Pseudologia Fantastica: What is Known and What Needs to be Understood

By Andrew Hull, MS, LPCC

Abstract

Pseudologia fantastica (PF) is a rare phenomenon that has not been well-researched outside of clinical observations and case studies. This article attempts to further explore how PF is defined, and the characteristics of this condition that differs from typical forms of lying. Based on the most current research, the etiological development will be examined with focus given to the psychological mechanisms that are thought to underlie the course of this behavior. The application of PF in forensic settings and related psychological disorders will also be reviewed. In addition, treatment strategies when working with clients presenting with PF characteristics are suggested, with current limitations and future recommendations provided.

Normal Lying vs. Pathological Lying

History has acknowledged religious doctrines that have strongly persuaded members of society from bearing false witness. Although a discouraged behavior, prior findings has estimated lying occurs as frequent as once to twice a day within the general population (Sadock & Sadock, 2000). The actual behavior of lying is defined as producing a false statement with the intention to deceive (Simpson & Weiner, 1989), as this deception can be further understood as a frequent activity for the purpose to gain or obtain a benefit (Muzinic, Kozaric-Kovacic, & Marinic, 2016). Lying can expand in application to be
used to avoid a distressing situation, compensate for inadequacies, or fulfill personal gain or manipulation. Though lying can be viewed as a comprehensive term with varying motives for dishonest behavior, pseudologia fantastica (PF) is an extreme type of lying that can further complicate the clinical work in psychology and forensic settings.

Pseudologia fantastica, also referred to as pathological lying, mythomania, or deception syndrome, is considered a rare phenomenon first recognized by German physician Anton Delbrueck in 1891 (Dike, Baranoski, & Griffith, 2005; Korenis et al., 2015). Within Delbrueck’s clinical notes were observations of patients telling lies that were excessive and disproportionate to reality, but otherwise would not be classified within any preexisting pathology. Delbrueck coined the term “pseudologia fantastica” to describe patients who told quasi-delusional tales that were stitched into their personal narratives and identities. Currently, there are no diagnostic criteria to define PF, as this condition continues to be defined by case studies of practitioners in the field witnessing first-hand these stories. Given a review of the literature (Birch, Kellnm, & Aquino, 2006; Dupre, 1989; King & Ford, 1988; Snyder, 1986; Thom, Teslyar, & Friedman, 2017; Wiersma, 1933) the key characteristics have included the following:

Table 1. Normal Lying vs. Pathological Lying (Birch et al., 2006).

<table>
<thead>
<tr>
<th>Normal Lying</th>
<th>Pseudologia Fantastica</th>
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<tbody>
<tr>
<td>Externally motivated: Situationally determined (e.g., financial gain, avoiding punishment or responsibility)</td>
<td>Internally motivated: Psychologically derived (e.g., self-esteem/fantasy fulfilling)</td>
</tr>
<tr>
<td>Example: “I never had a relationship with that person.” “I never stole your wallet.”</td>
<td>Example: “I hardly have time to establish friendships being a CEO, I work 80 hours a week for that big-time corporation, and spend the rest of my time volunteering overseas in the orphanages.”</td>
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**Etiology**

The developmental understanding of PF is limited, with scant research on the prevalence, demographics, and psychological underpinnings. The best estimates of the prevalence of PF in the general population is low (Weston, 1996). To date, the only known large-scale prevalence study was conducted by Healy and Healy (1915) with a population of 1,000 juvenile offenders. In this sample, 104 males (15 percent) and 80 (26 percent) females were identified as frequent liars. However, Healy and Healy (1915) conclude that of those identified as liars, only eight to 10 showed exaggerated lying (about 1 percent of the total sample) consistent with PF.

King and Ford (1988) further examined 72 case reports of suspected PF in a database of literature. This review concluded an equal gender distribution between males and females, with a typical onset of pathological lying beginning during adolescence and progressing to more consistent patterns of lying in young adulthood. The family systems were further reviewed, with indications of about 30 percent reporting a turbulent family environment, with additional recognition of a close family member or parent experiencing mental illness within the household (King & Ford, 1988). In addition, Healy and Healy (1915) reported a bimodal distribution in intelligence scores, with PF being either superior or below average. This however, marked some inconsistencies between King and Ford’s (1988) findings that indicated intelligence to be average to above average. Despite this discrepancy, there was a trend of superior
verbal ability over a performance quotient in the cognitive functioning (King & Ford, 1988). This may suggest an advantageous asset in telling a story that mesmerizes the audience.

Psychological Mechanisms of PF

The literature on PF is conclusively conceptualized from a psychodynamic perspective, viewing pathological lying to be used to defend the individual’s sense of self from the reality of the lived experience (Fenichel, 1954; Ford, 1996). According to Ford (1996) this serves two purposes — first, avoiding aspects of reality that cause anxiety and pain; and second, lying can act as a preserving trait repressing these uncomfortable feelings out of conscious recognition.

Underlying these basic tenets are suspected to be depleted self-esteem and an underdeveloped sense of self. The false sense of self relies on the defenses of overcompensating in traits consistent with a need for idealization, perfection, and grandiosity to protect the true self from the false self (Harter, 1999; McWilliams, 1994; Norcross & Goldried, 1992). Ultimately, the act of lying serves the purpose of preserving the false self, protecting the client from unpleasant feelings of low self-esteem (Muzinic et al., 2016). While other theoretical orientations may have a different interpretation of PF, the psychodynamic view has been the only perspective noted in the literature.

Comorbidity/Differential Diagnoses

Pseudologia fantastica does not reside in the Diagnostic and Statistical Manual of Mental Disorders: Fifth Revision (DSM-5) (APA, 2013), but there are core characteristics of PF that overlap with a number of DSM diagnoses. The three primary diagnoses reported in the literature include factitious disorder, delusional disorder, and borderline personality disorder (BPD) (Birch et al., 2006; Korenis et al., 2015; Muzinic et al., 2016; Thom et al., 2017). Distinguishing psychopathology from PF can be further understood by investigating the motivational factors, as Table 2 provides a comprehensive review of differentiating components.

In factitious disorder, there is the intentional production of symptoms with an unclear justification to the behavior; being motivated by assuming the sick role. Because of the external motivation to assume the sick role, PF can likely be ruled out given that this disorder is internally motivated (Gogineri & Newmark, 2014; Korenis et al., 2015). Delusional disorders are characterized by false beliefs, as the client reaches a level of conviction that the delusion is real. Thom et al., (2017) suggest delusional disorder can be differentiated from PF by the level of conviction, and response following being confronted. For example, PF is thought to be less confrontational in disowning the tale, unlike those with a genuine delusional disorder that will remain steadfast in their belief. Common among borderline personality disorder and PF are the characteristics of deceptive behaviors. While the departure between the two conditions are observed in the absence of prominent features of BPD, such as impulsivity, self-destructive behaviors, and fears of abandonment Gogineri & Newmark, 2014).

Hamilton, Feldman, Cunnien (2008) further indicates that PF may exist in isolation or be associated with another diagnosis, while recognizing this extreme form of compulsive lying should promote the clinician to further search for an underlying disorder associated with deception. Therefore, it can be a descriptive term for deceitful behavior, but it should not be used as a standalone explanation (Hamilton et al., 2008). Instead, it is suggested that PF be used as a subjective clarification to describe
the client’s storytelling capacities, or further prompt clarification for an associated disorder (Thom et al., 2017).

It has been further suggested in order to provide a comprehensive clinical picture that PF can be noted, but diagnostic attention should be directed towards a more empirically support disorder than what is proposed by PF alone. This may prompt a clinician to further evaluate substance use disorders, mood disorders, and personality disorders in better determining the rational for the falsehood.

Table 2. Differential Diagnoses (Birch et al., 2006; Gogineni & Newmark, 2014; Muzinic et al., 2016; Thom et al., 2017).

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<thead>
<tr>
<th>Condition</th>
<th>Motivation</th>
<th>Rational for Distinguishing</th>
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<tbody>
<tr>
<td>Antisocial PD</td>
<td>External</td>
<td>External personal profit</td>
</tr>
<tr>
<td>Factitious disorder</td>
<td>External</td>
<td>Intention to assume a sick role</td>
</tr>
<tr>
<td>Malingering</td>
<td>External</td>
<td>Intention for secondary benefit</td>
</tr>
<tr>
<td>Narcissistic PD</td>
<td>Internal</td>
<td>Less extreme stories, within bounds of reality</td>
</tr>
<tr>
<td>Substance use</td>
<td>External</td>
<td>Associated with convincing others of their sobriety from substances</td>
</tr>
<tr>
<td>Histrionic PD</td>
<td>Internal</td>
<td>Inappropriate sexuality, seductiveness, suggestibility</td>
</tr>
<tr>
<td>Borderline PD</td>
<td>Internal</td>
<td>Intention to avoid abandonment, with impulsivity and self-injurious behaviors</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>Not applicable</td>
<td>Associated with mania episode and flight of ideas</td>
</tr>
<tr>
<td>Confabulation</td>
<td>Not applicable</td>
<td>Associated with memory impairment</td>
</tr>
<tr>
<td>Delusional</td>
<td>Not applicable</td>
<td>Strong conviction to stories and upholds strong conviction when confronted</td>
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Forensic Significance

Based on the characteristics of PF, there are a number of challenges that exist between this condition and the forensic setting. The primary importance is the mitigation of punishment that can be gained from a deceptive presentation. Prior studies have further examined the types of offenses committed among participants suspected of PF, including theft, cheating, counterfeiting, and plagiarism (King & Ford, 1988). The challenges that further complicate the intersection between lying and forensic practices is when the client tells grandiose stories that muddle the discernment of truth. The task for the forensic psychologist is to untangle the truth amongst ulterior motives and malingering features, representing a complex task with no standardized assessment to aid this process.

Competency to stand trial can be further questioned with clients presenting as compulsive liars, as the question arises in determining if the person has control over his or her behavior and subsequent
lying, or if this condition prevents the individual from exhibiting responsibility for his or her behavior. Paraskevoulakou and Antonopoulou (2010) indicate that further explanation in the classification of pathological lying is required in order to answer the question of mental capacity. Without these guidelines in place, these questions lack a sufficient basis to construct a clinical decision, leaving it up to the practitioner to evaluate.

Treatment Strategies

Thom et al., (2017) acknowledges the few case studies and scant clinical research on PF have left the treatment approaches and management strategies underdeveloped and lacking in empirical support. Based on the literature available on this topic, there have been a few ideas proposed in addressing this notion. These include confronting the client about his or her deception or displaying limited interest with the intent to extinguish the reinforcing quality of the behavior (Thom et al., 2017). Teaford et al. (2002) and Hoyer (1959) recognizes the benefit of avoiding confrontation, as this could have a deleterious impact on future rapport that therapeutic progress. Due to this, it may be more valuable to avoid direct confrontation, or at least until a strong therapeutic relationship has been established that can withstand this level of discernment.

Specific client issues that could arise in the treatment process includes the client struggling to acknowledge having issues with honesty (Gogineni & Newmark, 2014). This could lead to further defensiveness, resistance, and rapture within the therapeutic alliance. Therefore, focusing on the therapeutic relationship can provide the most value for clinicians, as this may allow for a non-confrontational intervention that will preserve the alliance (Korenis et al., 2015). Further treatment strategies have included therapeutic services directed at issues with self-esteem, personal acceptance, and positive regard (Gogineni & Newmark, 2014). Through further addressing these clinical concerns a better understanding of PF may be provided, and validation of the psychological mechanisms influencing the behavior established.

Conclusion

Pseudologia fantastica is a rare and mysterious psychological condition that can further complicate diagnostic impressions, forensic applications, and treatment approaches. Because limited research has been conducted on PF, clinicians need to take precautions in placing too much emphasis on this condition until further clarification is available in regarding how PF applies to different clinical disorders and mental capacities. While expanding the empirical support for PF would be useful, this endeavor has its own limitations.

The limitations of further understanding and researching PF includes that this construct needs to be established and validated to provide a consistent definition before more detailed research can be completed. In addition, PF is primarily based on subjective experience, which would make the detection of PF difficult to conclude until conclusive criteria are developed. There are also no assessments available for detection of PF, as this results in a lack of internal consistency across psychology that needs to be further rectified. In addition, being able to develop a method for measuring PF is marked with shortcomings, specifically since lying has been a fascinating idea many have attempted to measure, but a difficult method to solidify.
In conclusion, there are a number of suggestions to keep in mind when suspecting PF. The first is to identify the validity of the client’s story. This includes an extensive file review to establish a level of consistency in reporting. Collecting collateral data from other sources would also be essential to determine reliability in behaviors and allow for differential diagnoses to be considered. Secondly, understanding the motives of the client can be valuable in determining the influence of PF. Identifying the subtle differences between a number of differential diagnoses can influence the clinical impression and later forensic decisions and treatment approaches. Lastly, the presence of falsehoods should prompt inquiry into underlying psychopathology. However, this should not be the standalone explanatory mechanism. Clinicians should link the diagnostic impressions to established criterion that allows for an incremental clinical conceptualization, rather than what can be offered by simply labeling the client as a pathological liar.

Biography

Andrew Hull is currently pursuing his Ph.D. in Clinical Psychology from Fielding Graduate University, while he is working as a mental health therapist providing psychological services to the incarcerated population. Andrew graduated from Western Illinois University in 2014, with his Master's Degree in Clinical Psychology and Community Mental Health. His research interests include investigating protective factors in clients with mental illness and violent behaviors, the association between mental illness and criminal behaviors, risk assessment of violent and sexual offending behaviors, and motivations for behavioral change. His clinical interests include forensic psychology, correctional psychology, psychological assessments, malingering and feigning, ethics and special issues in correctional and forensic psychology, and psychopharmacology.

References


