Papeles del Psicólogo, 2005. Vol. 26, pp. 109-114

DECEPTION AND LYING IN PSYCHOLOGICAL DISORDERS AND THEIR TREATMENTS

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This article attempts to examine the phenomena of lying, deception and self-deception as directly related to psychological problems and their treatments. We shall see how, in many cases, deception and self-deception are no more than a psychological or fictitious covering for life problems. But given that psychological problems can only be neutralized through psychotherapy, we shall see that all self-respecting psychotherapies should incorporate lying in their therapeutic games. And the therapist will put this psychotherapeutic lying into practice in a highly theatrical way, by means of the technique known as "paradoxical intention". Indeed, it is this technique, bound up with deception, that can best counteract self-deception in a psychologically disturbed client. Paradoxical intention will work when adjusted to the client's movements, shaping those movements on the "road" the client is moving along at each moment.

Este artículo pretende examinar los fenómenos de la mentira, el engaño y el autoengaño como términos que están directamente relacionados con los problemas psicológicos y sus tratamientos. Veremos que, en numerosas ocasiones, el engaño y el autoengaño no son más que la cobertura psicológica o ficticia de los problemas de la vida. Pero como los problemas psicológicos sólo pueden neutralizarse a través de psicoterapia, veremos que toda psicoterapia que se precie deberá incorporar en sus juegos terapéuticos a la mentira. Y el terapeuta ejercitará esta mentira de la psicoterapia, de una manera muy efectiva, a través de la técnica que conocemos como "intención paradójica". En efecto, será esta técnica intrincada en la mentira la que pueda contrarrestar la propia mentira del cliente aquejado de un problema psicológico. La intención paradójica funcionará cuando se administre acompasada con el movimiento del cliente, moldeando dicho movimiento en el camino que el propio cliente estará transitando en cada momento.

There are certain pithy phrases which attempt to give a concise definition of man: "man is an animal that uses tools"; "man is an animal with the capacity for language"; "man is an animal that eats bread", and so on. Our contribution to this catalogue of phrases is: "man is an animal that lies". Clearly, other animals use deceit for survival, but humans are perhaps the only creatures that use lies in a reflective way, that is, the only ones capable of using lies in relation to their person, to their identity. If the chameleon camouflages its body, humans would be capable of camouflaging the very depths of their guts. Suggestion is a prodigy particular to the human mind. Only man can see ghosts.

At the risk of exceeding the parsimonious objectives of this article, we should like to stress the enormous importance of lying, insofar as it can be associated with suggestion, since hidden behind is the foundation of psychology itself: the self, reflectiveness.

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THE TRUTH OF LIFE AND THE VITAL TEXTURE OF PSYCHOLOGICAL PROBLEMS

We shall discuss this aspect with the help of a metaphor, and for two basic reasons. First, to aid understanding and to support our explanation. And second, in honour of the psychotherapy we ourselves practice –an updated and adjusted version of what is generally known as Acceptance and Commitment Therapy (ACT)–, since one of the basic principles of this therapy is the conviction that metaphors are genuine therapeutic tools in the clinical context. They are used to help the client see a series of concepts and phenomena that would otherwise be difficult to discern.

The metaphor we shall use is that of "the road". And we do not mean a poetic road, a quiet country road with its charm and mystery. That's not the kind of road we are thinking of. The road we shall use as a metaphor is a modern, urban road, with its roundabouts, its shopping centres on either side, its busy crossings with traffic lights, zebra crossings, give way signs, and so on.

And it has to be a modern, urban road because psychological problems have emerged in a modern and urban context that is none other than the context of the city. In the societies of old there was little room for psychological problems, since life was highly normalized. Society was closed, and that meant that the way of life and the problems arising from it were contained by strict boundaries. The city, on the other hand, has its very origins in a crossing of ways of life. We could say that it is no longer the family that regulates ways of life, but rather "the market". Everything is commercialized now: food, clothes, everyday goods and products. But there is also a trade in ways of life, and we are offered different professional, family and leisure alternatives, which are not only alternative but also, in many cases, incompatible and contradictory. And the problem with having access to different ways of life is that the individual begins to exercise the "responsibility of choice". We might say –looking ahead to what will be our principal thesis– that psychological problems are related, more or less directly, to this responsibility of choice.

Returning to our metaphor of the modern, urban road, let us imagine that *life* is a roundabout. A roundabout with the function of distributing the traffic. It gives order to a crossing of ways and it is the part of the urban road that helps us to change direction.

What would happen if there were no roundabouts? We would probably leave one road and take another without further delay, directly, without a waystation. Haven't you ever gone round our roundabout more than once to sort out your ideas about which direction to take? It's a kind of extra-decisional time. But what if we stay on the roundabout indefinitely without taking any exit? These are for us *psychological problems.* It is a "life jam" in the decision about which way to take at a particular moment. We have several alternatives, all with their advantages and disadvantages. Some offer a very easy passage but lead to unattractive places. Others are very hard, with a lot of traffic, with traffic lights, but lead us to much more inviting places. But we make no decision, we are "jammed". And while just one of us is jammed on the roundabout, there's no great problem. The problem grows when the roundabout gets jammed up and no longer allows others to use it properly. This is when the individual psychological problem turns into a problem of social dimensions. And the problem also increases when, being permanently on the roundabout, we get nowhere –we don't do our job in the city properly, we fail to meet our family obligations, and so on.

For this situation an entire circulatory network, alternative and outside of life, has been created, which permits us to continue driving, but with no destination. We drive in circles because we have to keep moving. Our sole objective is to remain in "pause" for the time we need to get back onto our ordinary urban road.

This alternative circulatory network, sterile and removed from life, is *psychologization*. And we are not referring only to the psychologization practised through the word, but also that which makes use of drugs, of flowers –read "Bach Flower Essences" for example–, of magic, of futurology, and so on. This whole network is at the service of those who got stuck on the roundabout indefinitely, and were unable to make a life decision.

Psychotherapy has become an intermediate institution (Pérez Álvarez, 1999) between institutions that fail. When people break down between various life alternatives, none of which satisfy, there emerges a concealed or covered way that makes sense at the time but ultimately does not, which is "psychological problems". The psychotherapeutic institution provides the necessary coverage for psychological problems by giving a functional explanation. A person can live between the conflicting alternatives of wanting to be slim and bingeing on food. The breakdown situation for this person would be that in which they put off indefinitely the decision between one way and the other: gorging themselves on food without worrying about the consequences, or trying to eat appropriately. The intermediate way (the roundabout of psychopathological life) tends to be to gorge oneself and vomit. The certainty that taking one road or the other depends on oneself is clearly unbearable. And this is the attraction of the third way, the dead and empty road of labelling this absence of personal decision a "psychological problem". This is the origin of a whole normative framework that protects and explains such irrational behaviour as gorging oneself and vomiting it all out. The psychological problem is called bulimia, and the professional who has to get rid of it is the psychologist or psychiatrist. From that point on, the only person who could turn the situation around –the person with bulimia– becomes subjugated to the psychotherapeutic institution, which now does everything for them. It is precisely this loss of responsibility that turns life problems, temporary log-jams, into psychological problems, into dead-end streets, without structural exits.

But of course, paradoxical as it may seem, it is only through psychotherapy that the lost sanity can be re-established. It is by means of psychotherapy that we are to turn psychological problems back into life problems, into challenges or difficulties that require continual decision-making by the person experiencing the problem. When decision-making becomes encysted –and we get stuck on the roundabout– we are feeding a problem until it becomes psychological. Put succinctly, we must depsychologize the client from psychology itself. Depsychologizing means, in this context, removing the psychological covering –external to the client and unable to be confronted– from life problems. Decisions must be made by clients, and it is precisely the psychologist's duty to avoid being tempted to make those decisions for them. Using the framework that permits a full and comprehensive explanation of psychological problems, "author-actor" (Quiroga Romero, 1999), we can state that psychotherapy, from the perspectives we are concerned with here (contextual, behavioural, ontological) is simply the attempt to move clients along the gradient from the irresponsibility and indecision of the life they are living, as mere actors playing a role, to responsibility and real contact with that life, becoming the actual author of it. How to achieve this change is what we shall try to explain below.

SELF-DECEPTION AS MODULATOR OF PSYCHOLOGICAL DISORDERS

A relevant aspect in psychopathological casuistry is revealed through the phenomenon of self-deception. If deception in general is a near-universal element of social interaction in modern societies, from the political and economic spheres to the most intimate contexts, self-deception might be seen as the de-generated extension that ends up insidiously impregnating personal consciousness and will.

Self-deception could be defined as way of leading our life when not only are we ignorant of what the chosen direction involves, but when, above all, we are ignorant or try to be ignorant of the fact that we have irremediably taken a route that brings with it a series of consequences. This is the meaning Plutarch gave to the term, when he said that self-deception was something more than the inability to recognize that we know nothing of many things, since in the end, the most dramatic thing is that we do not know what we are. If uncertainty and insecurity paralyze us, and out of prudence we decide to stagnate, we might ask ourselves whether paralysis might not also be an option involving risks, and therefore sometimes an imprudent option.

A lie can have different variants. It can be innocent or humorous, it can be somewhat perverse, and even kind or useful. Self-deception, on the other hand, without prejudice to its consideration as innocent, humorous, perverse, compassionate and useful, is not of one type alone, but rather a little of all of them. Deception involves a conscious objective, but self-deception is unconscious –we do not know what we are doing; as Oscar Wilde so pertinently remarked, "she is a veil, rather than a mirror" (Wilde 1889). Psychological disorders display this peculiarity in the majority of cases. Thus, a person affected by anorexia is often ignorant of their fear of public rejection, focusing their efforts on slimming or a struggle with their body. Neurotics with compulsive behaviours are unaware that, concealed behind their need to wash their hands constantly or their dread of contamination, is their stubborn refusal to accept the necessarily uncertain nature of life.

The main challenge for the psychologist tends to be to clearly reveal the real problem, which is generally hidden from the person suffering from it.

In general, people with psychological problems suffer because of something that they themselves exclude or push away, but to which they are nevertheless committed. Conscious will, we might say, is given over to the attitude of struggling reflectively with the problematic psychological elements, and this distraction keeps the person from acknowledging and perhaps being able to overcome the real problem affecting their life. As the philosophy of Acceptance and Commitment Therapy, and other, previous philosophies and authors have emphasized, what underlies a person's striving to control emotional and cognitive symptoms (which they paradoxically feed) is existential or vital (experiential) avoidance, a difficulty to accept things that cannot be changed (Luciano & Hayes, 2001).

Here, the phenomenon of self-deception emerges as something crucial, in the sense that the effort of concentrating on the psychological elements ends up concealing the substantial elements of an unresolved personal conflict (Fuentes Ortega, 1994), and this in turn confers a psychic character on a problem that only personal confrontation can finally resolve. A person complaining of

depression can thus hide their responsibility to confront the pain, suffering and sorrow behind their insistence on staying in bed, on remaining apathetic and scarcely active. But it is only when they abandon themselves to continual self-inflicted torture, reproaching themselves for their state of depression, that the self-deception or a true psychological problem becomes crystallized (the circle is closed), since it is critical reflection with oneself that creates an inert space, where the patient devotes his or her efforts to removing a psychic framework whose essential purpose is to block out confrontation with the genuine problem. In this context, the self-deceiver ends up losing the perspective of the original problem, and frequently appeals for help to escape from a disastrous circuit that was entered with the intention of calming the unpleasant perception of a conflict, but that will eventually leave the person without the capacity for response, or blind to this conflict, which, despite going unperceived, is nevertheless disturbing, and basically sustains and consolidates the psychological unease. In this regard, it is interesting to consider the example mentioned by Paul Watzlawick, recalling how the anthropologist Margaret Mead distinguished the Americans from the Russians. While the former, she observed, simulated headaches to elude responsibilities, the latter needed to actually suffer the headache for the same purpose (Watzlawick, 1975). So, perhaps a psychological problem is more than anything a "Russian headache", self-generated so as to tiptoe around the important aspects of life, and a headache that once it has struck, becomes more severe when one strives to find analgesics for a problem that the headache was only trying to get around.

In the end, self-deception, as we intend to represent it, coincides perfectly with the idea of the symptom as described in a recent essay (Pérez Álvarez, 2003), and overlaps with the expression or manifestation of a real problem, but also fulfils the function of an attempt to adapt, a truce or even a way of life.

THE STRANGE TRUTH OF PSYCHOLOGICAL TREATMENTS

On countless occasions, psychologists have to conceal things, keep quiet, tell half-truths, and make biased comments based on deception, lies or, at the very least, avoidance of the naked truth. Sometimes this is to avoid hurting the patient's sensibility, and in other cases it is merely a question of politeness. Nevertheless, we feel that pretence and appearances play a substantial role, rather than a superficial one, in the task of the therapist.

Using the example of medicine, we could say that the surgeon can operate without the patient's awareness. And medication functions relatively independently of the actual beliefs of the person taking it, but the same is not true in the context of psychology. If there is one thing that characterizes psychological therapy it is the crucial importance of the phenomenon of appearance, to the extent that it is impossible to carry it out without a "performance", without the psychologist "performing" for the patient and vice versa (it is even doubtful whether true therapy could take place without the awareness that the therapeutic process is actually happening). The doctor can be absent, but the psychologist has to be at least co-present.

In our view, a psychological treatment is somewhat similar to a game of football (similar analogies have been proposed previously: therapy appears as a game of chess, and in general as a game, and as a challenge full of unexpected turns, for example, in the novels of the existential psychologist Irvin D. Yalom [Yalom, 1992; 1996]). The game will determine victory, but in order to win, the game has to take place within a framework that imposes certain rules, but never guarantees success in advance. Psychological treatment is carried out in the framework of a ceremony (García Sierra, 2001), which we might call the psychotherapeutic ceremony. As regards the importance of the concept of ceremony for psychology, Juan Fuentes and Ernesto Quiroga have produced a significant work on the subject (Fuentes & Quiroga, 1998). What we are trying to point out is simply that therapy is always developed in the context of a series of transitory sequences that follow certain rules: sessions are more or less regulated in terms of time, the psychologist and the patient take turns to speak, corrections are made more in one direction than in the other, authority belongs more to one participant than to the other, and so on.

With this in mind, our position is as follows: a treatment or therapy is, above all, tactics put into practice, like the tactics employed in football by a coach, which have to continually be adjusted to the real conditions occurring on the field of play, or in the psychologists' consulting room (in this case, the "play·" is what is being said). Psychologists cannot simply apply a series of steps until they reach a goal, because they continually have to adjust

their steps in response to those of the patient, as a forward does in football when he faces an opposing defender, and this means –let us say it loud and clear– that therapy is a game of risky lies in which psychologists have to keep patients convinced that they will provide the solution their problem –a solution which (as we said above) is never assured in advance–, which will only be true insofar as psychologists can sustain during the process the lie that they possess that solution. All of this can be summed up euphemistically: psychologists, if they aspire to the name, have to maintain their credibility. But without recourse to euphemisms we would add: through diverse acts of sleight of hand.

Shaping is a procedure used by behaviour therapists that consists in starting out from a series of previous behaviours and gradually extending partial achievements until a final point or achievement is reached. An agoraphobic might, for example, accept going out in certain places but would not accept going out in others at all. The secret, we might say, consists in getting the patient to go out in places he would not accept by beginning with getting him to go out in those he accepts without much resistance. If we think carefully about this, we realize that what is really involved is the patient's will, and that to control it, it has to be in some way deceived, for in fact it is not clear that habituation might not be achieved by doing directly what the patient refuses to do, but it can be more effective to get him to do what he doesn't mind doing so as, eventually, to get him to do what he would never be persuaded to do, and which is what is really necessary for a successful outcome. Successive approach techniques are in this direction. It is not that a person with a phobia of lifts is incapable of going up to the sixth floor, but rather the psychologist has to get them to decide to go up to that floor, and moreover, it must be the patient him/herself who decides to go up in the lift voluntarily, despite having sought professional help because they are not prepared to go up of their own free will. It is not difficult to realize that all that comes in between contains a great deal of belief, more than of reality, since the client has to attribute to the procedure a value that is not strictly true: it is not the habituation that reduces the fear, and therefore permits the patient to go up in the lift, but rather the decision to go up that kickstarts the habituation process, and it is the patient's free decision that must always be the focal point of the psychologist's work.

Cognitive *rationalist* techniques also have their degree of deceitful skill, since they are often based on counteracting rigid catastrophic thinking with equally biased conflicting evidence, for the fact is that the therapist's discourse is frequently no more than a manner of speaking, which the therapist can actually readapt to each case to the extent of saying one thing or the opposite, as appropriate, with the functional aim of overcoming patients' rigidity, rather than of convincing them of another truth, which could be counter-productive.

Some techniques, such as *role interchange*, clearly reveal in what the therapeutic game consists, namely: finding the truth through pretence. The psychologist adopts the role of patient so that the latter can realize that some element of his/her discourse is an obstacle to progress. But why not tell the patient directly? The idea of the technique is that the client realizes without feeling offended or attacked, which can lead to defensive reactions or to the client ignoring the basics.

All therapies, it could be said, contain a good deal of paradoxical components, be they behavioural, cognitive or other types of therapy. But in reality, the above references to shaping, biases and role interchange should be interpreted as particular cases of a general form of approaching therapy. Within the psychological literature we find, in fact, an applied technique of a consistent, global nature, and which we believe is particularly successful if it fulfils the function for which it is designed and intended, namely, the technique of *paradoxical intention*. Since Adler, passing through Victor Frankl and up to the current Acceptance and Commitment Therapy, there is a tradition through which it has become a well established way of working. Within this psychological tradition, this technique can be interpreted not so much as a technique per se, or as a residual aspect of therapeutic programmes, but rather as an authentic way of dealing with psychological problems. And this is, moreover, the position to which we are committed in the present work.

Paradoxical intention clearly reveals the phenomenon of self-deception present in psychological disorders. A man with erectile dysfunction may desire sexual relations but not want to risk failure. A person with social phobia may desire relationships with other people but find it hard to accept the possibility of encountering setbacks in those relationships. A person may want to make advances to someone, but is afraid of turning bright red in the face. Someone who wants to slim may not fancy having to do exercise or go on a diet. In all of these cases

the patient focuses on the struggle against the secondary elements of a psychological nature (fear, anxiety, rumination, etc.), rather than confronting the original conflict. Thus, paradoxical intention resolves, or attempts to resolve, the problem with a disguise, that is, it tries to involve patients in paradoxical secondary elements in order to thrust them into a confrontation with the basic conflict. If as a result of anxiety a person begins to ruminate on how to avoid tripping over their own tongue, the therapist asks them to *want* to stumble over words, since in this way the ruminative element loses functional meaning, confronting the person with the conflict of speaking even at the risk of tripping up, which will quite probably increase their fluency of speech.

The manoeuvre of paradoxical intention is based on discrediting the secondary (psychological) conflict, trying to make the client become involved in provoking a problem that he or she attributes to an emotion or feeling, and not to the will to avoid a confronting a situation. And so, curious as it may seem, if patients bend their will to suffering the unpleasant psychological effects, these will disappear.

Paradoxical intention takes advantage of the self-deception of the person who experiences their problem (emotion as obstacle to the action of confrontation) to favour a psychological achievement (cognitive-emotional relief) through action. Success is clearly more than likely, since although the confrontation is set in motion with the intention of gaining psychological relief, the action is in fact dismantling the basic conflict that explains the entire framework of the problem. What paradoxical intention destroys is the excuse of putting the psychological content before the action, and this is achieved by making the patient think that through a paradoxical action, which will moreover show itself as effective, the adverse psychic content will disappear. And it probably will disappear, but, as we say, because it ceases to make any utilitarian sense for the person on actually confronting the primary conflict, that is, running the risk of taking a direction and not going round and round the roundabout indefinitely. It is equally important to mention the recommendation that paradoxical intention, given its importance in highlighting the base conflict, be presented (concealed) in the form of humour, through encouraging patients to laugh at themselves (Frankl, 1946)

Let us conclude by saying that the present work represents no more than a frank attempt to acknowledge that lying, strategy, the oblique approach, are essential and defining aspects of a large part of what we call Psychology, and that this should not necessarily give the discipline a bad name. Perhaps the same idea was expressed in another way by one of the fathers of our discipline, Alfred Binet, when in measuring intelligence he discovered that what he was really doing was assigning value to errors, and not to correct answers: "while Logic concerns itself with intellectual processes to do with the truth, Psychology is especially concerned with intellectual processes to do with error".

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