thorough (but insane) reader who might also fix on that phrase and go out and harm others. I remind the professor that at least one politician blamed the acts of the Columbine shooters on the fact that they were taught evolution in school. If that kind of leap can be made, then anything I might write about anything might be blamed for bad events.

For what it is worth, the Philadelphia audience chuckled at the remark, as I imagine The Queen's hearers did. With wits like Disraeli around, even conservative politicians of that time could afford to accept an occasional laugh on themselves.

My renewed thanks to Professor Brakel for paying such close attention.

Thomas G. Gutheil, MD
Professor of Psychiatry
Harvard Medical School
Boston, MA

Editor:

Joel Dvoskin's legendary wit is at its lambent and penetrating peak when he pretends that my didactic article on boundaries[1] is some sort of forensic report requiring objectivity and a comprehensive database; an artist at the top of his form is always a treat to read.[2]

For those who missed the irony, in my article, I described and analyzed six vignettes of patients with boundary issues. The material was presented in the service of dynamic understanding and risk management instruction.

In his commentary, Dr. Dvoskin correctly pointed out that, when presenting the clinical material, I omitted the individual sources of the data. Because the article is clearly risk management advice and a form of warning for the practitioner—and equally clearly not a forensic opinion—I omitted individual sources in the interests of space and efficiency and the wish to avoid diluting the central points of focus.

However, to heighten the satire, Dr. Dvoskin ignored the fact that—since the cases in question went to actual trials and hearings—due to my function as expert, I did have access to a large database in each case, which I employed to validate my opinions. I had to summarize or even ignore most of that vast data to save space, and highlight only the material relevant to my core risk management point. Dr. Dvoskin also pretended that I did not know that one cannot take the unilateral claims of a litigant as factual.

In reality, Dr. Dvoskin expresses some doubt about the rule, in the foreign country I mentioned, that a consultant had a duty to report a consultee who disclosed a boundary issue, including sitting in an office while the patient masturbated. I did not merely accept the litigant's claim that a consultant in the foreign country would have to report him. Instead, I checked the regulations and interviewed some native practitioners. The defendant was right. Of course, this represents a terrible solution to the misconduct problem, in my opinion, since it deprives the practitioner of the benefits of consultation.

Finally, since my aim was not to persuade (which would fail) but to teach, I am left with the hope that that aspect of the piece succeeded. I offer my renewed thanks to Dr. Dvoskin for his brilliant satire.

Thomas G. Gutheil, MD
Harvard Medical School
Boston, MA

References

1. Gutheil TG: Boundaries, blackmail, and double binds: a pattern observed in malpractice consultation. J Am Acad Psychiatry Law 33:476–81, 2005
2. Dvoskin JA: Commentary: two sides to every story—the need for objectivity and evidence. J Am Acad Psychiatry Law 33:482–3, 2005

Editor:

We read with interest the article by Dike *et al.*,[1] on pathological lying, as well as the excellent commentary provided by Professor Grubin.[2] We feel that, while the concept of pathological lying serves as a great debate within academia, Dr. Dike and his colleagues missed the opportunity to advocate for the removal of the pejoratively and medically unproductive adjective "pathological," which has been colloquially ingrained in psychiatric literature. The adjective dates back to the "moral viewpoint" of psychiatric disorders rather than the "disease viewpoint," and its removal would be a necessary first step toward jettisoning our negative and countertransferential emotion about liars, thus facilitating the search for medical interventions for the sufferers.

Just like any other universal behavioral concept, lying cuts across cultures and may be part of normal

development and individuation.[3] 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[1] 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,[2] 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.*[1] about the link between pathological lying and central nervous system disorders[1,4] and right hemithalamic dysfunction,[1,5] there is a very recent landmark study by Yang *et al.*,[6] 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.

Babatunde Adetunji, MD
MHM Correctional Services
Philadelphia, PA

Biju Basil, MD
Maju Mathews, MD
Drexel University College of Medicine
Philadelphia, PA

Kumar Budur, MD
Cleveland Clinic Foundation
Cleveland, OH

Olakunle Oladinni, MD
Epsom General Hospital
Surrey, UK

References

1. Dike CC, Baranoski M, Griffith EEH: Pathological lying revisited. J Am Acad Psychiatry Law 33:342–9, 2005
2. Grubin D: Commentary: getting at the truth about pathological lying. J Am Acad Psychiatry Law 33:350–3, 2005
3. Ford CV, King BH, Hollender MH: Lies and liars, psychiatric aspects of prevarication. Am J Psychiatry 145:554–62, 1988
4. King BH, Ford CV: Pseudologia fantastica. Acta Psychiatry Scand 77:1–6, 1988
5. Modell JG, Mountz JM, Ford CV: Pathological lying associated with thalamic dysfunction demonstrated by [99mTc] HMPAO SPECT. J Neuropsychiatry Clin Neurosci 4:442–6, 1992
6. Yang Y, Raine A, Lencz T, *et al*: Prefrontal white matter in pathological liars. Br J Psychiatry 187:320–5, 2005

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