiatry*, *24*, 179-187.
Harrington, B. (2009). Introduction: Beyond true and false. In B. Harrington (Ed.), *Deception: From ancient empires to internet dating* (pp. 1-18). CA: Stanford University Press.
Harris, S. (2013). *Lying*. Cleveland, OH: Four Elephants Press.
Higgs, R. (1985). On telling patients the truth. In M. Lockwood (Ed.), *Moral dilemmas in modern medicine* (pp.187-206). New York, NY: Oxford University Press.

Hind, D. (2009). Dan Hind. In M. Gordon & C. Wilkinson (Eds.), *Conversations on truth* (pp. 113-127). New York, NY: Continuum.
Houdek, P. (2017). Professional identity and dishonest behavior. *Society*, *54*, 253-260.
Hsieh, D. M. (2004). False excuses: Honesty, wrongdoing, and moral growth. *The Journal of Value Inquiry*, *38*, 171-185.
Imel, Z. E., Wampold, B. E., Miller, S. D., & Fleming, R. R. (2008). Distinctions without a difference: direct comparisons of psychotherapies for alcohol use disorders. *Psychology of Addictive Behaviors, 22*, 533-543.
Jacobsen, C., Fosgaard, T. R., & Pascual-Ezama, D. (2017). Why do we lie? A practical guide to the dishonesty literature. *Journal of Economic Surveys.* Advance online publication. https://doi.org/10.1111/joes.12204
Jenkins, S., & Delbridge, R. (2017). Trusted to deceive: A case study of 'strategic deception' and the normalization of lying at work. *Organization Studies*, *38*, 53-76.
Kaslow, N. J., Grus, C. L., Allbaugh, L. J., Shen-Miller, D., Bodner, K. E., Veilleux, J., & Van Sickle, K. (2018). Trainees with competence problems in the professionalism domain. *Ethics and Behavior.* Advance online publication. doi: https://10.1080/10508422.2018.1438897
Kemp, R., & Lorentzatou, D. (2013). The place of truth in psychoanalysis: a Heideggerian contribution. *European Journal of Psychotherapy and Counselling*, *15*, 5-17.
Keyes, R. (2004). *The post-truth era: Dishonesty and deception in contemporary life*. New York, NY: St. Martin's Press.
Koocher, G. P., & Keith-Spiegel, P. (2016). *Ethics in psychology and the mental health professions: Standards and cases* (4th ed.) New York, NY: Oxford University Press.
Kottler, J. (2010). *The assassin and the therapist: An exploration of truth in psychotherapy and in life*. New York, NY: Routledge.
Kottler, J. (2018). Clients lie—a lot—and it might not matter. In J. Kottler (Ed.), *The secrets of exceptional counselors* (pp.91-99). Alexandria, VA: American Counseling Association.
Kottler, J., & Carlson, J. (2011). *Duped: Lies and deception in psychotherapy*. New York, NY: Routledge.
Krauss, F. S. (2017). Lying, risk and accuracy. *Analysis*, *77*, 726-734.
Levine, E. E. (2017). Lie to others as you would have others lie unto you: community standards of deception. *Academy of Management Proceedings.* Retrieved from https://journals.aom.org/doi/abs/10.5465/ambpp.2015.126
Levine, E. E., & Schweitzer, M. E. (2014). Are liars ethical? On the tension between benevolence and honesty. *Journal of Experimental Social Psychology*, *53*, 107-117.
Levine, E. E., & Schweitzer, M. E. (2015). Prosocial lies: When deception breeds trust. *Organizational Behavior and Human Decision Processes*, *126*, 88-106.
Lieberman, M. A., Yalom, I. D., & Miles, M. B. (1973). *Encounter groups: First facts*. New York, NY: Basic Books.
Lippmann, P. (2017). The scandal within psychoanalysis itself. In J. Petrucelli & S. Schoen (Eds.), *Unknowable, unspeakable, and unsprung: Psychoanalytic perspectives on truth, scandal, secrets, and lies* (pp. 199-205). New York, NY: Routledge.
Love, M., & Farber, B. A. (2018). Honesty in psychotherapy: Results of an online survey comparing high vs. low self-concealers. *Psychotherapy Research*. Advance online publication, *2*, 1-14.
Lupoli, M. J., Jampol, L., & Oveis, C. (2017). Lying because we care: Compassion increases prosocial lying. *Journal of Experimental Psychology: General, 146*, 1026-1042.
Lupoli, M. J., Levine, E. E., & Greenberg, A. E. (2018). Paternalistic lies. *Organizational Behavior*

and Human Decision Processes, *146*, 31-50.
Lynch, M. P. (2009). Deception and the nature of truth. In C. Martin (Ed.), *The philosophy of deception* (pp. 188-200). New York, NY: Oxford University Press.
Mahon, J. E. (2015). The definition of lying and deception (Rev.) *The Stanford Encyclopedia of Philosophy.* Retrieved from https://stanford.library.sydney.edu.au/entries/lying-definition/
Malin, N. (2000a). Introduction. In N. Malin (Ed.), *Professionalism, boundaries and the workplace* (pp. 1-4). New York, NY: Routledge.
Malin, N. (2000b). Professionalism and boundaries of the formal sector: The example of social and community care. In N. Malin (Ed.), *Professionalism, boundaries and the workplace* (pp. 7-24). New York, NY: Routledge.
Marar, Z. (2008). *Deception*. Stocksfield, UK: Acumen.
Martin, M. W. (2000). *Meaningful work: Rethinking professional ethics*. New York, NY: Oxford University Press.
Martin, C., Vaught, W., & Solomon, R. C. (2017). What is it to be a professional? The professions, leadership, and work. In C. Martin, W. Vaught, & R. C. Solomon (Eds.), *Ethics across the professions: A reader for professional ethics* (pp. 1-2). New York, NY: Oxford University Press.
Mearsheimer, J. J. (2011). *Why leaders lie: The truth about lying in international politics*. New York, NY: Oxford University Press.
Miller, C. B. (2013). *Moral character: An empirical theory*. United Kingdom: Oxford University Press.
Miller, M. J. (1992). The Pinocchio syndrome: Lying and its impact on the counseling process. *Counseling and Values*, *37*, 25-31.
National Association of Addiction Treatment Providers [NAATP]. (2017, December 31). *NAATP Code of Ethics*. Retrieved from https://www.naatp.org/resources/news/naatp-launches-new-year-ethics-code-20/jan-8-2018
National Association of Social Workers (2008). *NASW Code of Ethics*. Washington, DC: Author.
Nyberg, D. (1993). *The varnished truth: Truth telling and deceiving in ordinary life*. IL: University of Chicago Press.
O'Sullivan, M. (2009). Why most people parse palters, fibs, lies, and whoppers, and other deceptions poorly. In B. Harrington (Ed), *Deception: From ancient empires to internet dating* (pp. 74-94). CA: Stanford University Press.
Patterson, J., & Kim, P. (1991). *The day America told the truth: What people really believe about everything that really matters*. New York, NY: Prentice Hall.
Perlmutter, M. (1998). *Why lawyers (and the rest of us) lie and engage in other repugnant behavior*. Austin, TX: Bright Books.
Peterson, C. (1996). Deception in intimate relationships. *International Journal of Psychology*, *31*, 279-288.
Pope, K. S., Sonne, J. L., & Greene, B. (2006). *What therapists don't talk about and why*. Washington, DC: American Psychological Association.
Pope, K. S, Sonne, J. L., & Holroyd, J. (1993). *Sexual feelings in psychotherapy: Explorations for therapists and therapists-in-training*. Washington, DC: American Psychological Association.
Provis, C. (2010). The ethics of impression management. *Business Ethics: A European Review*, *19*, 199-212.
Rogers, T., Zeckhauser, R., Gino, F., Norton, M. I., & Schweitzer, M. E. (2017). Artful paltering: The risks and rewards of using truthful statements to mislead others. *Journal of Personality and Social Psychology*, *112*, 456-43.

Rutschmann, R., & Wiegmann, A. (2017). No need for an intention to deceive? Challenging the traditional definition of lying. *Philosophical Psychology*, *30*, 434-453.
Ryan, C. J., de Moore, G., & Patfield, M. (1995). Becoming none but tradesmen: lies, deception and psychotic patients. *Journal of Medical Ethics*, *21*, 72-76.
Saarni, C., & Lewis, M. (1993). Deceit and illusion in human affairs. In M. Lewis & C. Saarni (Eds.), *Lying and deception in everyday life* (pp. 1–29). New York, NY: Guilford.
Saul, J. M. (2012). *Lying, misleading, and what is said: An exploration in philosophy of language and in ethics*. New York, NY: Oxford University Press.
Schauer, F., & Zeckhauser, R. (2009). Paltering. In B. Harrington (Ed), *Deception: From ancient empires to internet dating* (pp. 38-54). CA: Stanford University Press.
Serban, G. (2001). *Lying: Man's second nature*. Westport, CT: Praeger.
Serota, K. B., & Levine, T. R. (2015). A few prolific liars: Variation in the prevalence of lying. *Journal of Language and Social Psychology*, *34*, 138-157.
Shibles, W. (1985). *Lying: a critical analysis*. Whitewater, WI: The Language Press.
Shulman, D. (2007). *From hire to liar: The role of deception in the workplace*. Ithaca, New York, NY: Cornell University Press.
Smith, D. L. (2004). *Why we lie: The evolutionary roots of deception and the unconscious mind*. New York, NY: St. Martin's Press.
Smith, D. L. (2009). David Livingstone Smith. In M. Gordon & C. Wilkinson (Eds.), *Conversations on truth* (pp. 167-181). New York, NY: Continuum.
Solomon, R. C. (1993). What a tangled web: Deception and self-deception in philosophy. In M. Lewis & C. Saarni (Eds.), *Lying and deception in everyday life* (pp. 30–58). New York, NY: Guilford.
Solomon, R. C. (2009). Self, deception, and self-deception in philosophy. In C. Martin (Ed.), *The philosophy of deception* (pp. 15-36). New York, NY: Oxford University Press.
Stokke, A. (2013). Lying, deceiving, and misleading. *Philosophy Compass*, *8*, 348-359.
Stokke, A. (2017). Lies, harm, and practical interests. *Philosophy and Phenomenological Research*. Advance online publication. Advance online publication. doi: 10.1111/phpr.12439
Strudler, A. (2016). Respectful lying. *Ethical Theory and Moral Practice*, *19*, 961-972.
Szasz, T. (1979). The lying truths of psychiatry. In R. Duncan & M. Weston-Smith (Eds.), *Lying truths: A critical scrutiny of current beliefs and conventions* (pp. 121-142). New York, NY: Pergamon.
Sussman, M. B. (1992). *A curious calling: Unconscious motivations for practicing psychotherapy*. Northvale, NJ: Aronson.
Sussman, M. B. (1995a). Introduction. In M. B. Sussman (Ed.), *A perilous calling: The hazards of psychotherapy practice* (pp. 1-12). Hoboken, NJ: Wiley.
Sussman, M. B. (1995b). Intimations of mortality. In M. B. Sussman (Ed.), *A perilous calling: The hazards of psychotherapy practice* (pp. 15-22). Hoboken, NJ: Wiley.
Taleff, M. J. (2006). *Critical thinking for addiction professionals*. New York, NY: Springer.
Taleff, M. J. (2010). *Advanced ethics for addiction professionals*. New York, NY: Springer.
Trivers, R. (2011). *The folly of fools: The logic of deceit and self-deception in human life*. New York, NY: Basic Books.
Tuckett, A. G. (2004). Truth-telling in clinical practice and the arguments for and against: a review of the literature. *Nursing Ethics*, *11*, 500-513.
VanZandt, C. E. (1990). Professionalism: A matter of personal initiative. Journal of *Counseling and Development*, *68*, 243-245.

Varki, A., & Brower, D. (2013). *Denial: Self-deception, false beliefs, and the origins of the human mind*. New York, NY: Twelve.
Vrij, A. (2008). *Detecting lies and deceit: Pitfalls and opportunities*. Hoboken, NJ: Wiley.
Weiner, M. F. (1978). *Therapist disclosure: The use of self in psychotherapy*. Woburn, MA: Butterworth.
Weissman, B., & Terkourafi, M. (2018). Are false implicatures lies? An empirical investigation. Advance online publication. https://doi.org/10.1111/mila.12212
Wiegmann, A., Samland, J., & Waldmann, M. R. (2016). Lying despite telling the truth. *Cognition*, *150*, 37-42.
Wiltermuth, S. S., Newman, D. T., & Raj, M. (2015). The consequences of dishonesty. *Current Opinion in Psychology*, *6*, 20-24.
Witt, C. L. (2013). What is professionalism? *Advances in Neonatal Care*, *13*, 303-304.
Yonatan-Leus, R., Tishby, O., Shefler, G., & Wiseman, H. (2017). Therapists' honesty, humor styles, playfulness, and creativity as outcome predictors: A retrospective study of the therapist effect. *Psychotherapy Research*. Advance online publication. doi: 10.1080/10503307.2017.1292067
Yourman, D. B., & Farber, B. A. (1996). Nondisclosure and distortion in psychotherapy supervision. *Psychotherapy: Theory, Research, Practice, Training*, *33*, 567-575.
Zur, O. (2005). The dumbing down of psychology: Faulty beliefs about boundary crossings and dual relationships. In R. H. Wright & N. A. Cummings (Eds.), *Destructive trends in mental health: The well-intentioned path to harm* (pp. 253-282). New York: Routledge.

Acknowledgments: I wish to express my gratitude to Barry Farber for reviewing an earlier version of this paper and providing editorial feedback.
Competing Interests: none
Address for Correspondence: e-mail: izaakw@hawaii.edu
Date of Publication: November 30, 2018