

development and individuation.<sup>3</sup> Consequently, we do not believe there are pathological lies or pathological liars, in part because of the difficulty in determining what is pathological. Do we go with the numbers, as seems to be suggested by Dr. Dike and his colleagues<sup>1</sup> or do we go with the incredulity of the lies? Of what significance is “not being found out”? Does it mean that if you are a smooth liar who compulsively seduces women, but are rarely exposed, you can never be classified as a pathological liar? Where do we place politicians who consistently promise voters things they cannot deliver? What about the advertisers who hide significant information about their products in the “fine print”?

With regard to Professor Grubin’s commentary,<sup>2</sup> we would like to point out that it is not uncertain whether the concept of lying involves demonstrable physiological abnormality. Apart from the studies mentioned by Dike *et al.*<sup>1</sup> about the link between pathological lying and central nervous system disorders<sup>1,4</sup> and right hemithalamic dysfunction,<sup>1,5</sup> there is a very recent landmark study by Yang *et al.*,<sup>6</sup> who found that liars have increased prefrontal white matter volumes and reduced gray/white matter ratios compared with normal control subjects. This difference remains the same when compared with an antisocial control group and means that, with further research, more could be uncovered about the pathophysiology of lying. The revelations could lead to more studies in the area of psychotherapeutic and psychopharmacologic intervention.

Removing the adjective means we can evaluate people in a more objective manner. We will then be able to categorize those who are found to lie repeatedly, as to whether they perceive their repeated lying as ego-syntonic or dystonic and whether they want treatment or not. This would be akin to a serial adulterer or someone who excessively eats, smokes, or drinks, but does not want medical intervention. If it is ego-dystonic and the individual wants treatment, we can then determine whether the repeated lying is primary or secondary. Of course, if it is secondary, intervention could be directed toward the cause. However, if it is primary, we can then determine whether it is primarily compulsive or impulsive. If compulsive, would behavior therapy or selective serotonin reuptake inhibitors (SSRIs) help? If impulsive, considering the trends of current research linking lies to prefrontal lobe abnormality, would anticonvulsants have any role? Would those two

groups benefit from a support group such as “Pathological Liars Anonymous,” which, in line with our views, should be more appropriately named “Impulsive-Compulsive Liars Anonymous”? These are the exciting challenges we could face, if we can do away with the sensational adjective “pathological” and replace it with nonjudgmental nomenclature.

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## Reply

Editor:

We thank Adetunji *et al.* for their insightful commentary and appreciate their contribution to the discussion of this fascinating phenomenon.

Their proposition that the word “pathological” should be dropped with regard to lying is well taken. We concede that putting pathological in front of lying is problematic, but even more troubling is

lumping all liars together in one group as if they were homogenous. Further, removing pathological does not help in solving our dilemma. We were trying to describe a unique phenomenon,<sup>1</sup> a subgroup of lying that has been repeatedly described in the literature over the years with the terminology “pathological lying.” Our goal was to sharpen the definition while keeping the terminology.

In the letter, the authors referred to the recent study by Yang *et al.*<sup>2</sup> In fact, Yang *et al.* complicate things even more by referring without justification to different subgroups of liars as pathological liars. Their use of pathological lying is not the same as ours, and their work is not helpful in clarifying the interesting question of Adetunji *et al.*

Adetunji *et al.* suggested that pathological should not be used to describe lying behavior that may be secondary to cerebral abnormalities, as may be the case with pathological lying, to reduce stigmatization and encourage help-seeking. We appreciate the merits of this viewpoint. However, if brain pathology were responsible for the lying behavior, would it not be more appropriate to refer to the phenomenon as pathological lying? That will then be consistent with the “disease viewpoint” of psychiatric disorders described by the authors.

In our article,<sup>1</sup> we defined pathological lying as “falsification entirely disproportionate to any discernable end in view, may be extensive and very complicated, and may manifest over a period of years or even a lifetime.” Pathological lying is not defined by the magnitude of the lies *per se*, but by the chronicity, frequency, and apparent lack of benefit derived from the lies. Hence, the different examples of liars described by Adetunji *et al.* are not pathological liars by our definition. The benefit of lying in each case is obvious.

Adetunji and colleagues state that they do not believe there are pathological lies or pathological liars “because of the difficulty in determining what is pathological.” This is analogous to saying Schizophrenia did not exist before the development of the DSM criteria for its diagnosis.

We are pleased by the recent interest in the subject of pathological lying and continue to advocate more discussion and systematic studies of the phenomenon. We maintain, however, that what is most important is not so much what name the phenomenon is called, but the development of uniform criteria for

identifying it, the etiology of the phenomenon, and available treatment options.

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Editor:

We read with great interest the report, “Asperger’s Disorder and Murder,” by Dr. Schwartz-Watts.<sup>1</sup> Her article highlights the increasing psychiatric interest in Asperger’s Disorder (AD) and criminality,<sup>2–5</sup> and the need to clarify our current knowledge base in this area. To enhance forensic appreciation of this fascinating area, we would like to make the following points.

Recent reviews of AD and its association with violence, written from different perspectives, suggest that an association between AD and violence may exist.<sup>2–5</sup> Other important contributions in this area have also appeared during the past two decades.<sup>6–7</sup>

In addition to the study by Siponmaa and colleagues<sup>2</sup> discussed by Dr. Schwartz-Watts, a broad screening survey of an adult forensic population found a prevalence rate of between one and three percent for AD.<sup>8</sup> Also, the most comprehensive and technically sound work concerning the epidemiology of Asperger’s Disorder provides a prevalence of pervasive developmental disorders other than Autistic Disorder of 0.367% (or 36.7 per 10,000).<sup>9</sup> These results, coupled with the work of Siponmaa and colleagues,<sup>2</sup> support the idea that both AD cases and individuals with PDD NOS are at elevated risk for violent acts compared with the general population and that the number of individuals who suffer from autism and engage in violent crimes may be substantially higher than 2.5 per 10,000. Dr. Schwartz-Watts makes an important point when she states that there is a need for well-trained psychiatrists to recognize and diagnose PDD spectrum disorders, including AD. As forensic clinicians deepen their investigation into these disorders and violent crime, it will be crucial to identify various risk factors in subgroups of affected persons. For example, a murder may