



Self-deception and the therapist: An interpretative phenomenological analysis of the experiences and understandings of therapists working with clients they describe as self-deceptive

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Objectives. The aim of this study was to explore how participants experience working with clients they describe as self-deceptive, as well as the participants' reflections on the experience and their understandings of self-deception.

Design. Data were collected in two stages. In the first stage, participants were asked to provide a written description of a specific incident or of a set of sessions in which it seemed to the therapist that the client was deceiving him/herself. The second stage consisted of a semi-structured interview, designed to follow-up the written description in greater detail.

Methods. Four participants took part in the study. The data were analysed using interpretative phenomenological analysis.

Results. Three superordinate themes were identified in the analysis: therapists' self experiences; engaging with the client; and therapists' experiences and perceptions of the client.

Conclusions. The concept of self-deception offered participants a perspective for describing and understanding clients who present a range of 'difficult' attitudes and behaviours, such as evasion and denial of the 'truth' of their predicament as understood by the therapist, conflicting, and contradictory attitudes to the process of self change, avoiding taking responsibility for themselves, lack of self-understanding, withholding from engagement in therapy, and from relationship with the therapist. The findings also bring to light therapists' experiences of discomfort, frustration and anger, and feelings of incompetence when working with clients they described as self-deceptive. The construct of client's self-deception constitutes one possible interpretation but other interpretative possibilities are considered.

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The concept 'self-deception' in the context of psychotherapy tends to describe maladaptive attitudes and behaviours of clients (Bonanno & Siddique, 1999), such as evasion and denial of the 'truth' of their predicament as understood by the therapist, conflicting, and contradictory attitudes to the process of self change, avoiding taking responsibility for themselves, lack of self-understanding, withholding from engagement in therapy, and from relationship with the therapist. In this study, we focus on therapists' specific experiences and understandings of issues which may arise in working with clients they describe as self-deceptive. The reader is then able to engage in the process of considering this study in relation to their professional and personal experience as well as the relevant literature we have discussed here.

The literature on self-deception provides numerous 'stock examples of self-deception . . . people who falsely believe - in the face of strong evidence to the contrary - that their spouses are not having affairs, or that their children are not using illicit drugs, or that they themselves are not seriously ill' (Mele, 2001, p.9). In these examples, people appear to be self-deceived in believing something that they want to be true. Conversely, Mele refers to 'twisted' self-deception, cases of people who are self-deceived in believing something that they want to be false: 'For example, an insecure, jealous husband may believe that his wife is having an affair despite his possessing only relatively flimsy evidence for that proposition and despite his not wanting it to be the case that she is so engaged' (*ibid*, p. 4).

Traditional approaches to self-deception are modelled on intentional other-deception (e.g. Bermúdez, 2000; Davidson, 1985). According to this view, to be self-deceived a person must hold two contradictory beliefs simultaneously. The person is only aware of one of these beliefs, and is motivated to remain unaware of the other (Gur & Sackeim, 1979). The question arises 'how one person can simultaneously know (as he must, if he is to be a deceiver) and not know (as he must, if he is to be deceived) a single thing' (Neu, 1988, p. 82).

Such possibilities are premised on psychological and temporal partitioning that separate the two opposed beliefs in some 'fragmented model of consciousness' (Clegg & Moissinac, 2005). For example, the psychoanalytic approach conceptualizes self-deception by engaging the notion of a dynamic unconscious. In this view (Lockie, 2003), a person is made up of parts which have their own motivational interests. These are not necessarily known to the other parts or the person as a whole and they have means of concealing, revealing, and deceiving the other parts. The activities of the various parts 'may often be revealed only obliquely, by skilled inference (psychological 'detective work') to uncover the meaning revealed in slips, dreams, bungled actions, selective amnesia . . . typically by using clinical interview techniques - free association, hypnosis, and other techniques allied to the clinical experience' (Lockie, 2003, p. 128).

Sartre's (1956) account of self-deception ('bad faith') emanates from an alternative model of consciousness. In his view, consciousness entails intentionality and self-reflection and we define the nature of our consciousness through the choices we make with regard to how to direct our consciousness. Awareness of our freedom in making choices gives rise to anxiety and anguish, and bad faith is an attempt to escape the anguish by denial of freedom and responsibility. Similarly, Fingarette (1969) refers to a 'disavowal' of responsibility in self-deception. In Sartre's view, accepting the anguish offers a possibility of acting in good faith. However, bad faith is inevitable. Everybody is engaging in bad-faith at one time or another, even though it may not be recognized as intentional.

How is it possible to describe consciousness as intentionality and at the same time not to recognize one's intention? Sartre posits two modes of consciousness: one mode engages intentionality and self-reflection, whereas the other, pre-reflective consciousness, is a form of consciousness prior to being aware of an object for reflection. In Sartre's account we must be at some level pre-reflectively aware of acting in bad-faith, although this is not fully intentional. Sartre's notion of pre-reflective consciousness resembles Freud's concept of preconsciousness. Perhaps, despite strongly rejecting the Freudian unconscious, by locating the source of bad faith in pre-reflective consciousness, Sartre, like psychoanalysis, points to what may be concealed from full awareness and what may be revealed in consciousness' call for self-reflection.

Other approaches offer alternative explanations of self-deception that are not dependent on fragmented consciousness. For example, in Mele's (1997, 2001) motivation-centred description of self-deception there is no requirement of possessing two contradictory beliefs. Mele contends that the motivating force of self-deception is either a desire for something to be true, or the fear that something is true. The desire or fear gives rise to a motivational biased processing which involves a formulation of interpretative and perceptual constructions to 'make it so', followed by the gathering of evidence to 'confirm it is so'. This may involve selective attention to evidence in our possession, selective means of gathering evidence and negative or positive misinterpretations, etc. For self-deception to be perceived, an 'impartial observer' (Mele, 2001, p. 26) is required, either an impartial person observing that someone is self-deceiving, or the self-deceiver realizing at a later examination that he/she was deceiving him/herself.

The notion of self-deception shares a common conceptual space with delusion and defence (McKay, Langdon, & Coltheart, 2005). McKay *et al.* point out that although the terms self-deception and delusion have sometimes been used as synonyms, they consider them to be distinct but overlapping concepts. They view delusion as a dysfunctional belief that is 'both unwarranted by the evidence at hand, and that jeopardizes their day-to-day functioning' (p. 315). Self-deception, on the other hand, is regarded as a process through which beliefs are formed. In this view, delusions 'may result from an incremental process of individual self-deceptive acts' (*ibid*). While both self-deception and delusion refer to beliefs and processes of belief formation, 'the notion of defence refers more generally to a style of experiencing the world' (*ibid*, p. 316). In psychoanalytic theory defence mechanisms are defined as mental processes that operate unconsciously to reduce painful emotions. In this view, repression is considered as one of the most basic of defences and is commonly conceived as a variety of self-deception (Boag, 2007).

In a shift away from locating self-deception in individual consciousness, Clegg and Moissinac (2005) suggest that the discrepancies at the heart of self-deception flow from the multiple and ambiguous qualities of experience rather than from fragmented consciousness. They contend that 'it is the experiential world itself that is fragmented by the intersection of, and negotiation between, multiple unique experiential fields. . . within the larger experiential field that we call social or cultural' (Clegg & Moissinac, 2005, p. 102). In this account, the possibility of self-deception is located at the intersection of the multiple, ambiguous, and conflicting qualities of experience in a confusing and contradictory world of demanding responsibilities and relationships. Such an account of self-deception also questions the notion of an 'impartial observer' perceiving the biased processing involved in self-deception, for every observation is taken from a perspective, and thus always 'biased' and engages interpretation.

The relational dimension of self-deception highlighted by Clegg and Moissinac is crucial to conceptualizing self-deception in the context of psychotherapy, as the relationship between therapist and client is considered one of the key factors in the process and outcome of therapy (e.g. Cooper, 2005; Norcross, 2002; Stern, 2004). This is further discussed below. From a therapist's perspective, the notion of an 'impartial observer' is also contentious, as such an account thrusts the therapist 'into the role of arbiter on matters of self-deception' (Gergen, 1997, p.115) and implies that the therapist is in possession of objective, impartial knowledge. Gergen (1997, see also Gergen, 1985) challenges the traditional claim of professionals (psychologists, psychiatrists). Spinelli (2007, p.77) contends that narrative, social constructionist, and existential approaches to psychotherapy 'might be thought of as a co-creation of novel meanings via mutual dialogue'. In his view, 'existential psychotherapists avoid adopting the role of a superior, objective instructor who distinguishes for the client those dispositional stances that are assumed to be 'unreal', 'false', and/or 'irrational' (*ibid*, p.60). The therapist assumes no privileged understanding of the meanings, beliefs, fears, and aspirations contained in the client's narrative. During therapy the therapist may initiate a mutual exploration of what remains implicit or unstated in the client's narrative.

The concept of narrative offers another perspective for conceptualizing self-deception. Sarbin (1986) argues that self-narrative is a necessary construct for understanding self-deception. He contends that human beings organize experience as stories and that people construct their life histories in order to maintain or enhance self-identity: 'In self-narratives that assign truth value to the contrafactual, the narrator constructs the text so that the self as narrative figure is protected, defended or enhanced' (p.16-7). Similarly, Silver and Miceli (1989, p.220) contend that the self-deceiver 'constructs a compelling story'.

Despite the potential difficulties with the concept of self-deception, Kirby (2003, p.110) suggests that an understanding of the issues involved 'can alert the therapist to the importance of exploring the possibility of the client's experiencing an underlying anxiety or unacknowledged desire'. For example, Mele (1997) contends that self-deception is motivated by desire while Dalglish (1997) and Lazar (1999) highlight the affective dimension of strong emotions that are implicated in self-deception. Most attempts to explain the functions of self-deception refer to a desire to avoid or protect from difficult feelings, for example, attempts to reduce anxiety (Barnes, 1997; Johnston, 1988); or to maintain self-esteem (e.g. Hilgard, 1949; Sackeim, 1983).

Traditionally self-deception has been seen as maladaptive (Bonanno & Siddique, 1999), and as threatening to the project of self-knowledge and self-consciousness (Rorty, 1994). However, Bonanno and Siddique suggest that although in some situations repressive, emotionally dissociative, or self-deceptive habits may result in a maladaptive lack of insight, in other situations self-deception may be quite adaptive. For example, in their work with adult bereavement Bonanno and Siddique (1999, p.260) found that 'self-deception and emotional avoidance were consistently and robustly linked to a better outcome' in terms of well-being over time. Taylor and Brown (1988) consider self-deception to be beneficial for normal psychological functioning. Similarly, Rorty (1994) contends that 'deception and self-deception are often benevolently and insightfully motivated' (p.218), as 'self-deception is sometimes construed as an effective measure against the despair of global scepticism' (p.221). In her view, the danger of self-deception lies in the damaging habits it develops: inflexibility, a tendency to generalize, as well as falsity, irrationality, and manipulation it is presumed to bring.

The aim of this study is to explore how participants experience working with clients they described as self-deceptive, as well as the participants' reflections on their experiences and their understandings of self-deception. While this study explores how therapists engaged with perceived self-deception in clients, the construct of self-deception questions also the status of the therapists' accounts in the interviews. As Churchill (2000, p. 44) points out: 'When we ask patients or research subjects to describe their experiences, they do so with many of the same operative defenses and self-deceptions that were inherent in the experiences they described'. As researchers we are twice removed, trying to understand the participants' narratives of their experiences of engaging with their clients' accounts of their experiences. From our perspective as researchers we acknowledge the impossibility of unmediated access to the experience. Investigating how events and objects are experienced and given meaning requires an interpretative activity on the part of the researcher (Smith & Osborn, 2003). In this study, we have used interpretative phenomenological analysis (IPA) as it embodies this dual concern. The phenomenological perspective involves an account of participants' subjective experiences, while the interpretative perspective questions and investigates the emergent analysis in relation to relevant literature.

Method

Participants

The first author prepared an information sheet describing the study and inviting participation of therapists who experienced working with a particular client (or clients) whom they regarded as self-deceptive. The leaflet was distributed through associate therapists and other contacts. Four participants took part in this study. All were actively in practice and seeing clients on a regular basis. All had been seeing the client they described for this study for more than 12 sessions. Participants signed a consent form and their names were changed to protect confidentiality. A summary of their length of experience, theoretical backgrounds, and details of the context and the population of their clients is given in Figure 1.

Data collection

Data were collected in two stages as described in Langdridge (2007). In the first stage, participants were asked to provide a written description of a specific incident or of a set of sessions in which it seemed to the therapist that the client was deceiving him/herself. The concept of self-deception was introduced through a description adapted from previous phenomenological research on self-deception (Fischer, 1985; Watson & Welch-Ross, 2000) which suggests that self-deception involves holding a false belief and denying the truth. One acts according to one's false belief and may make excuses to justify one's actions and maintain illusions about oneself. Participants were asked to describe their experiences and feelings during the session(s), their reflections on the experiences, as well as how they worked with the client. The second stage followed 2 weeks later and consisted of a semi-structured interview, designed to follow-up the written description in greater detail. The first author read the written descriptions and identified specific topics to be included in each follow-up interview, but the process remained flexible to enable following up interesting possibilities emerging during the interview. Each participant answered different and individually constructed interview

Participant	Theoretical background	Number of years in Practice	Details of practice
Richard	Integrative	11 years	Private sector full time short term adults
Lynn	Person centred	4 years	Private sector part time long term young adults
Cheryl	Psychodynamic	12 years	Private sector full time long term adults
Sarah	Existential	7 years	Private sector full time longer term all ages

Figure 1. Summary of participants' details.

questions. An extract from an interview is given in the Appendix, including interview questions and participant's responses. Langdridge (2007, p. 75) maintains that 'This is a particularly appealing method, since it encourages active reflection on the topic under investigation between the production of the written account and the interview. The written component gives participants the opportunity to tell their own story, while the interview allows researchers to explore topics of particular interest'. The interviews were recorded and later transcribed verbatim. As the material from the interviews elaborated on the same areas as the written descriptions, they were analysed following the same procedures for thematic analysis outlined below and integrated in the overall discussion of the results.

Analysis

IPA is considered a particularly relevant method for this study as it aims to give voice to and examine the personal experience of participants and how participants make sense

of their experience (Smith, 2004). IPA is also interpretative in recognizing the role of the researcher in making sense of the experience of participants. Smith refers to 'double hermeneutics. The participant is trying to make sense of their personal and social world; the researcher is trying to make sense of the participant trying to make sense of their personal and social world' (p. 40). IPA provides flexible guidelines which can be adapted by researchers in accordance with their research aims (Smith & Osborn, 2003). The analysis followed several stages: The first stage consisted of reading the written description and the transcript of the first participant a number of times to become immersed in the data. During reading notes or comments which appear significant or interesting were recorded. The second stage involved returning to the written description and transcript to transform the initial notes into emerging themes or concepts, taking care not to lose the connection between the participant's own words and the researcher's interpretations. The third stage consisted of examining the emerging themes and clustering them together according to conceptual similarities. The clusters were given a descriptive label which conveys the conceptual nature of the themes in each cluster. As the clusters of themes emerged, the written description and the transcript were checked to ensure that the connection with what the participant has actually said was maintained. In the final stage, a table of themes was produced. The table shows the structure of major themes and subthemes. This process was repeated for each participant. The tables of themes of all participants were compared and a master table of themes was created (Figure 2). An audit of the first author's thematic analysis was conducted by the second author, to ensure that the themes identified were warrantable (Streubert, 1994).

Results

All participants provided an example of a particular client whom they regarded as self-deceptive. Richard described a client deceiving herself about what would facilitate weight loss (the initial presenting problem). He described her as holding many self-deceptions that excused what she ate and how much she exercised. She provided justifications that discharged her of all responsibility for what she was eating and how she was exercising, all of which were unlikely to lead to the loss of weight that she originally sought therapy for. Lynn described a client who presented herself as wanting to change her jealousy around her boyfriend, recognizing her 'irrational thoughts and behaviours' in the relationship. However, to Lynn it seemed that the client's actions and explorations during therapy were indicative of an 'unwillingness to change, with the notion that the world should change around her'. She cancelled sessions at the last minute, failing to attend about a third of the designated number of meetings, and when she did attend, she implied it wasn't her that needed to change but it was everyone else around her who needed to do things differently. Any alternative way of looking at these situations appeared not to be heard by the client. Cheryl described her client as narcissistic and as having an 'unswerving ability to project everything on to everyone else in her life and me'. According to the client, all arguments with other people were their fault even though Cheryl at times said she was shocked at the provocative behaviours and aggravated discussions the client reported. Sarah's client was described as having many contradictions that he didn't hear himself expressing. Although he said he wanted to change he did very little in the way of moving towards change. In Sarah's account, the client described himself as an alcoholic, which he took to mean that

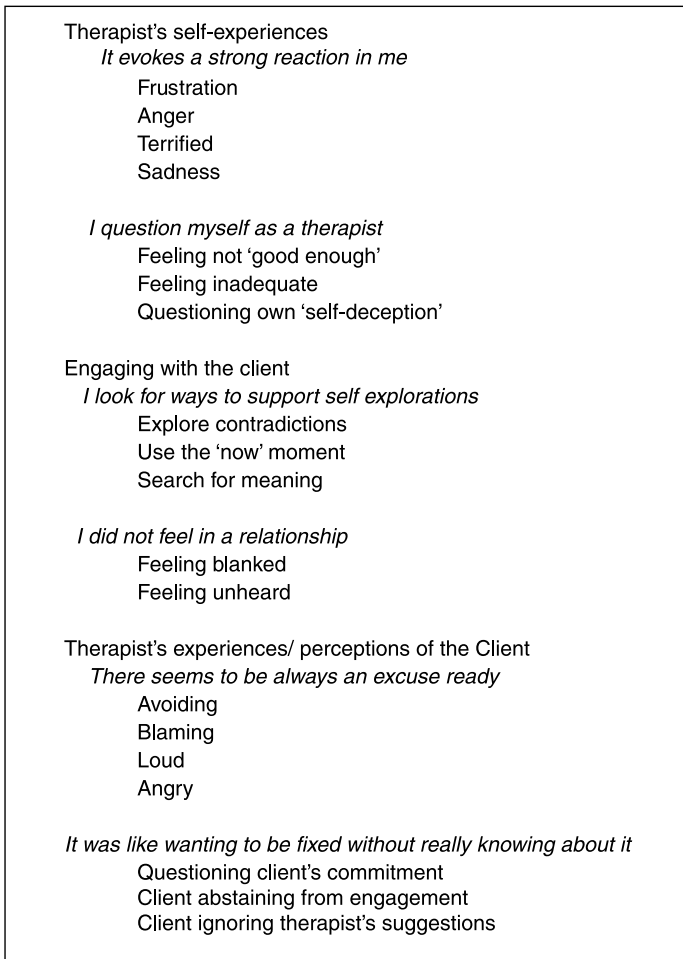


Figure 2. Summary of the master and sub-themes arising from the participants' accounts.

drinking to excess was not his fault, thereby evading taking responsibility for his own actions. He believed that it was up to everyone else around him to prove that it was worthwhile for him to give up drinking. However, if anyone attempted to help him find this 'fulfilling life' he was not interested, saying that it was boring or that he was too afraid.

Three superordinate themes were identified in the analysis: therapists' self experiences; engaging with the client; and therapists' experience and perceptions of the client. A summary of the results is given in Figure 2, which describes the master and the subthemes that arose from the participants' accounts.

Therapists' self-experiences

It evokes a strong reaction in me

All participants described feelings of frustration and anger as a feature of their experiences of the self-deceptive client (with the words 'frustration' and 'anger' seemingly used interchangeably), for example in the following extract from Sarah:

Int: In your writing you talk about his contradictions. Can you say a bit more about that and what this is like for you?

Sarah (line 49–52): There are so many contradictions that he doesn't hear himself saying. The contradictions are about his beliefs about himself, life and people. When I try and explore the contradictions and present them to him, he gets frustrated, confused and a sense of despondency. This often goes into expressing anger at me and my therapy and me. This is quite frustrating as he obviously says two different things but they seem to make complete sense to him. It's hard not to react and tell him a few home truths. Internally at times it does my head in.

These feelings at times seemed to run high for the participants and appeared to constitute an undercurrent for the descriptions. The interviewer felt that the tone of voice, choice of vocabulary, fervour, and emphasis used to express the therapists' emotional responses to these clients may be more colourful than for other clients. Participants reported experiencing exasperation and annoyance with their client's lack of self-understanding and reluctance to take responsibility. This often led to the therapist constructing a frustrated imaginary response to the client. For example:

Richard (54–8): My main feeling though, I remember, which was present all those years ago, and also in our current meetings, was that of anger! STOP EATING! That's what I thought! Why not just stop stuffing your mouth with rubbish? It's not THAT hard is it?

Lynn (87–8): She really frustrated me and sometimes her childlike helplessness and her looking to blame others made me want to tell her to grow up. She was very needy.

Sarah (123–5): I get sometimes angry at his stubbornness with his sedimented beliefs, 'don't change then' I think. To challenge them and for him to consider an alternative leaves him angry and scared. I do feel very sad for his 'lack'.

Participants described the frustration and anger as experiences that moved them away from 'being with' the client as this interrupted the experience of the 'immediate':

Cheryl (71–3): At the start of therapy with her it was terrifying and I felt that the therapy was always on the verge of breaking down. She was so angry all the time and any challenges about this just didn't work at all and produced even more anger at me.

Sarah (110–121): I feel I need to be careful how I put things and at times I feel under pressure to come up with the magic. I am sometimes drawn into focusing on how much he is drinking and probably come across as judgemental. This is not me as I am about exploration and descriptions rather than strategies formation. I am angry at myself at times at not meeting the challenge to stay in the relationship and with the feelings and thoughts that he is trying to describe and understand. I am allowed to be distracted here as sometimes he throws comments in that in some ways feel like they are to throw us of where we are at. Usually when we are exploring life and projects. When this happens it really evokes a strong reaction in me and in these moments I find it very difficult to bring into the room what is happening which I need to be doing. How he is presenting things. It is like I avoid the relationship too, I can't reveal the moments. It seems too much to bear. I question myself as a therapist in these times.

I question myself as a therapist

In the extract from Sarah above, she reported that at times the client's behaviour evoked strong reactions which led her to question herself as a therapist. Similarly, other participants indicated that the experiences of anger and frustration were leading them into an appraisal of their experiences and at times to a value judgment of themselves.

There was a feeling of being inadequate in some way, leading participants to doubt their competence as therapists:

Lynn (27-32): Initially I felt that I must be phrasing my suggestions in a way she was unable to hear or I was moving too fast for her. But as the multiple series of sessions went on and were continually static, I began to realise that this was not me but about her and I got very frustrated, angry and helpless. She made me feel like whatever I did it was not good enough - which for a short time locked me into a cycle of offering more. Whatever I offered was not good enough. I felt this was an insight in to how her partner must feel.

Richard (129-140): Makes me question myself. Am I the one in self-deception. Has she got it right and I've got it wrong? Then I start thinking about what is self-deception? . . . I then a little uneasy. Who is right? Is there a right and wrong? There are so many questions here . . . It's like I question myself and in some ways forget all my knowledge, experience, and training.

Int: Can you give me any other questions that come up for you when working with this client?

Richard: What if I mess something up? What if she knows she is doing this and is actually deceiving me. There is a sense, now I think about it that sometimes I am concerned that I am the one being deceived and hence I do keep an eye on things and what she is saying and how she is being in the session.

Engaging with the client

I look for ways to support self explorations

All participants reported that they encouraged self-reflection, helping the client to attend reflectively rather than intellectualize or avoid difficult issues. Participants described their specific interventions in supporting the client in undertaking a more authentic self exploration:

Sarah (48-9): When I try to explore the contradictions and present them to him, he gets frustrated, confused and a sense of despondency.

Sarah (129): [I] look for ways to support self exploration in himself and his feelings and thoughts.

Richard (72-7): geared towards working with the parts of the personality that felt under nourished . . . [moving towards] life as a whole with the issue of food becoming almost irrelevant. My client is now engaged in a search for meaning in her life . . . we are looking to feed her current understanding of herself so that she can live without the need to be seen.

Lynn (67-8): I needed to put things back to her in a way that she may be able to hear it.

Cheryl (80-2): I wasn't blaming her . . . This was the first time that she was able to hear that she had a part to play in this and she stopped and explored this.

Other features of supporting clients' self-reflection included congruence, genuineness, empathy and maintaining boundaries (Lynn), containment and holding (Cheryl), and the use of the 'now' as a means of reaching the client:

Richard (170-171): When I bring into the session how she has presented something in that very moment. When I use immediacy she does pause and consider what was happening in that situation.

Lynn (72-3): If I said how I felt about what she had just said. If I expressed an emotion it seemed like she would consider this for a bit. It seemed to hit home.

I did not feel in a relationship

Participants described how despite repeated attempts to find ways of reaching the client, they sometimes felt manipulated, angry, frustrated, and doubting their own competence. There was a feeling of being excluded and invisible in the relationship with the client:

Lynn (58-9): She seemed to talk at me and I didn't feel in a relationship with her. She seemed to do everything to avoid this or at least make it as difficult as possible.

Richard (154-5): She completely blanks me.

Cheryl (107-8): There still can't be an 'us' in the therapy room. I describe it in supervision as she tippexes me out. She doesn't always hear me.

Therapist's experiences/perceptions of the client*There seems to be always an excuse ready*

Participants described avoidance behaviours, for example, changing the subject (Richard, 156), avoiding (Lynn, 59), blaming others (Sarah, 82; Lynn, 87) and exploding in an 'outburst of anger' (Cheryl, 66), ignoring the therapist (Richard, 174; Lynn, 17, 52, 54), and finding excuses, as in the extract below:

Richard (119-125): There seems to be always an excuse ready to explain her unhelpful actions. It seems what everything I say, or how ever I react, she misses it. If I raise an eye brow, look shocked or surprised or even look sad for some of the things she has shared about the past, it isn't noticed. She doesn't seem to see any of it. I think she doesn't always see me actually, now I am talking about it.

Clients were portrayed as generally loud in voice, and/or demeanour:

Lynn (89-90): One thing I did really notice was that she was so loud in the room. I would inwardly wince and feel like I would want to back away to get away from the noise. She hurt my ears.

Richard (150-2): I often want her to turn the volume down. She also coughs loudly in the session too. It's like she has to be noticed. It certainly keeps me away from her at times as it feels like she is shouting at me.

Cheryl (43-5): She would and has shouted at me in the session about what a c*** therapist I am. A f***ing sh** therapist and she thought I was meant to be on her side. She really goes for it if I say the wrong thing.

Participants noted that their clients used words that seemed to fix themselves as someone who 'is' and/or 'does', a label or a thing. For example, Richard's client believed she has an illness, Sarah's client described himself as an alcoholic while Lynn and Cheryl's clients described themselves as being helpless and blameless respectively. Lynn described her client as very demanding during and also outside sessions with 'constant calls to therapist and unreasonable demands on session times'. She also generally found her client demonstrating childlike behaviours and pushing boundaries. Other participants observed signs of anger:

Sarah (49-50): This often goes into expressing anger at me and my therapy and me.

Richard (154-5): When I have tried to connect things . . . she completely blanks me, pauses for a moment, looking so angry.

Cheryl (72-3): She was so angry all the time and any challenges about this just didn't work at all and produced even more anger at me.

It was like wanting to be fixed without really knowing about it

Clients' behaviour was interpreted as on the one hand, a desire to change (demonstrated by seeking and attending therapy), and at the same time resistance to being a part of this therapeutic process and even resenting the therapist's participation in their own change. Clients were described as generally abstaining from engagement in the process of therapy:

Lynn (50-1): It was like she wanted to be fixed without really knowing about it. It felt like she wanted magic.

Richard (107-8): It feels like what she was asking of me was to stop her doing the behaviour without knowing it. It is almost like she doesn't see or hear things that she says or I say in the session.

Cheryl (55): The truth would be seen as me being the enemy.

Lynn (16-18): From these behaviours I began to wonder if the client was committed to change. In the sessions any suggestions I made about how to be different were glossed over, virtually ignored by the client.

Sarah (26-7): Although he says he wants to change he has done very little in the way of moving himself towards this.

Various constructs emanating from the different theoretical backgrounds were used to explain the client's predicament. Cheryl described the client's difficulties with '*separation*' and a need for '*sameness*'. Sarah referred to '*fear of accepting the givens and the challenge of freedom and choice*' as being too much for the client to be with. Lynn seemed to call to question the perfect childhood as described by the client and Richard believed that the client's past '*was about not being seen*'. Generally, it can be seen that the participants interpreted clients' behaviours as an evasion of deeper self-reflections and not wanting to take responsibility for their own feelings and actions/reactions. Participants in this study perceived certain clients and a range of their attitudes and behaviours as self-deceptive. Self-deception was generally understood as a harmful phenomenon, an obstruction on the road to what is considered a positive outcome: insight, self-knowledge and a more authentic, and honest living.

The concept of self-deception offered participants a perspective for understanding clients' predicaments and adopting a therapeutic approach in keeping with the theoretical orientation of each participant: Richard suggested that an individual's past experience shapes the meaning behind the self-deception and it is through revealing its meaning that the self-deception may recede. Lynn seemed to have a similar stance although she believed that by creating the core conditions, the client gains the opportunity to view their self-concept honestly. Cheryl saw the self-deception as an early attachment issue and the inability to be separate. By working '*with*' and '*within*' transference the client will find separateness. Sarah understood self-deception as an avoidance and refusal to accept the givens of life including freedom, choice, and responsibility.

Discussion

The construct of client's self-deception offers one possible interpretation of the situations described by participants. However, other interpretative possibilities may be relevant, including the possibility of the therapist's own self-deception, as articulated by

Richard in the interview: 'It makes me question myself. Am I the one in self-deception? Has she got it right and I've got it wrong?', recalling Churchill's observation (see above) that research participants describe their experiences 'with many of the same operative defenses and self-deceptions that were inherent in the experiences they described'. Participants located the difficulties encountered in the process of therapy in the self-deceptive client. However, it is equally plausible to consider some of these difficulties as emanating from therapists' own issues. For example, in the psychoanalytic tradition the therapist's counter-transference is considered to influence the dynamics of therapy (e.g. Gelso & Hayes, 2007; Hayes, McCracken, & McClanahan, 1998).

Participants reported feeling inadequate and doubting their competence, which they attributed to their experiences with the self-deceptive client. However, additional factors may be involved. As Thériault and Gazzola (2006) point out, the experience of self-doubt and feelings of incompetence 'plague therapists throughout their careers independently of the actual efficacy of their work' (p. 313). Their research established several main sources for feelings of incompetence, including professional issues, process issues, and personal issues. They note that the personal issues were more difficult for participants to discuss and these affected them at a more profound level than the other categories. Considered in this way, it is possible that attributing difficulties to the self-deceptive client averts the gaze from focusing on therapist's own difficulties which might be contributing factors. Similarly, other studies of therapists' experience of difficulties in practice (e.g. Davis, Elliott, & Davis, 1987; Schröder & Davis, 2004; Smith, Kleijn, & Hutschemaekers, 2007) suggest various factors contributing to therapists' difficulties, including clients' factors, therapists' factors, and situational factors.

As discussed above, the relationship between therapist and client is considered one of the key factors in the process and outcome of therapy. In this study, relationships with clients were described as predominantly challenging and frustrating. Participants' attempts to develop and maintain therapeutic relationships were frequently met with clients' resistance to engage in the process. Clients were described as avoiding being in relationship and ignoring the therapist's presence and interventions. Some participants commented that the client did not seem to know 'how' or 'who' to be within the relationship and it appeared to be an 'unknown' and deeply feared experience for the client. Therapists' reported that the challenging, often volatile and fragile relationship with the client sometimes left them feeling manipulated, angry, frustrated, and doubting their own competence. Difficulty in developing a relationship with clients has been recognized as a significant factor in the study of the experience of self-doubt and feelings of incompetence discussed above. Thériault and Gazzola (2006) suggest that 'building and maintenance of a strong relationship was viewed as the *sine qua non* of feeling competent. The absence of a strong relationship had the opposite effect.' (p. 321).

A relational perspective is central to Clegg and Moissinac's (2005) conceptualization of self-deception. In their view, the potential for self-deception is located at the intersection of the multiple, ambiguous, and contradictory qualities of experience. Considered in this way, clients perceived as self-deceptive may be confounded and anxious at what seems to be a confusing and contradictory world of demanding responsibilities and relationships. As noted above, to the therapist it appeared that the client did not seem to know how to be in a relationship. By seeking therapy, the clients described in this study all indicated at some level a desire to change. Yet engaging in a relationship, facing conflicting worldviews and giving up long entrenched ways of being, can be deeply unsettling and frightening for a client. Participants in this study reported on their repeated attempts to find ways of reaching the client. Through

practising various modes of relating in the therapy, the scope for self-deception may be gradually narrowed, as Spinelli (2007, p. 87) contends 'the very entry into a therapeutic relationship . . . permits the client to entertain and 'try out' possibilities of being that provide a *temporary* means by which the worldview is reconfigured'.

Conclusions

While it is not possible to draw wide-ranging conclusions from an exploratory study, it is also the case that not many previous studies give voice to therapists' experiences and understandings of issues which may arise in working with clients described as self-deceptive. By focusing on a small number of participants, we have been able to provide a detailed nuanced account of the participants' experiences and understandings. The reader is then able to engage in the process of considering this study in relation to their professional and personal experiences as well as the relevant literature we have discussed here. Further studies could be conducted to develop a richer picture of experience, including also a longitudinal study, following participants through the process of therapy with a client who is perceived as self-deceptive, and possibly to study the client's experience of the process. It is also interesting to explore how therapists come to apply the concept 'self-deception'.

The findings bring to light therapists' experiences of discomfort, frustration and anger, and feelings of incompetence when working with clients they described as self-deceptive. From our perspective as researchers and psychotherapists we believe this study illuminates the potential of the concept of self-deception for providing a focus for examining the relational dynamics between client and therapist. It seems that this view was shared by the participants. Following the interview three of the four participants contacted the interviewer to report that their work with the client felt more positive and constructive than previously. The interview served as a reminder that the client was not necessarily aware of what the therapist perceived as self-deception. There was an acknowledgement that perhaps the therapist does not understand enough of the contradictions, ambivalence, and conflicting issues that go on for the client. There was also an awareness of the possibility of the therapist's own self-deception. There was the therapists' increased sensitivity towards, and appreciation of the therapeutic relationship, acknowledging more fully the client's deep anxieties of being in a relationship. It appears that these issues have not been fully addressed in personal reflection, in professional development or in supervision and that the interview provided a much needed avenue for reflecting on these issues.

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Appendix

Extract from the interview with Lynn

Box 1

Int: Thanks for taking part and writing your description. I would like to ask you a few questions to clarify some things and gain a little more detail in some things. Is that ok?

L: Fine. No problem.

Int: You said her self-deception was her unwillingness to change. Could you explain that a little further?

L: Let me see. She came because she didn't feel alright and she wanted to be ok. But then she didn't really want to do anything about it. She seemed desperate as she didn't know what to do, but she didn't really want to do anything different. It was like she wanted to be fixed without really knowing about it. It felt like she wanted magic. So anything I reflected that inferred she could be and do things differently she ignored. So for example, I would say 'I wonder if in feeling this . . . you are doing that'. This was where I was looking to link things showing her part in the situation. But she would either say 'no, it's not that' or she would ignore it. I would say she was incongruent for want of a therapeutic word, but if I was being me, I would say that what ever she said, her behaviour was different and at odds with it.

Int: How did you find this during the sessions?

L: She seemed to talk at me and I didn't feel in a relationship with her. She seemed to do everything she could do avoid this or at least make it as difficult as possible.

She wouldn't even commit to the same day of therapy and several times she would cancel late and have to pay for sessions she didn't attend.

Int: You mention that you worked with the core conditions. I know what that means according to Rogers, but can you describe the core conditions that you worked with?

L: It felt very important to be as genuine and congruent as possible. This was not easy as I felt that I needed to be firm with her. Keeping the boundaries regarding timings of the sessions and when she wanted to change that day, I would not do that after it had been pre-arranged. I did feel I had to be very careful how I put things. I needed to put things back to her on a way that I felt she may be able to hear it. I really had to believe that if she was given the right environment, she would be able to hear herself. Some of the sessions were based around a single statement that she made, but she just couldn't hear or she wouldn't hear anything at odds with her statement.

Int: Did you find that there was anything that you felt helped?

L: If I said how I felt about what she had just said. If I expressed an emotion it seemed like she would consider this for a bit. It seemed to hit home. I noticed how even the slightest body movement from me could change the atmosphere. I really had to be aware of that. It seemed that she was looking for people to lie to her so I really felt I had to be as honest as I could. Goodness, she was hard work and I never really looked forward to the sessions.

Int: You said that when you reflected on this client that you felt empathy. Could you explain that little more?

L: I did empathise with some of the big events that she had experienced in her life. The times when she felt so lost she just didn't know what to do with herself. In some ways she really didn't know how to be with me and to be in the space. She seemed very lost in the sessions. I could feel that lost anxious place.