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Pseudologia Fantastica (i.e. Pathological Lying) as a Possible Outcome of Complex Trauma

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Abstract

Pseudologia Fantastica is an interesting syndrome as it is commonly talked about yet remains elusive in many regards. Thus, this presentation will aim to shed light on its purpose within the mind of the pathological Liar as well as the potential unconscious ramifications of complex PTSD and psychotherapeutic treatment. In order to explore these topics, we will first define pseudologia fantastica and explore the interpersonal dynamics of this syndrome, after which we will draw a direct link between pathological lies and the traumatic truth. Next, we will present four different phases of psychotherapy. Lastly, we will conclude with a discussion of the inherent limitations of this paper. In this essay, pseudologia fantastica will be analysed as a standalone disorder and in light of psychoanalytic theories, namely those of Bion, Lacan, Klein, Kernberg, Fairbairn and Kohut, as well as my observations and ideas based on my clinical experience with pathological liars.

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What is Pseudologia Fantastica?

Pseudologia Fantastica is a relatively rare syndrome in which the individual lies by wildly exaggerating or creating events, presenting their fantasies as reality, thereby aggrandising their sense of Self.

This disorder is known by many names in the mental health community: *Compulsive lying, pathological lying, mythomania and pseudologia fantastica*. All these names regroup the same clinical reality. Interestingly enough, this syndrome is not recognised by the DSM-5 nor the ICD-11 as a standalone disorder but as a symptom of a larger personality organisation (ex, borderline personality disorder, narcissistic personality disorder, factitious disorder, histrionic personality disorder, antisocial personality disorder). I believe this lack of an 'official' nosological delineation has contributed to the vagueness of its definition and absence in our professional discourse.

So, for the sake of clarity, I am going to provide a list of ten features partially inspired by the perspectives of psychoanalysts such as Kernberg (1992), Kohut (1971) and Bollas (1987), as well as my own clinical experiences, encounters, and observations of people experiencing pseudologia fantastica:

● Pseudologia fantastica is compulsive, meaning that the person cannot control themselves as if lying were stronger than them, despite all the negative impacts of this behaviour on themselves and others.

● The content of pathological lying can vary, but its purpose is to attract the attention/sympathy and admiration (or, in some cases, anguish) of others, at least in part.

● On a psychological level, pathological lying is a fantasy (=imaginary thought) presented to others as reality.

● The person does not feel guilt, remorse or distress about lying/deceiving others.

● If the lie is exposed as false, the person can either retreat into denial or experience deep shame, but this shame cannot be mobilised as a transformative element.

● Lying does not inherently have as its objective material or financial gain, identity theft, an increase in the standard of living, etc. Unlike the con man, who seeks material gain,

● The content of the lie is often grandiose, incredible, exceptional and easily refuted by an outsider.

● The content of the lie is not impossible in itself, but it seems unrealistic, unlikely and very theatrical/dramatic.

●The person resorting to pseudologia fantastica is aware in his inner Self that his lies do not coincide with reality, even if he can refuse to admit it to others. In this sense, reality testing is not lost, unlike psychosis.

● Pseudologia fantastica is intrinsically connected to a feeling of enjoyment (jouissance in French) in the person who suffers from it. That is, they take pleasure in creating and sharing their lies.

Please note:

Although I can attest to the clinical usefulness of these criteria, as they have helped me navigate the disorder, I am not implying that they are an exhaustive listing or that they constitute the absolute definition of pseudologia fantastica. There very well might be symptoms or manifestations that are missing from the list. So please keep this in mind during the lecture on this essay.

In this paper, I will be working with three Apriori:

● Firstly, pseudologia fantastica is a separate (standalone) nosological entity. As such, I will leave out co-occurrences and comorbidities to focus on the topic at hand.

● Secondly, pathological lying has an unconscious meaning, aetiology and purpose for the individual suffering from it. It is a creation of the mind that is made manifest; hence, it is akin to a positive symptom (in the psychiatric sense) as it adds rather than withdraws from the person's experience of the world.

● Thirdly, I believe pseudologia fantastica to be on a spectrum from limited to a specific area of life in the mildest cases and all-encompassing in the more severe ones.

Lastly, I would like to emphasise that my intention is not to reduce or override the variety of manifestations and hypotheses linked to pseudologia fantastica but only to add my own understanding based on clinical experience and the literature I have read.

Key takeaway:

A lie always implies a truth, and pseudologia fantastica is no exception. In the case of pathological lying, it is buried as deeply as possible but still retains its intensity, as often this truth is intertwined

The interpersonal dynamics of Pathological lying

In her 1921 article "On the Pathological Lie (Pseudologia Fantastica)", psychiatrist and psychoanalyst Helen Deutsch (1884-1982) argued that this syndrome isn't directed towards others but only towards the Self. Thus, the relationship is incidental, and the lie is created solely for the Liar's sake and to aggrandise their sense of Self.

Although I agree with the narcissistic aspect of her theory, I do take issue with the relationship being incidental. My clinical experience has led me to the opposite conclusion. The pathological lie is addressed to the other(s), those receiving the lies. I believe the Receiver is as important as the Emitter[1]

This dynamic is based on the feeling of excitement. Indeed, the Liar creates a fictional narrative that they share with others. The Emitter will often put considerable effort into their 'storytelling,' steering the tall tales to elicit the desired reaction from the Receiver. The aim is often to stimulate suspense and excitement while maintaining and controlling the relationship with the lie.

These thrilling lies tend to fascinate the receivers and lower their critical reasoning skills and scepticism, at least at the beginning of the process.

From a psychoanalytic perspective, we could argue that the Emitter uses a form of projective identification, an archaic defence mechanism theorised by psychoanalyst Melanie Klein (1946). This mechanism involves projecting into the psyche the aspects of oneself that cannot be integrated.

In the case of the Emitter, we could speculate that he is unconsciously replaying an infantile pattern in which the lie not only eclipses the truth but also stimulates the other and controls them with the presented narrative. Thus, the Emitter is splitting between an idealised, grandiose false ego he incarnates and a vulnerable, gullible yet genuine true self he projects into others. Thus, this creates a loop in which the Emitter gains a temporary boost to their pride and sense of Self by manipulating the gaze of others.

If we were to consider this dynamic from the perspective of Fairbairn’s Endopsychic structure (1944), we could argue that the Emitter plays the role of an Exciting Object (i.e. a relationship that creates an unconscious hope of perfect love and fascination) and through projective identification triggers the Receiver's libidinal Ego (=the part of the mind that seeks an perfect relationship that is flawless).

[1] Throughout this section, I will name the pathological Liar, the Emitter (of the lies) and the person experiencing the lies, the Receiver.

This interaction gives the Emitter relational control and maintains the splitting process.

Please note that this dynamic can also be based on anxiety. The Emitter might lie about an illness, a traumatic event, or a loss to create unrest (like excitement) in the Receiver and prevent them from being too critical of this behaviour or enjoying the anguish it causes. In these cases, the projective identification aim is to reduce the Receiver to a state of powerlessness that the Emitter experienced as a child.

However, when the lie is discovered, the Receiver often shifts from excitement/anguish to hate, bitterness, rejection and suspicion for the Emitter. In this state, the presented narrative collapses. The relationship enters a dynamic in which the Receiver sees the Emitter as a Rejecting Object (= a terrible relation that aims to destroy them), which sparks the Antilibidinal Ego of the Receiver (= a part of the mind that seeks to defend against the rejecting Object by all means).

In this phase, the splitting is still present but inverted. The Emitter becomes a feared enemy, and the Receiver a potential victim. This can also create a narcissistic gain for the Emitter, as they are perceived as all-powerful and thus become the ruthless parent they feared as a child. Nevertheless, it will most likely destroy the relationship between both parties, as the Emitter no longer controls the bond.

The reader might wonder what happens when the Emitter is deprived of a Receiver (i.e., someone who will engage in this interpersonal dynamic). Often, the Pathological Liars will try their utmost to reach out to 'new' people, whether in person or on the internet. However, if this no longer works for them, they might try to repeat this dynamic with former Receivers. When this fails, they will attempt to become both the Emitter and Receiver. This tentativeness is made in front of other people. In these cases, the pathological Liar doesn't engage others and can only project and not use projective identification (which makes the dynamic incomplete and unfulfilling).

Moreover, if they run out of options, they might regress to a more archaic state of mind by attacking their own body to draw attention (substituting words with actions, i.e. Acting Out). In these cases, they might deploy fictitious disorders or attempt suicide to get medical attention and recreate the interpersonal dynamic with medical staff members.

An important question we might ask is why the pathological Liar constantly tries to repeat this dynamic.

● The first and most manifest reason is to supply their narcissism and reinforce their feeling of omnipotence, grandiosity and control over the Object (i.e. the other, as we call them in psychoanalysis).

● Secondly, this dynamic strengthens the lie by making it masquerade as reality. Indeed, having one or more people believe the falsehood reinforces the obfuscation of the truth and makes it even harder to reach or hold the Emitter accountable.

● Thirdly, on an unconscious level, this dynamic allows the Emitter to externalise internal tensions and conflict. Tensions and conflicts that cannot be integrated into the conscious mind are expelled onto another person.

Finally, I will mention that pseudologia fantastica constitutes a form of societal transgression. This attack is a result of the distrust and suspicion caused by lies, as our entire society is built on trust and confidence, from our daily interactions to the macro level, encompassing the global economy and international relations. Furthermore, repeated falsehoods undermine the integrity of global systems.

Key takeaway:

Pseudologia Fantastica is fundamentally an interpersonal phenomenon. In it, the pathological Liar seeks to create an emotional state of excitement and/or anguish within the person listening to the falsehood. Thus, the pathological lie is always addressed to another person in addition to oneself

Pseudologia Fantastica and the Traumatic Truth.

Before diving into the notion of trauma and its connections to pseudologia fantastica. I would like to take the time to develop the following question:

What is a lie?

This may seem futile to ask at this point, but it is nevertheless necessary. A lie is a false statement, a falseness that implies that there is a truth, something genuine. The lie cannot exist without the truth, as a shadow cannot exist without the casting of the light.

To further this point, the philosopher Martin Heidegger (1927), in his book *Being and Time*, ties the notion of truth to the ancient Greek word *ἀλήθεια* (Aletheia). This means etymologically what is 'unhidden' or 'unconcealed', i.e., what is obvious. So, in this perspective, the lie obfuscates and hides the truth, as there is no need for a lie if there is no truth, just as there is no need for a forgery if there is no genuine object to copy.

In the ‘classical’ sense, also known as the everyday lie, this obfuscation is relatively easily explained by the desire to avoid negative consequences or to gain a certain advantage. However, in the cases of pseudologia fantastica, this obfuscation is not as straightforward.

In my clinical experience, it is quite common for the pathological Liar to deny any meaning or truth behind the lie (at least in the first months of psychotherapy) as if the lie was 'pointless' or merely a form of enjoyment. This posture casts the truth even further away, with the lie being a way of burying the truth and the excitement/ anxiety a tactic to generate in others a distraction that aims to mislead.

They operated under the axiom 'Any lies are better than the truth'.

A position that goes against the collective values of society and inverts them.

A second question now arises:

Why does the pathological Liar need to conceal the truth to such an extent?

I believe this phenomenon occurs because the truth is experienced as inherently destructive by the compulsive Liar.

A destructiveness that is felt on both an unconscious and preconscious level. The truth is experienced as a powerful force to rupture the continuity of the Self and break it down (i.e., the fear of losing the sense of Self). A breakdown that must be avoided at all costs. The question now is, what are the roots of this force?

At the core, I believe the trauma to be a fundamental truth that cannot be detoxified or integrated into the conscious mind, so the only option left is to cover it.

It is important to note that the pathological Liar has often undergone highly traumatic experiences in childhood (sexual assault, rape, violence, neglect, extreme humiliation, belittlement, utter rejection, hate). The nature of the trauma can vary, but it is often severe and repeated throughout the psychological and physical development of the individual. Making it impossible to avoid or escape the situation. Thus, we can postulate that the pseudologue has a form of C-PTSD.

The inescapable nature of trauma pushes the pathological Liar further and further into falsehood as an ultimate way of creating a new reality that is not just manageable but fantastic and flamboyant, rewriting the lived terror. If we were to use a metaphor, it is as if the pseudologue were constantly burying a corpse that continuously resurfaced.

From a psychoanalytic perspective, there would be two ways of explaining this phenomenon:

- The first would be to use Bion's (1962) ideas of Beta-elements (β) and the Alpha function (α).
- The second would be that of the three orders as defined by Jacques Lacan (1953).

In the early sixties, British psychiatrist and psychoanalyst Wilfred Ruprecht Bion developed a theory of the mind in which traumatic and unbearable events, sensations and effects are slowly processed and transformed by the caregiver during the first years of life into bearable and integrable elements within the mind. In addition, with time and repetition, the infant can identify and copy the caregiver's ability to transmute the displeasure events. He called this transformational capacity the Alpha function and the destructive elements the Beta elements (β).

Thus, for Bion, trauma can be conceptualised as an accumulation in quantity and intensity of Beta-elements that override the ability of the Alpha function to contain and process them. From this perspective, our psychotherapist role is to help the patient process and digest those beta-elements by leading them to our alpha function through interpretation, the setting, and our positive regard.

In the best-case scenario, the Alpha function should drive clinician and patient into a reverie in which the Beta elements are contained and transformed into thinking, hoping, loving, etc.

In regard to the syndrome of pseudologia fantastica, we can postulate that the traumatic truth has never been processed or digested by the pseudologue. It has remained in the mind as a beta element capable of destroying the individual's psyche as if it were a foreign object in the body, something that does not belong there. Thus, the mind tries to contain it through the lie as the body tries to contain the effect of the foreign Object through inflammation and antibodies. However, this defence of the mind is limited, as the traumatic truth does not diminish in intensity or force. The ability to detoxify the beta elements is lost and replaced by the lie instead of the reverie. As such, this process is not an alpha function, but a pseudo-alpha function that only limits, but does not process, the traumatic truth.

The Alpha functions often don't fully develop or even regress because, during childhood, the individual was neglected, left alone with this destructive event, not knowing what to make of it. In some other cases, the child might have been mystified[1] by adults around him. Caregivers who would deny the trauma called the child a liar, an idiot, or an attention seeker.

In such cases, the child has nowhere to turn but to a lie to save their identity. The fantastical falsehood becomes a refuge from the unbearable truth as the environment never processed or acknowledged it.

In time, the survival mechanism becomes pleasurable for the individual as they witness the control and admiration it grants them to others, pushing them further and further away from integrating the traumatic truth.

In the early fifties, Jacques Lacan, a French psychoanalyst and psychiatrist, conceptualised three orders that organise the human subjective experience:

- *The Symbolic*

The symbolic order is the realm of rules, laws, and meaning. It represents the Other on a radical level, as we must inscribe ourselves into a collective set of symbols and understanding (including language). These symbols and laws aren't 'us', but we must abide by them. By doing so, we gain structure and develop the reality principle and a Superego (i.e., a limit to the pleasure principle and moral compass).

[1] A process that is now commonly known as gaslighting

● *The Imaginary*

In the Lacanian conception, the imaginary is the order of identification and alienation, as the Ego is forced to identify with others and become aware of itself in a social setting (through the mirror stage). Thus, a gap is created between one's self-image and what one presents to others. However, this gap implies losing a part of ourselves in the process. This is also the root of deception, allure, and masquerading, among other things.

● *The Real*

Finally, the Real is a phenomenon that the mind cannot assimilate, as it cannot be symbolised or played with. The Real is beyond understanding, and it does break down the Ego as it cannot be assimilated into meaning. It remains meaningless and even dissolves the narrative of one's life. In many ways, the mind is built against the experience of the Real. This order is inherently traumatic, but it isn't just the trauma. It encompasses the effects of trauma on the identity of the person themselves.

Tying it back to the question of pathological lying, we can speculate that the truth, because of its highly traumatic nature, fragments the narrative the pseudologue tries to build. Hence, the truth becomes part of the Real and must be fought against. In this perspective, the pathological lie is like a *neo-reality* that aims to maintain the sense of Self of the individual, as discontinuous and bizarre as it may seem. Moreover, without the lie as an ultimate safeguard, the individual might fall at risk of collapsing into psychosis.

However, the fight against the Real would be unconscious as the pathological Liar, on a conscious level, experiences feelings of elation, pleasure and power through his lies, what Lacan (1958) calls *Jouissance* or Surplus enjoyment in English. A pleasure is intertwined with the action of transgression, meaning the lie isn't part of the symbolic order but the imaginary, in which deception is central, and what matters is the masquerade and the image.

In a way, it was as if the pseudologue clung to the Imaginary order to push back the Real and resist the integration into the Symbolic realm. The laws and rules fell meaningless as they were not enforced, operative, or disavowed when the pathological Liar was a child, preventing the pseudologue from building and maintaining a proper Superego.

In both cases, the truth, due to its intensity, becomes an unbearable part of the mind (Beta-elements or the Real) that cannot be integrated, as the individual lacks the necessary processes to do so (absence of the Alpha function or the symbolic order). Thus, the pathological Liar is stuck in a constant struggle to prevent the truth from resurfacing and, by doing so, prevent it from being forgotten.

Please note:

● That even though both theories can be complementary, these ideas are part of very different schools of thought, and they might be issues if one tries to merge them.

● In this essay, I have tried to make Bion's and Lacan's models more accessible to a layperson in psychoanalysis. However, by doing so, I have omitted many of the complexities, intricacies, nuances, and depth that these two authors are renowned for. I can only invite the reader to further their understanding of these brilliant thinkers.

● Although I have found these intellectual constructs to be valuable in explaining pseudologia fantastica, I am by no means implying that these are the only meaningful ways of explaining this syndrome.

Key takeaway:

A lie always implies a truth, and pseudologia fantastica is no exception. In the case of pathological lying, it is buried as deeply as possible but still retains its intensity, as often this truth is intertwinedPsychotherapy and its effects on Pseudologia Fantastica.

Psychotherapy and its effects on Pseudologia Fantstica

Pathological liars are seldom interested in psychotherapy. Despite the negative consequences, they do not tend to suffer consciously from the falsehoods they create and share. More often than not, they come for another reason (a relative threatens to cut ties, an impending divorce, or social isolation). If this alternative is often presented as 'the only one', an astute clinician will quickly spot the pseudologia fantastica and how it impacts the patient's life. However, this syndrome is rarely treatable in a direct fashion, as would be the case with anxiety or depression, as pathological Liar would often vehemently deny the presence of lies in their discourse. As such, the process of psychotherapy can be quite challenging and complicated with the pseudologue, but it remains possible in some cases.

These specific instances are what I will be exploring in the next paragraphs. I am now going to present the four phases of psychotherapy I have identified through my clinical work with pathological liars.[1]

I. The centrality of the lies

This is the first phase of psychotherapeutic treatment. At this stage, the pseudologue will try to recreate the emitter-receiver dynamic with the therapist. The patient will often show disinterest when the clinician asks about information that isn't tied to the lie, putting the discussion back on track. During this period, the pseudologue blocks all attempts to avoid or go beyond the falsehood, and the lie(s) take centre stage in treatment.

If the therapist attempts to interpret, confront or expose the lie(s) of the patient. They can show signs of withdrawal or aggression towards the professional as if they were going to be ripped apart and destroyed. At this stage, the truth is unbearable and a threat to their sense of Self and being in the world.

Thus, they might see the therapist as a malevolent individual who is out to harm them and doesn't care about their well-being. In these moments, they developed what psychiatrist and psychoanalyst Otto Kernberg (1992) calls a paranoid transference towards the professional.

[1] The four phases are a construct of mine, but they provide a heuristic framework that I want to share because I find it valuable.

In this early stage, the clinician should refrain from directly interpreting the lie or drawing attention to it as a defence mechanism. However, this doesn't mean the clinician should take everything the pseudologue says at face value; the professional can also 'reframe' the information to subtly indicate that the lie doesn't fool him. This reframing can be achieved through formulations such as: 'This is your perspective', ' How do you feel when you share this information?' and' It seems important for you to share this information with me'. This reframing aims to show the patient that the psychologist is not tricked while respecting the necessity of recourse to pseudologia fantastica.

This space given to the lie is essential in developing the therapeutic alliance (what we call transference in psychoanalysis). Without this 'respect ' given to the lie, the pseudologue is at risk of leaving therapy prematurely, as it is experienced as deeply dangerous, as it seeks the destructive truth. The tolerance and patience shown toward the lies (without the feelings of excitement or anxiety) are also what will differentiate the therapeutic relationship from other relations. The pathological Liar will slowly feel less interested in recreating the interpersonal dynamic and more open to another type of interaction. In this phase, the therapist might feel profound boredom or aggression. These states of mind indicate a form of countertransference, an impossible connection, and a lack of genuineness on the part of the patient, as the truth remains hidden.

Side Note:

The clinician may not be able to detect pseudologia fantastica in the patient for a few reasons:

- Because of a high level of masking by the patient.
- Because of the coherence of the lies being presented.
- Because the interpersonal dynamics of the syndrome sway the clinician.

Whatever the case may be, if pseudologia fantastica remains undetected, it will most likely go unaddressed, and the following consequences will not occur.

II. The rewriting of the lies

The lies are still very present in this phase, but their nature seems to have somewhat changed. They are more flexible, and the pseudologue can ‘rewrite’ them to fit his current state of mind or external events in front of the clinician. The patient frames this change as: ’I was joking’, which Kohut (1971) called a ‘half-joke’ or ‘I have remembered a new aspect’. In the best-case scenario, he will even explicitly state the falsehood of the information: 'I lied about the first version. The one I am giving now is the real one.' 'No, that was a lie. This is what truly happened.' In this phase, the lie is exposed for both the therapist and the pseudologue, creating a sort of 'game' between them.

This game can be extended to aspects of the setting, such as the patient trying to guess the dates of the therapist's next holidays or counting the number of sessions before the end of the year. The lie loses its centrality in this phase, and other topics become available for conversation. At this stage, the patient will not be as strongly denied the traumatic truth, and he may even show glimpses of it.

The aim of the pseudologue through the lie now becomes to maintain the ‘good enough’ relationship as it evolves beyond the interpersonal dynamics. In many ways, it is as if the patient has started playing again, similar to the young child who plays to experience the world and its relationships.

From a psychoanalytic perspective, we could interpret this phrase as a regression to an earlier stage of life that involves making beliefs rather than overt falsehood. This regression also reduces the need for pseudologia fantastica as a defence mechanism for the individual, as the pseudologue enters a positive transference towards the therapist and starts to trust them.

At the tail end of this stage, the individual may even admit and apologise for the lies he has told the clinician. I believe that these moments are critical in the therapeutic process as they show that the pseudologue expresses gratitude for maintaining the relationship and a form of reparation toward the other and trusts them enough not to fear repercussions in the therapy.

Although the lie has decreased in both intensity and frequency, the clinician should not directly confront it as it could weaken the therapeutic 'game'. However, the therapist can now gently question the validity of what the patient is saying through formulations such as: ‘Is that really so?’, ‘Are you sure?’, ‘Is this the full picture?', and ' What you are saying seems quite extreme'.

However, this soft redirection by the clinician feeds the playfulness of the interaction and thus transforms the lie into a more flexible defence mechanism for the patient. At this stage, the traumatic truth remains destructive and cannot be brought into the therapeutic space; it can only be pointed to and denied.

Regarding countertransference, the therapist might start to feel sympathy towards the patient and a sense of playfulness as the therapeutic relationship opens up to something real, as the truth emerges.

III. From lies to reverie

At this stage, the lies become infrequent, and the patient starts to present his constructs as fantasies, i.e., something that could have been or could have the potential to be. In this phase, the sharing of information is closer to a daydream than anything else but presented as such through words like: ' If only it had gone this way…', ' I could have been so much better…', ‘ I would have loved to have done this…', ‘ If I were like this I would…’.

This stage shows a transition from lies to reverie in which the patient can allow themselves to investigate their subjective experience while recognising and sharing it as such, and no longer presenting it as facts. In addition, the interpersonal dynamic at this point is less about excitement/anxiety and more about potentiality and introspection.

In regards to the traumatic truth, the patient can now talk about it to the therapist in a prolonged manner, explaining the events and their repercussions for them (both psychologically and physically) and their family.

Although the traumatic truth is now exposed, it is not yet accepted by the patient. As such, the lies might come back at any point to try to cover up the trauma. Tentatives might still be made to divert the clinician's attention to lies. However, the step from consistent lying to reverie is as important as the pseudologue becomes increasingly capable of distinguishing the delimitations between their inner world (made up of fantasies and daydreams) and the external world. Thus, the internal world does not 'leak' out into the external one.

From a psychoanalytic perspective, we could interpret this subjective change as the patient becoming able to process beta-elements with their own mental apparatus without feeling the need to expel them. We could argue that the pseudologue has internalised a good internal therapist with an operational Alpha function that can detoxify the suffering they experienced (what Fairbairn would call an Ideal Object). In addition, we could think that enough detoxification has occurred that the trauma isn't threatening their existence, a diminished menace that consequently frees mental resources that can now be used to daydream about a potential past or future.

At this point, the patient can acknowledge the trauma and talk about it, but he may resist it if the clinician brings it up too frequently or too directly. However, the clinician can now encourage introspection in this direction and even offer interpretations that would 'normally' be rejected by the patient. Through their interpretations, the therapist is helping the patient make sense of his traumatic experiences and slowly developing an intrapsychic space in which reverie slowly replaces the lies. By doing so, the truth starts to lose its destructive nature and is reintegrated into the mental life of the patient.

The clinician might also start developing a deep and interesting reverie when the patient talks about what they wish for or how they would do things differently. This form of countertransference is a type of co-thinking (Widlöcher, 2012) in which the clinician unconsciously shapes the patient's fantasies, thus reinforcing their subjectivity.

Side Note:

At this point, the astute reader might wonder how the clinician can tell if the events mentioned are real or just another lie.

It seems to me that if the patient shares the information to worry or excite the therapist, it is most likely a falsehood. The truth, however, is not a matter of excitement or a way of triggering anxiety; it is a painful experience that the pseudologue is reluctant to talk about, contrary to the lies that they enjoy spreading. So, I would postulate that the resistance to communicating the information and exploring its impacts is a sign of genuineness.

IV. Boredom and the acceptable truth

In this final phase, the patient begins to experience a state of boredom, characterised by the absence of excitement and/or anxiety. The lies become rare and seem more procedural than stimulating. Other topics take centre stage, such as grief, regret, fear of the future…

At this point, the pseudologue has developed what I would call a healthy state of boredom in which he can tolerate the mundanity of life and day-to-day issues. These struggles are more frequently talked about in therapy.

This ennui shows that the patient has developed a stronger reality principle that can postpone the instant gratification of the lie or reverie to focus on harder yet more important aspects of human existence. In a sense, it is as if the fantastical elements have resorbed into the inner subjectivity of the individual, leaving them to deal with current problems or existential questions (such as death, freedom, etc.).

At this stage, the truth is no longer destructive, and it becomes acceptable to openly talk about it. Feelings of sadness, vulnerability, loss, and grief become prevalent, and the patient can let go of the pseudologia fantastica as a defence mechanism. The truth cannot erase their identity as it once did.

In terms of psychoanalysis, we would interpret the following improvements as the transition from a paranoid-schizoid (Klein, 1928) position in which the individual feels complete, all-powerful, merged with the others and persecuted to a depressive position (Klein, 1928) in which the individual experience themselves as limited and others as separate. The pseudologue goes from fantasies of absolute excitement and control over others, themselves and the truth to a position of boredom and renunciation of the defence mechanism. The renunciation is also more fundamental because omnipotence is given up.

The corollary of this renunciation is the addressing of the repressed feelings of powerlessness, despair and terror linked to the trauma that, up until then, was unbearable for the patient. The trauma becomes an accepted part of the patient's subjective experience.

In this final stage, both the patient and the therapist can openly discuss the trauma. Even though the patient might still find it difficult or painful, he will go there.

Regarding countertransference, the clinician might start to truly feel connected to the patient even if the content of the sessions is more mundane. This is because the interpersonal exchange is now genuine in both parties. In addition, the clinician might even feel hopeful.

Please note:

Although I have chosen to present the four phases separately, there are many intersections between them, and some aspects of one phase may be present simultaneously in another. Therapy is a dynamic process in which rigid categories are only provided as a general 'map' rather than rails to follow.

There might also be other hurdles in the psychotherapeutic treatment of pseudologia fantastica, among which:

● *In and out relationships.*

It is frequent for pseudologues to quit therapy only to come back a few months later. This difficulty is because some of them resist transference, and they might be afraid of truly trusting the therapist. As such, they might present a form of 'In and Out relationship' as defined by Harry Guntrip (1969).

● *Subversion of therapy*

Some pseudologues might present a perverse personality or what psychiatrist Otto Kernberg (2009) called malignant narcissism, and they might try to pervert therapy by making it a destructive process rather than a healing one. In these cases, the pseudologue will try to triumph over the therapist, and the lies will be weaponised against the professional in a sadistic manner to enjoy the distress that they might cause. Needless to say, the prognosis for such individuals is not good.

● *It is easier to treat pseudologia fantastica in institutions than in private practice.*

I would also add that the treatment of pseudologia fantastica might be easier in an institutional setting. The patient may have more professionals to consult and review their scenarios, making the process more contained and manageable than in a private practice. In addition, the patient may be able to trust the clinician more, as the transferential investment is in the entire institution rather than in one individual therapist.

● *Comorbidities*

Lastly, there might be comorbidities such as borderline personality disorder or histrionic personality disorder that necessitate specific treatment. In addition, it might be, depending on circumstances, better to prioritise the treatment of the personality disorder rather than the pseudologia.

Key takeaway

In this section, I outlined four phases for the psychotherapeutic treatment of pseudologia fantastica. These phases provide a theoretical 'map' for the clinician working with pathological liars and demonstrate that psychotherapy is possible and valuable for these individuals.

Discussion of the main ideas and their limitations.

This paper presents my perspective on the pseudologia fantastica syndrome, its possible origins, and psychotherapeutic treatment. Although I strongly believe in the value of my work, I must also acknowledge its limitations. I will now be addressing the following points:

- *The Neurological atypicality of the pathological liars.*

In a study headed by Yaling Yang, titled "Localisation of increased prefrontal white matter in pathological liars," scientists found an increase between 23% and 36% in white matter in multiple brain parts compared to the standard population.

According to Yang and his team, this difference in brain matter could indicate a potential cause for pseudopodia, or, conversely, be the neurological result of consistent lying. This is a biological chicken-and-egg situation in which I cannot contribute, as my knowledge of neuroscience is quite limited and beyond the scope of this article.

- *The lies are part of the family system.*

Some French psychologists like Simone Korff-Sausse have argued that the root causes of pathological lying could be found in the family dynamics and that it is often the parent who lies to the child. A lie that is allowed and even encouraged in order to escape/ survive the perceived wrath of the outside world/ society. Although I agree with this hypothesis, my work centred more on the intrapsychic and interpersonal processes of the pseudologue rather than the family interactions. That said, I do not think these two perspectives are mutually exclusive; rather, I believe they are complementary. I just think that the issues are not approached from the same angle.

● *The limitations of my clinical data*

To be fully transparent with the reader, I have only encountered ten patients who would fit the criteria listed at the beginning of the essay. Out of these ten individuals, I only met four of them once. Two of them came for five sessions or fewer. For the remaining four, I provided psychotherapy ranging from six months (for the shortest) to six years (for the longest). Although the sample size could be considered statistically negligible, I believe the insights we (both I and the patients) have gained are relevant and important in treating pseudologia fantastica as a syndrome.

● *This model is psychoanalytically incomplete*

In this paper, I described both interpersonal and subjective dynamics. However, I haven't inscribed my theory within a global metapsychological framework (e.g., drive theory, the endopsychic structure, etc.). This means that the explanations provided are insufficient to understand the psychodynamic process implicated in pathological lying.

Conclusion

In this essay, I have presented pseudologia fantastica as a standalone syndrome (without the comorbidities). Although this distinction may seem artificial, I believe it is valuable and necessary to better understand the processes at work. I have also tried to demonstrate that the pathological lie is not meaningless. Quite the opposite, it makes sense as a defence mechanism against an unacceptable truth based on a deeply traumatic experience. Thus, the truth becomes associated with the experience of trauma and disavowal, which makes it destructive. Destruction the individual avoids at all costs on an unconscious level. This defence becomes a source of surplus enjoyment, and the lies bury the truth. Lastly, psychotherapy can help the pseudologue to manage and work on the lies. I defined the process of therapy in four stages that I have observed:

I. The centrality of the lies

II. The rewriting of the lies

III. From lies to reverie

IV. Boredom and the acceptable truth

My aim with this paper is to open the conversation and share new insights on this unusual and relatively rare disorder. A syndrome that is still often dismissed or relegated to a mere symptom of a wider personality disorder by many professionals.

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Key takeaway:

Although this paper aims to gain a deeper understanding of pseudologia fantastica, it remains a contribution to a broader understanding of the syndrome, as limitations in neurology, family dynamics, and metapsychology persist.

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