Online supplement for 10.1176/appi.psychotherapy.20210006

Appendix A
Demographics

Age:_____
Sex: ___Male ____Female
Gender: ___Woman ____Man

Race/Ethnicity:
African American/Black
Caucasian/European American
Asian/Asian American/Pacific Islander
Native American/Alaskan Native
Hispanic/Latina/Latino
Bi Racial
Multi racial
Other: _____

Education (Highest):
____ Master's degree
____ M.D.
____ Psy.D.
____ Ph.D.
____ Other: _____

Training Program:
___ Psychiatry
___ Clinical
___ Counseling
___ School Psychology

License:
___ Licensed Marriage and Family Therapist
___ Licensed Psychological Associate
___ Licensed Professional Counselor
___ Licensed Psychologist
___ Licensed Psychiatrist
___ Other: _____

Current Therapy Work Setting:
Counseling Center
Hospital
Veterans Affairs
Military
Private Practice
Prison/Correctional Facility

Rehabilitation
Mandated Clients
Not Practicing
Other: _____

Theoretical Orientation (Please select only 1):
Cognitive
Behavioral
Cognitive-Behavioral
Emotion Focused
Humanistic/Existential/Experiential
Psychodynamic/Interpersonal
Solution-Focused
Narrative
Family/Systems
Feminist/Multicultural
Integrationist/Eclectic
Other: _____

Survey of Patients' Pathological Lying Behaviors (SPPLB)

Pathological Lying definition:

> *A persistent, pervasive, and often compulsive pattern of excessive lying behavior leading to clinically significant impairment of functioning in social, occupational, or other areas, causing marked distress, and posing a risk to the self or others, occurring for longer than a six month period (Curtis & Hart, 2020, p. 63).*

1. Do you believe that pathological lying should be a diagnostic entity? Yes or No
2. What treatment(s) do you believe may be effective for someone who suffered from pathological lying? _____
3. Has a patient/client ever come to you with pathological lying as their presenting problem? Yes or No
4. If yes, how many patients/clients? _____
5. Have you ever worked with a patient/client that you considered to be a pathological liar or compulsive liar? Yes or No
6. How many people have you worked with that you considered to be pathological liars (who explicitly stated that they struggled with excessive lying behavior)? _____
7. How many people have you worked with that you considered to be pathological liars (who you thought to be based on information they provided)? _____
8. If you answered no to ever seeing someone with problems of pathological lying, are you willing to read case study vignettes and rate whether or not you think the person may be a pathological liar? Yes or No or I answered yes (continue)
9. Based on your overall caseload, what percentage of your patients/clients would be pathological liars?
10. Did those patients lie to you during your work together?
11. How often?
12. If you have ever worked with a client/patient that you thought or knew to be a pathological liar, please answer the following questions based on that individual.
13. How many lies did that person tell within a 24 hour day? _____
14. Did you formally diagnose that person with a psychological disorder? Yes or No
15. What diagnosis? _____
16. What is the earliest stage that the person has been a pathological liar?
    Childhood (3-10 years)
    Adolescence (10-20 years)
    Early adulthood (20-40 years)
    Middle Adulthood (40-60 years)
    Late adulthood (65 years or more)
    Don't know

17. How long has the person been telling numerous lies/engaged in pathological lying?
    3 months
    6 months
    1 year
    1-5 years

More than 5 years
Don't know

Please answer the following questions about the person's lying behaviors
1 (*strongly disagree*) to 7 (*strongly agree*)

18. His/her lying behaviors have resulted in impairment in:
    Their occupation
    Social relationships
    Finances
    Legal contexts

19. His/her lying causes he/she significant distress.

20. His/her lying has put he/she or others in danger.

21. His/her lying is something out of his/her control.

22. His/her lies tend to grow larger from an initial lie.

23. Most of the lies he/she tells appear to not have a reason.

Deception or Lying definition: "*a successful or unsuccessful deliberate attempt, without forewarning, to create in another a belief which the communicator considers to be untrue*" (Vrij, 2008, p. 15).

Delusion: A false belief, held by communicator.

Pathological Lying:
A persistent, pervasive, and often compulsive pattern of excessive lying behavior leading to clinically significant impairment of functioning in social, occupational, or other areas, causing marked distress, and posing a risk to the self or others, *occurring for longer than a six month period.*

Questions asked after each vignette:
If pathological lying was a diagnosis, would this person meet diagnostic criteria? Yes or No
If yes, any additional diagnoses? _____
If no, what diagnosis would you provide? _____

Case Vignette 1 (Pathological Lying)

The patient is a 28-year-old man with a history of major depressive disorder, hepatitis C, biliary colic (status postcomplicated cholecystectomy), multiple concussions, and chronic back pain who presented to the emergency department with abdominal pain clinically concerning for acute appendicitis. He localized his pain to the right lower quadrant, complained of right lower quadrant pain with palpation of the left lower quadrant (Rovsing's sign), and indicated his pain was reproducible with extension of the right hip (psoas sign). His vital signs on presentation were notable for the absence of fever or tachycardia and his initial laboratory findings revealed normal chemistries and a normal white blood cell count of 4.2. He received intravenous morphine and an urgent CT scan of his abdomen. Enroute to the CT scanner, the patient mentioned that he had been struggling with sadness and suicidality since his pregnant fiancee had recently been killed ´ in an automobile accident. The emergency physicians felt the pretest probability for acute appendicitis was extremely high and asked the psychiatry consult-liaison team to "evaluate him quickly before he goes to surgery." Ultimately, the imaging was negative for acute appendicitis, surgery was cancelled, and his disposition from the emergency department was left to psychiatry.

Review of the electronic medical record showed that the patient had established care at this institution one month prior to this presentation when he presented with biliary colic resulting in a lengthy hospitalization for a complicated cholecystectomy, challenging postoperative pain management, and a new diagnosis of hepatitis C. During that hospitalization, he was seen by social work who documented that he was baffled as to how he had contracted hepatitis C but offered that he had endured many losses in his life including the death of his mother when he was 6 years of age and the death of his brother when he was 19, so felt he had developed strong coping skills. In terms of his social history, he reported that he was engaged to be married and worked as a mathematics and physics professor at a prestigious university as well as an

engineering consultant in the private sector. He also reported that he had sustained a number of musculoskeletal injuries resulting in chronic pain while playing Division I football in college and that he had been drafted by the National Football League. Upon discharge from that admission, he established care with a primary care physician for ongoing management of chronic pain. At his initial appointment he reiterated the social history he provided to the social worker and signed a narcotics agreement.

On initial assessment in the emergency department by the psychiatry consult-liaison team, the patient was observed to be a young, overweight Asian male dressed in a plain white T-shirt and track pants. His hair was greasy, his fingernails were long and dirty, and one of the lenses of his eyeglasses had a small crack. He made poor eye contact and focused his gaze on his tablet computer for most of the interview. His affect was withdrawn and had minimal range. On interview, he began the conversation by requesting placement at an inpatient psychiatric facility for electroconvulsive therapy, reporting that he had been suffering from very low mood since his pregnant fiancee had been killed by a drunk driver ´ eight months ago. Because the electronic medical record indicated that he had been engaged to be married just one month ago, we asked him to confirm the date of his fiancee's ´ death, which he could not recall. He answered all questions in a matter-of-fact tone and showed very little range of affect. In terms of his mood, he did not elaborate on his experience other than to say he felt "depressed and suicidal" with the vague plan of jumping in front of a train. He evaded further discussion of his mood symptoms by spontaneously offering details of his social history. He spoke about his profession as a tenured mathematics and physics professor at a prestigious university although when asked about the nature of his research he could only vaguely describe studying "time bends in space using some of Einstein's old formulae." He spoke in some detail about his career as a varsity football player, citing football injuries as the source of chronic back pain. When asked to provide a collateral contact, he reported that both of his parents, multiple siblings, and cousins had died during his early childhood.

The patient was accompanied by a male friend who was casually but neatly dressed and of approximately the same age. The patient provided us with permission to speak with his friend who appeared uncomfortable, saying "I didn't know I'd have to talk!" He reported that he and the patient were work colleagues who had known each other for a few years but refused to reveal where they worked. He provided no further information, other than saying "He's been really depressed and I just know he needs help before something happens." He then quickly left the hospital without saying goodbye to the patient.

Although, the patient initially reported that both parents were deceased, his father was listed as an emergency contact in his medical record. When confronted with this, the patient said that this was his step-father and gave consent for contact. The father reported that, five years ago, his son graduated with poor grades from a university which does not have a Division I football team. He confirmed the patient had played football in high school and had sustained multiple concussions. The year after graduation, the patient had lived with his parents briefly, but because of escalating narcotic use and lack of employment was asked to leave. Since then, he has suffered from severe opioid use disorder and has been homeless and unemployed. He has travelled to various hospitals within the city and even out of state to seek pain medication and care and has told a similarly fictional narrative to other physicians.

We obtained information from a local emergency community outreach agency which indicated that the patient had presented with the chief complaint of suicidality to multiple emergency departments in the city resulting in two previous inpatient psychiatric stays over the

past year. We obtained records from his most recent inpatient psychiatric hospitalization about six months ago, where he presented with depression related to his girlfriend's putative recent breast cancer diagnosis. He was discharged on an antidepressant, a mood stabilizer, and oxycodone for chronic back pain.

When gently confronted with these inconsistencies, the patient appeared unperturbed and easily provided further elaborate details to explain them. However when further pressed, he stated he believed he needed a "dramatic" reason for his depression and suicidality to receive help and asked, "Can I just be depressed and suicidal?" He appeared perplexed as to why we attempted to clarify his previous statements or their relevance for his care. Despite this, he continued to state that he felt very depressed and would not be able to maintain his safety in the community.

Case Study 2 (Trichotillomania)

Amelia had the most pleasant smile and was an energetic and highly motivated person. She was a small, 20 year-old, African American woman, with short dark hair. Amelia was attending college, pre-med. She had dreams of becoming a pediatrician. Amelia had concerns of her hair pulling behavior. At the age of 8 years old she became shamefully aware that she pulled her hair. Amelia's stepmother had noticed her playing with her hair and yelled at her, telling her "you will be a hideous woman that no one will ever like if you pull out all your hair." A few years later she had also noticed and admired one of her great uncle's bushy eyebrows. Her family told her that if she did not pull her hair out, then she would be beautiful too. The stress of school, family, and work had been weighing heavily on her. Amelia noticed that she had been pulling out more hair and more frequently.

Most people in Amelia's high school would often look at her with disgust, shock, or they would ignore her. She always felt insecure about the patchy bald spots on her head. She would sometimes wear wigs or hats to try to cover up her bald spots. Amelia often had thoughts of "wanting to be pretty like other girls" and "wanting to have full pretty hair" like other girls. Some of her peers would actively ridicule her and refer to her as an old balding woman or having mange.

When Amelia was 17 years old she met a boy, Mason, in whom she had some interest. He was the first person in Amelia's life who did not react to her bald spots with disgust or surprise. She quickly felt more romantically attached to him and they dated throughout high school. Following high school, Amelia married Mason, they moved in an apartment together, and began college together. Mason loved Amelia for who she was and thought she was beautiful regardless of her physical appearance.

Amelia liked to be involved in as many activities as she could because she enjoyed being busy and she wanted to prepare herself for medical school. Amelia volunteered with numerous organizations at her university and off-campus. She also was a biology tutor on campus. Amelia found that when she was highly stressed with many tasks to complete, she would find herself pulling more hair. Amelia began pulling hairs on her head and then would also pull her eyebrows. Recently, Amelia has only been pulling hairs from the back of her head which was increasing the bald spot on her head.

Along with hair pulling, Amelia found herself missing deadlines of work and being late to volunteer activities. Amelia was also getting lower grades in her classes. Driving to school became problematic for Amelia as well. She would sometimes find herself feeling anxious and distracted while driving, pulling out her hair. Amelia would think of all the things she did not do and things that needed to be done. Once while driving, Amelia had almost hit another car at a stop light. She was able to veer off the road and avoid the accident.

Amelia had been attending group therapy to work on interpersonal skills and relational concerns of how to be more assertive with people. She wanted to learn affective strategies to approach others with confidence, especially as she prepared for medical school and future interviews. While in group therapy, Amelia realized that she should attend individual therapy to specifically work on trichotillomania and ways to effectively manage her stress. Amelia attended individual therapy to treat her symptoms and work on her goals.

Amelia discussed wanting to stop pulling her hair with her therapist. She stated that she wanted to focus on trichotillomania because it was not addressed previously in therapy and she wanted to stop pulling out her hair. She is not always aware of when she pulls her hair but told the therapist that she is most aware of pulling her hair when she is experiencing more stress in her life. As she has been recently experiencing more and more stress, her desire to stop pulling her hair has also increased. She told her therapist that she tried vitamin supplements to regrow her hair and other things but none of them have ever worked and that she was hopeful that therapy would help.

Amelia had no health concerns or birthing complications as a child. Amelia was the oldest of three children, she had a younger brother and sister. Amelia's parents divorced when she was 6 years old and her father remarried 4 months later. Amelia did not have a good relationship with her stepmother; she often blamed her parents' divorce on her stepmother. Amelia's stepmother also would frequently yell, call Amelia names, and fight with her. Amelia called the police one night after a fight with her stepmother, in which her stepmother had thrown her into a wall, leaving a large hole in the wall.

Amelia's relationship with her father was distant. Her father would rarely talk with her and would encourage Amelia to go to her stepmother to sort out all of her problems, which left her bitter toward her father. Amelia was not very close to her siblings and often felt that she had to be more of a mother to them than a sister. She believed that she had to protect them from her stepmother.

Amelia's closest relationship is with her husband. She and her husband currently live together and are attending the same university. Her husband Mason is supportive and encouraging of Amelia. Her husband is the only source of support and the only one who does not judge her.

Case Study 3 (Antisocial Personality Disorder)

G.A., 50 years old, is admitted to the psychiatric ward of Bacau County Hospital on 29.09.2012, in the conformity with the ordinance Prosecutor to assess mental status. The patient brought to the prison of Targu Ocna hospital was arrested for attempted murder, assault against morality and public disturbance. In fact, in the morning of August 7, at around 3, being in a

public venue, under the influence of alcohol, his partner has applied several stab wounds in the abdomen with impaired liver and spleen.

Historical

The case study subject completed eight years and worked 30 years as a labourer. He lives in concubinage with the victim for 17 years, concubinage after which resulted two children recognized by the father. He has three convictions in the record:

1. desertion from the army--one year and eight months imprisonment;
2. concealment theft--seven years imprisonment;
3. theft--one year imprisonment.

Medical history

It originates from the detention sheet that the patient was diagnosed with pulmonary TB 15 years ago. He also has a ticket out of the hospital with the diagnosis "Delirium tremens. Organic personality disorder ethanolic fund".

Clinical exaxination devices: there is no evidence of disease.

Psychiatric exam

--Neat;

--Defensive attitude (depression);

--Easy psychic contact, answers questions;

--Recognizes and relates some of the events, which also reminds him stating that he does not recall some of the sequences/facts;

--Consciousness: the conscious, oriented temporal-spatial, and autopsihic allocated admits alcohol and nervousness, aggression and violence, alcohol and having no consciousness of personality and behaviour disorders, which are not considered a disease;

--No disturbance of perception, attention present;

--Memory: no major disturbances of memory, thinking, judgment and reasoning;

--Language: appropriate level of training and intellect--normal;

--Imagination: the rich imagination, deep, prominent elements of jealousy and appropriate interpretative tendencies and mental state due to alcohol;

--Affectivity: reactive depression, marked lability, guilt, blame, derealisation;

--Will and voluntary activity: decreased ability instinctively, the inability to control impulses and suppression of aggressive actions and minimum intensity conflicts;

--Instinctual life at baseline, primary;

--Personality: amended, impulsivity, aggression, self-and hetero-aggressiveness, irritability, difficulties in socio-professional integration and family values and moral standards in non-compliance with their multiple violations;

--Has difficulty sleeping, decreased appetite and weight loss.

Case Study 4 (Pathological Lying)

The patient was 15 when he was first referred to a psychologist by his parents and physician. At the time, he had repeatedly complained of migraine headaches, which led to him missing many days in school. After the patient had been assessed by a physician and there were no signs of a prevailing psychological disorder, his doctor and parents thought he should seek psychological treatment. The patient had been in psychotherapy for about one year in six months before being terminated. Now that the patient is 22 years old he has recently sought psychotherapy on his own volition. He presented by claiming that he has a history of lying and that has caused him difficulties within his social relationships. He stated that he has never had any legal problems and never engaged in violence or aggression but just seemed to get into situations where he would make up many details about anything. He stated that he frequently lied to his parents, which led to him being in therapy the first time. He also reported that he lied to his therapist the entire time he was in therapy. The patient reported that he told his therapist that he had nightmares, problems sleeping, and frequently experienced headaches. The patient stated that he currently feels guilty for having cost his parents so much money for a therapist during his adolescent years. He stated that he lies less than he did in the past but still finds himself lying to other people, in that he will tell a lie that seems to grow into more stories and exaggerations. The patient said that when he lies to people he will feel guilty and ashamed afterwards and wanted to learn how to stop telling lies to people.