Histrionic personality disorder

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Personality DISORDERS

Toward the DSM-V

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Contents

8 Histrionic Personality Disorder

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Histrionic personality disorder (HPD) is familiar to clinicians who attend to personality pathology and to literature devotees who ponder the nature of superficially dramatic, manipulative, and insatiably attention-seeking characters such as Blanche DuBois in Tennessee Williams's play *A Streetcar Named Desire.* Millon, Grossman, Millon, Meagher, and Ramnath (2004) provided the following description of HPD across nine clinical domains: behavioral acts are dramatic, interpersonal conduct is attention seeking, cognitive style is flighty, self-image is gregarious, representations of others are shallow, regulatory mechanisms rely on dissociation, the psychic structure is disjointed, and the mood and temperament are fickle. Despite its familiar feel, HPD remains enshrouded in a degree of historical confusion and conceptual uncertainty that researchers have not yet resolved. In this chapter, we track some of the theoretical and empirical efforts in clarifying the nature of HPD, summarize the available literature on treatment recommendations for the disorder, and propose directions for future research.

Current Definition

The current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association [APA], 2000) defines HPD primarily as a pervasive pattern of excessive emotionality and attention seeking that begins in early adulthood and presents across situations. Individuals may receive the diagnosis (code 301.50) if they meet five or more of eight criteria (APA, 2000, p. 714):

(1) is uncomfortable in situations in which he or she is not the center of attention

(2) interaction with others is often characterized by inappropriate sexually seductive or provocative behavior

(3) displays rapidly shifting and shallow expression of emotions

(4) consistently uses physical appearance to draw attention to self

(5) has a style of speech that is excessively impressionistic and lacking in detail

(6) shows self-dramatization, theatricality, and exaggerated expression of emotion

(7) is suggestible, i.e., easily influenced by others or circumstances

(8) considers relationships to be more intimate than they actually are

Thus a person with HPD may behave theatrically, dress provocatively, make up stories, engage in flattery and flirtation, complain of dramatic ills, throw a tantrum, or make a suicidal gesture all to draw attention to the self. The individual may fail to focus attention on the self, in which case the associated features of manipulativeness, inappropriate seductiveness, and dependency may become apparent. These features, along with a cognitive/emotional style characterized by shallow investment, excitement seeking, and shifting interests may thwart the person's relationships, thus depriving him or her from much-sought attention and leading to distress and depression. The DSM-IV estimates a 2% to 3% prevalence in the general population and a 10% to 15% prevalence in mental health settings (see Blashfield & Davis, 1993, for a higher estimate of 24%). HPD prevalence appears to be equal in men and women (Nestadt, Romanoski, Chalel, & Marchant, 1990) in nonclinical settings, even though in clinical ones more women received the diagnosis than did men. Means of attention seeking and dramatic expressiveness may vary across culture, gender, and age. Because of its hypothesized pervasive nature and resistance to change, the disorder is coded on Axis II (Cluster B).

Historical Roots

Hysteria

HPD shares a divergent history with the Axis I somatoform conditions called conversion disorder (a sensory or motor deficit due to psychological causes that mimics a neurological disorder, code 300.11) and somatization disorder (recurring and clinically significant somatic complaints other than pain not fully explained by a general medical condition, code 300.81). Historically, they are all linked to the ancient concept of *hysteria*, or "wandering womb." Such authors as Hippocrates and Plato attributed conversion symptoms and emotional outbursts in women to a displaced uterus caused by sexual discontent, reflecting Greek society's derogatory view of women as irrational creatures of lust. Similarly, Christian asceticism during the Middle Ages and the Reformation blamed women's mental illness on involvement in witchery due to sexual hunger and moral weakness in resisting Satanic temptation. During the Enlightenment and through the 19th century, medicine struggled to divorce itself from theological doctrines of possession. Explanations of hysteria shifted to a constitutional weakness of women's nervous system caused by their biological sex. Thus, whether physical or spiritual, and despite the fact that hysteria was diagnosed with increasing frequency in men, the construct tended to reflect the predominant sociocultural stereotype of women as inherently vulnerable, inferior, and emotionally uncontrolled. The extent to which the current criteria for HPD reflect gender bias remains the subject of a controversy today (see below).

Conversion Hysteria and Hysterical Personality

The term *hysteria* has been used to denote a variety of conditions ranging from extreme reactions to stress to isolated conversion symptoms, somatization, immaturity, a personality disorder (PD), or a personality trait (Easser & Lesser, 1965; Lazare, 1971; Pfohl, 1991). The differentiation between conversion hysteria and hysterical personality began with psychoanalytic literature on character as well as with the writings of Kraepelin, Schneider, and Kretschmer (see Bornstein, 1999). Freud's famed case work in this area (e.g., Freud & Breuer, 1895/2000) dealt primarily with conversion hysteria (e.g., the neurologically inexplicable loss of sensation in part of the body), which he explained as a neurotic compromise among sexual urges and internalized societal prohibitions. Psychoanalytic authors sought the origins of hysteria in the psychosexual development of the child (e.g., Abraham, 1927/1948; Fenichel, 1945; Marmor, 1953) and speculated about the importance of character (or personality) to the formation of symptoms. Reich (1933, 1949) drew attention to hysteria as a set of personality characteristics and differentiated conversion hysteria as a transient functional disorder from hysterical character (see Baumbacher & Amini, 1980–1981; Shapiro, 1965). The early analytic conceptualizations of both kinds of hysteria carried notions of women's deficiency

due to penis envy and feelings of castration. In this way, they paralleled the antiwoman sentiment seen throughout the history of hysteria (Chodoff, 1982). Current psychoanalytic thought regarding histrionic personality has evolved considerably, and will be discussed in the section on psychotherapy.

The concept of hysterical personality was well developed by the middle of the 20th century (Alam & Merskey, 1992) and strongly resembled the current definition of HPD. DSM-I (APA, 1952) featured a symptom-based (neurotic) category, "hysteria" (conversion), and a personality-based category, "emotionally unstable personality." DSM-II (APA, 1968) distinguished between hysterical neurosis (conversion reaction and dissociative reaction) and hysterical (parenthetically, histrionic) personality. DSM-I and DSM-II received much criticism for their poor psychometric properties (Nathan, 1998). Nevertheless, they contributed to clarifying the distinction between conversion symptoms and hysterical personality, a concept that later found support in early empirical studies (e.g., Luisada, Peele, & Pittard, 1974).

Somatization and Briquet's Syndrome

Hysterical personality underwent further differentiation as findings emerged that, despite some overlap between hysterical personality and somatization, the two were not the same (Pollak, 1981). For example, in a survey of 91 psychiatric residents and faculty, Slavney (1978) found that all considered self-dramatization, followed by attention seeking, emotional instability, and seductiveness, to be the most diagnostically important and reliably recognized features of hysterical personality. These participants ranked conversion symptoms among the least important and reliable symptoms. The notion that hysterical personality features covaried with somatization symptoms persisted for some time in the diagnostic entity of Briquet's syndrome. Difficulties in distinguishing patients with isolated somatization features from patients with the more severe and pervasive Briquet's syndrome (e.g., Cloninger, Martin, Guze, & Clayton, 1986; Liskow, Clayton, Woodruff, Guze, & Cloninger, 1977) contributed to abandonment of the notions of hysteria and Briquet's syndrome and to the emergence of somatization disorder in DSM-III (APA, 1980).

HPD may not be as strongly associated with somatization disorder (SD) as might be expected from their shared historical roots. Estimates of HPD prevalence in individuals with SD have varied from 7.4% to 81.8% across samples (Rost, Akins, Brown, & Smith, 1992). The heterogeneity in these estimates is probably attributable to differences in both criteria used to operationalize SD and the characteristics of each sample. Using a structured interview (the Structured Clinical Interview for DSM-III-R Personality Disorders [SCID-II; Spitzer, Williams, & Gibbon, 1987]) with 94 patients with SD recruited from primary practices in Arkansas, Rost and her colleagues found prevalence rates of 12.8% for full-criteria HPD and 10.6% for subthreshold HPD (compared with an HPD prevalence of less than 5% in the general medical population). However, 61% of the patients had a co-occurring PD, the most

prevalent PDs being avoidant, paranoid, self-defeating, and obsessive-compulsive. The authors speculated that these latter disorders may predispose patients to SD due to an overall discomfort with feelings, inability to view oneself as deserving of good health, or concerns over becoming sick. These PDs may go undocumented in patients with SD because they often do not prompt clinicians in general medical settings to consider a consultation with a mental health professional. On the other hand, patients with histrionic, antisocial, and borderline PDs, due to their interpersonally disruptive outbursts, are more likely to be referred for a psychiatric evaluation, and hence these disorders' co-occurrence with SD relative to that of other PDs may have been overestimated in older studies.

Histrionic Personality in DSM-III and DSM-III-R

In DSM-III (APA, 1980), the term "hysterical personality" was changed to "histrionic personality" to emphasize the histrionic (derived from the Latin word *histrio*, or actor) behavior pattern and to reduce the confusion caused by the historical links of the term hysteria to conversion symptoms (Chodoff, 1974; Spitzer, Williams, & Skodol, 1980). Some DSM-III criteria dropped out of the DSM-III-R (APA, 1987; i.e., craving for activity and excitement; irrational, angry outbursts or tantrums; and proneness to manipulative suicidal attempts) as a way of reducing the diagnostic overlap with other conditions, particularly borderline PD. Criteria 2 (inappropriate seductiveness) and 8 (impressionistic speech) in the DSM-III-R, in contrast, had been absent in the DSM-III and represent a return to the historical roots of the disorder.

Livesley and Schroeder (1991) examined the factorial structure of dimensional self-report ratings of PD symptoms in a sample of 274 heterogeneous volunteers and 133 patients with a primary diagnosis of PD and no major DSM-III-R Axis I diagnosis. Participants rated themselves on a five-point scale along symptoms of antisocial, borderline, histrionic, and narcissistic PDs as defined by the consensual judgment of a sample of psychiatrists familiar with the literature. The solution for HPD yielded four factors, two that appeared to overlap with other disorders (an exploitativeness factor similar to one seen in BPD, and a dependency factor similar to the DSM-III-R construct of dependent PD) and two that appeared specific to HPD: one representing the hysterical cognitive style and one related to dramatization.

According to Pfohl (1991), all criteria but 1 (constant demands for reassurance and praise) and 7 (self-centeredness and low frustration tolerance) for HPD in the DSM-III-R had good sensitivity coefficients and contributed to the overall internal consistency of the diagnosis.

External Validity of HPD

Pollak (1981) and Pfohl (1991) summarized research findings on HPD and concluded that sufficient evidence had accrued for the disorder's external

validity. One concern, however, is that many of the older findings may be based on operationalizations of HPD that are not fully consistent with the current definition. Furthermore, many of the findings have not been sufficiently replicated. Unlike other PDs such as antisocial and borderline, we know little about the relation of HPD, particularly in the general population, to some of the most theoretically and clinically relevant external criteria. For example, we know little about its links to relationship satisfaction and stability, employment history, general health, and life satisfaction. Below we summarize some of the more recent findings that modestly build upon the reviews by Pollak (1981) and Pfohl (1991).

Projective Testing and Defense Style

Blais, Hilsenroth, and Fowler (1998) correlated DSM-IV symptom counts for HPD, as well as borderline, antisocial, and narcissistic PDs, with Rorschach variables in an archival study of 79 records of PD patients. Consistent with previous literature, only HPD symptoms correlated with the *FC* + *CF* + *C* and *T* indices from the Exner system (r_s = .35 and .30, $p < .01$) with controlling for the number of responses (*F* denotes "form" responses, *C* denotes "color" responses, and *T* denotes "texture" responses). The *FC* + *CF* + *C* variable measures the number of responses based primarily on color features of the blots and has been hypothesized to reflect emotionality, whereas *T* reflects the use of texture by the respondent and may be indicative of loneliness and interpersonal neediness. *FC* + *CF* + *C* tended to correlate with ratings of the DSM-IV symptoms of seductiveness, shallow emotion, impressionistic speech, and focus on appearance, whereas *T* was linked to attention seeking, self-dramatization, misconstruing of the intimacy of relationships, and impressionistic speech. In addition, the attention seeking symptoms and scale 3 (Hysteria) of the Minnesota Multiphasic Personality Inventory–2 (MMPI-2) were linked to Lerner's denial (DEN) index for the Rorschach.

In Cramer's (1999) study of 91 adults of age 23 (45 men and 46 women), ratings of denial and projection based on the Thematic Apperception Test (TAT) correlated with the extent to which participants' California Q-Set profiles matched expert prototypes of borderline, psychopathic, narcissistic, and histrionic pathology. When defenses were coded as mature versus immature, immature denial and identification predicted histrionic features, with immature identification predicting histrionic pathology but not features of the other three disorders. The findings contradicted the proposition that histrionic features would be linked to maturity more so than would those of other PDs. Instead, like other kinds of personality dysfunction, histrionic personality exhibited a continuum of severity such that the more histrionic the person, the more immature his or her defense style. The nonclinical nature of the sample limits further interpretation. Nevertheless, it should be noted that the evidence linking *C* responses to emotionality is at best equivocal (Frank, 1990).

Neurocognitive Findings

The literature on neurocognitive and other biological markers of HPD is limited. Shapiro (1965) proposed that a global cognitive-perceptual style predisposes people to a hysterical personality, and Millon (1981) suggested that hysterical individuals lack cognitive-perceptual integration. Tests of derivative hypotheses have generally not found links between measures of histrionicity and perceptual variables (see Cale & Lilienfeld, 2002; Maynard & Meyer, 1996; Yovel, Revelle, & Mineka, 2005). In comparison with people with obsessive-compulsive tendencies, participants with histrionic personalities appear to be less rigid in their cognitive style but not necessarily inattentive to detail or distractible (Sacco & Olczak, 1996).

Biological Findings

Svanborg, Evenden-Matilla, Gustavsson, Uvnas-Moberg, and Asberg (2000) recruited 99 participants who were either beginning or undergoing nonpharmacological treatment for mood ($n = 37$) or anxiety ($n = 29$) disorders. The participants completed personality self-report questionnaires and a modified SCID-II screening questionnaire (Ekselius, Lindstrom, von Knorring, Bodlund, & Kullgren, 1994; Spitzer et al., 1987). There were no significant associations between symptom and personality measures and plasma levels of insulin or glucagon. Low fasting plasma glucose levels were associated with low Global Assessment of Functioning (GAF) scores, high scores on an impulsivity questionnaire, and a high number of self-assessed histrionic and narcissistic traits in men. In women, the relationship between glucose level and histrionic traits was also significant but positive. In light of previous research linking diminished glucose levels to cognitive impairment (Taylor & Rachman, 1988), social-emotional distress (Messer, Morris, & Gross, 1990), and antisocial behavior (Virkkunen, 1986), Svanborg and his colleagues (2000) suggested that the relationship between histrionicity and low glucose in men may indicate that the traits are maladaptive for men. The reverse relationship in women may suggest that for them such traits are linked to better adaptation. The conclusions remain speculative and call for attempts to replicate these studies.

Discriminant Validity, Co-occurrence, and Comorbidity

When a PD such as HPD is diagnosed with other DSM disorders in the same individuals, it may be difficult to judge whether the issue at stake is poor discriminant validity of the diagnostic criteria (e.g., diagnostic overlap), true comorbidity, or co-occurrence (Lilienfeld, Waldman, & Israel, 1994). This is especially true of HPD, due to the limited amount of research literature and variability and inconsistency in the use of assessment methods and diagnostic criteria.

Borderline and Narcissistic Personality Disorders

In the 1980s, researchers observed substantial overlap between borderline PD and other PDs (e.g., Widiger & Rogers, 1989). In a review of studies conducted from 1983 to 1990, Grueneich (1992) found that HPD was the PD most frequently associated with borderline personality disorder (BPD), with a median reliability of .44 for four studies using DSM-III criteria. Grueneich noted that the association between HPD and BPD appeared to be lower in studies using DSM-III-R criteria, probably due to the removal of two overlapping items: angry outbursts and manipulative suicidal gestures. In studies of emotional regulation and identity disturbance, Westen (see Westen & Heim, 2003; Wilkinson-Ryan & Westen, 2000) reported a subtype of BPD with salient histrionic features. Thus, the links between HPD and BPD are likely to be revisited in the future. Criterion discrimination between HPD and narcissistic personality disorder (NPD) is still poor in the DSM-IV (Blais & Norman, 1997).

Dependent Personality Disorder (DPD)

The notion that dependency characterizes HPD disappeared from the DSM under pressure to improve discriminant validity and to reduce the overlap between HPD and DPD. Nevertheless, the psychodynamic notion that underlying dependency motivates attention seeking in HPD has not been ruled out. In a sample of 491 psychology students, Bornstein (1998) found that those who met criteria for HPD and DPD on the Personality Diagnostic Questionnaire—Revised (PDQ-R; Hyler, Skodol, Kellman, Oldham, & Rosnick, 1990) had comparable scores on an implicit dependency index derived from the Rorschach. Furthermore, students with HPD and DPD scored higher on this measure than did students with other PDs or no PDs. The dependency scores on a self-report inventory did not differ among students with HPD, students with other PDs, and students with no PDs, whereas students with DPD scored higher than the other three groups on this explicit measure.

Bipolar Disorder

Even though a small body of literature reveals overlap between HPD and mania, the finding is limited to structured interviews that rely heavily on retrospective self-report (Strakowski, McElroy, Keck, & West, 1994) and may reflect method bias. Histrionic personality and hypomanic states may share impulsivity and extraversion. Indeed, Schotte, De Doncker, Maes, Cluydts, and Cosyns (1993) observed that high scores on scale 9 (*Ma*) and low scores on scale 0 (*Si*) of the MMPI were most indicative of DSM-III-R HPD in an inpatient Dutch sample (assessed using the SCID-II). Furthermore, the ability of scales 9 and 0 as well as Morey's HST Scale (Morey, Waugh, & Blashfield, 1985) to predict HPD could be derived from their assessment of introversion-extraversion. In addition, bipolar spectrum disorders and HPD

share features of mood lability and emotional dysregulation, as Perugi et al. (1998) observed in a study of atypical depression. Within their sample of individuals with mood disorder and comorbid DSM-IV HPD, none met criteria for unipolar depression, whereas most met some criteria for bipolar II or cyclothymic disorder. Similarly, Westen and Shedler's (1999) empirical prototype for HPD contains items describing emotional dysregulation (i.e., "unable to soothe or comfort self when distressed," "emotions tend to spiral out of control," "emotions tend to change rapidly and unpredictably," and "tends to become irrational when strong emotions are stirred up"). The possibility that HPD and mania share an underlying cause or that HPD may predispose individuals to bipolar disorder requires further study.

Depression and Anxiety

HPD has been thought to make sufferers vulnerable to depression, anxiety, and parasuicidality due to its interference with obtainment of the relationships and attention such individuals so strongly desire. In a study of the relationship between PD symptomatology and Axis I disorders in an ethnically heterogeneous community sample of adolescent girls (Daley et al., 1999), 20.31% of the patients, (n = 63) met cutoffs for HPD on the Personality Diagnostic Questionnaire (PDQ; Hyler, Reider, Spitzer, & Williams, 1982) for DSM-III or the PDQ-R (Hyler et al., 1990) for DSM-III-R. Overall PD scores predicted concurrent depression scores as well as depression scores at follow-up 2 years later. Cluster B PD symptoms added to predictive power. HPD's relative contribution was unclear, but HPD was deemed present in 59% of the patients with a Cluster B disorder, who, in turn, comprised 34.38% of the sample. Thus, HPD may have been a factor in the development of depression (see also Crawford, Cohen, & Brook, 2001b) in light of the fact that the DSM-III and DSM-III-R criteria for HPD overlapped with those for BPD, which may be a better predictor of future Axis I symptoms than HPD. Using the SCID for the DSM-III-R, Ampollini and his colleagues (1999) selected 42 outpatients with panic disorder, 18 with major depression, 29 with both, and 48 healthy controls. Evaluations with the revised version of the Structured Interview for DSM-III-R Personality Disorders (SIDP-R; Pfohl, Blum, Zimmerman, & Stangl, 1989) by clinicians blind to Axis I diagnosis revealed that patients with panic disorder and patients with both panic disorder and major depression had significantly higher rates of HPD compared to controls or to patients with major depression alone. These and other studies support the notion that HPD may be comorbid with depressive and anxiety disorders.

Etiology

Little is known about the etiology of HPD. The clinically intuitive belief that HPD may develop in children whose strong needs for attention were met

inconsistently by their parents is prevalent (Kraus & Reynolds, 2001), but it has not received rigorous tests. Coid (1999) examined the histories of 260 adults in forensic settings for specific risk factors related to DSM-III Axis II pathology and was unable to establish associations between HPD and developmental adversity or temperamental factors. Below we summarize some of the positive findings.

Genetics

Research on genetic contributions specific to HPD is insufficient. According to Maier, Franke, and Hawellek (1998), evidence for genetic contributions to personality pathology has accrued overall, but the findings vary across different disorders. Cluster B disorders, in particular, have not emerged as highly heritable. Research on the genetics of neurochemical mechanisms governing the dopaminergic and serotonergic systems of the brain has sparked interest, but it requires further study and replication. Torgersen and his colleagues (2000) interviewed 221 adult twin pairs (92 monozygotic [MZ] and 129 dizygotic [DZ]) about their lifetime histories of mental disorders. Using data collected with the SCID-II (Spitzer et al., 1987), they compared the prevalence of HPD among MZ and DZ probands and their co-twins. HPD yielded a substantial heritability coefficient of .67 in an AE model (which includes additive genetic factors and excludes shared environment) and a .52 effect for shared environment in a CE model (which includes shared environment and excludes genetic factors). Thus even though the study's authors emphasized the genetic factors, their findings suggest that both genetic and environmental factors are influential in the development of HPD. The study was limited by the primarily Norwegian sample and the fact that MZ status may be confounded in the classic behavior genetics model (e.g., by evocative genotype-environment correlations). For example, the higher concordance of HPD in MZ twins may be due to their more similar treatment by adults and peers in childhood and adolescence based on their similar appearance.

Developmental Considerations

Clinicians have long theorized about the contribution of developmental events and family environment to the development of HPD, but the links remain speculative. In this section we review four studies that point to possible developmental trajectories and developmental contributors to HPD.

Cohen and his colleagues (1994) compared 473 persons 55 years old or younger to 289 older individuals in a community sample, and they found that the two cohorts differed significantly on the prevalence of two DSM-III PDs: antisocial and histrionic. HPD prevalence was 4.3% in the younger and 2.2% in the older sample, consistent with the common view that PDs are observed less frequently in older populations because of either lesser prevalence or lesser

severity. Possible explanations include cohort effects, age bias in diagnostic criteria, early mortality due to risky or impulsive behavior or suicide, social-emotional development due to learning, cortical maturation, and age-related neurochemical changes leading to decreased impulsivity or emotionality.

Baker, Capron, and Azorlosa (1996) screened undergraduates to find women who scored high on only the histrionic or the dependent scale of the Millon Clinical Multiaxial Inventory (MCMI; Millon, 1982) and also met DSM-III-R criteria for HPD or DPD but no other PD (as assessed by the SCID-II). Thus, 15 young women with "clean" HPD, 15 with DPD, and 15 controls completed a Family Environment Scale with 10 dimensions. The groups were similar on family cohesion, expansiveness, conflict, active-recreational orientation, moral-religious emphasis, and organization. The HPD group was higher than the DPD group and similar to controls on independence and achievement orientation. Participants with HPD rated the intellectual-cultural orientation of their families higher than did those with DPD or the controls. Both women with HPD and those with DPD rated their families higher in control than did controls. The study may be limited by the nonclinical nature of the sample and by the retrospective nature of the measures. In particular, people with HPD may recollect their family environments in ways consistent with their personality traits or interpersonal goals.

Crawford, Cohen, and Brook (2001a) assessed a large mixed-gender sample before age 10 and at ages 13, 15, and 20 using symptom scales for HPD, NPD, and BPD derived from items on the PDQ (Hyler et al., 1982), SCID-II (Spitzer et al., 1987), and other instruments. Overall, Cluster B pathology proved stable over time, yielding stability estimates of .63 in boys and .69 in girls over 8 years old. Specific disorder categories were less stable, with the likelihood of receiving a histrionic or narcissistic diagnosis declining between ages 13 and 18. Overall, Cluster B symptoms were strongly linked to internalizing symptoms in girls and to externalizing symptoms in both boys and girls, but the authors did not provide a breakdown of specific PDs. Subsequent analyses of the same data (Crawford et al., 2001b) indicated that in girls, internalizing symptoms at ages 10 to 14 predicted Cluster B symptoms in midadolescence, whereas externalizing symptoms at ages 12 to 17 predicted Cluster B pathology in young adulthood.

Cultural Factors

DSM-IV-TR cautions that cultural factors may affect specific manifestations of HPD symptoms, but it has been criticized for its lack of specificity regarding the nature of such factors and their specific impact on the diagnosis of most PDs and HPD in particular (Alarcon, 1996). For example, several authors hypothesize that HPD may be diagnosed less frequently in Asian and other cultures that discourage overt sexualization and more frequently in Hispanic and Latin American cultures that sanction overt sexuality (Johnson, 1993; Padilla, 1995; Trull & Widiger, 2003). However, there has been no

systematic study of cultural differences in the presentation of HPD or of cultural factors in its etiology. Such factors have been examined in relation to the other two descendants of hysteria (conversion and somatization). In a transcultural psychiatric study of "hysterical structure" with a sample of 30 African and 30 Belgian patients matched for age, sex, and socioeconomic status, Pierloot and Ngoma (1988) found that the African patients tended to experience somatic symptoms resembling organic ones (e.g., headaches), while the Belgian patients were more likely to experience psychic symptoms (e.g., apathy). Additionally, while African patients were more likely to attribute their problems to supernatural forces, Belgian patients were more likely to cite internal causes. While this study examined differences in cultural manifestations of "hysterical structure" (a construct comprising mixed features of HPD and somatization disorder), its findings can be considered a preliminary indication that further examination of cultural differences in HPD is needed.

Conceptual and Diagnostic Issues

Seductiveness and Sexualization

DSM-II described the hysterical or histrionic personality as "often seductive" for the purpose of self-dramatization (with or without awareness), whereas DSM-III omitted the seductiveness criterion due to critiques citing gender bias. Seductiveness reappeared in DSM-III-R and DSM-IV, phrased as an objective criterion with an emphasis on sexualized and seductive behavior under inappropriate circumstances. Such items as "tends to be overly sexually seductive or provocative, whether consciously or unconsciously," "fantasizes about finding ideal, perfect love," and "tends to choose sexual or romantic partners who seem inappropriate" were highly descriptive of the HPD prototype derived empirically by Westen and Shedler (1999).

Despite its centrality to the description of the disorder, the nature of seductiveness in HPD has received little rigorous empirical attention. Psychoanalytic writers observed that the coquetry of people with hysterical personalities easily turns into disparagement (e.g., Reich, 1949). These authors suggested that hysterical individuals may deal with their anxiety surrounding close relationships by "acting it out" in the form of pseudohypersexuality (Fenichel, 1945) while avoiding true intimacy and remaining sexually unsatisfied. Modern psychodynamic thinkers similarly view sexualization as a counterphobic defense (McWilliams, 1994). This hypothesis has not received rigorous empirical tests and seems difficult to falsify, as doing so would require the development of a valid measure of sexual avoidance.

Comparing 33 women with HPD with 33 randomly selected women with similar demographics (all participants were drawn from a marital therapy program), Apt and Hurlbert (1994) found meaningful differences on self-report measures of sexual attitudes. Women with HPD reported greater sexual self-esteem, but also greater levels of sexual boredom, erotophobia,

orgasmic dysfunction, lower sexual desire, and more frequent extramarital affairs. Apt and Hurlbert proposed that "sexual narcissism" characterizes patients with HPD, whose preoccupation with receiving attention and being attractive leads them to believe that they are also great lovers. Because they engage in sexuality as a means of ego gratification but do not experience intimacy or reciprocate, their sexual experiences are unsatisfying.

In hierarchical cluster analyses by Turner (1994), seductiveness loaded with self-centeredness and excessive concern with attractiveness, lending support to the notion of sexuality serving a narcissistic function. Excessive need for attention, however, loaded on a separate cluster. Finally, Reise and Wright (1996) did not find a relationship between histrionic features on the California Q-Set and uncommitted sexual relations in 195 undergraduates, although the tendency toward uncommitted sex correlated significantly with narcissism and psychopathy prototypes in men. Together, these findings suggest that sexualization in HPD may be a facet of self-centeredness or a means of regulating self-esteem.

Histrionic Personality and Gender

The extent to which gender influences or biases the diagnosis of HPD remains debated. Bias may influence clinical decisions more easily when clinicians make global decisions without considering individual diagnostic criteria separately. Ford and Widiger (1989) obtained 381 psychologists' ratings (24% women) of a case history of a person with HPD, antisocial personality disorder (APD), or balanced features. The sex of the person was either male, female, or unspecified. Clinicians rated a number of Axis I and II disorders on a seven-point scale, with ratings of 5–7 indicating presence of the disorder. For balanced histories, clinicians made the HPD and APD diagnoses with approximately equal frequency across conditions of patient gender. When the history was consistent with APD, clinicians tended to diagnose it much less frequently in a woman (15%) than they did in a man (42%) or a person with unspecified gender (48%), but they tended to diagnose HPD (46%) in women. When the history was that of HPD, they diagnosed it at very high rates in women (76%), lower rates for unspecified gender (64%), and the lowest rates in men (44%). The HPD history of a man elicited relatively high ratings of APD compared with the other gender conditions, although this difference was not statistically significant. Clinicians' ratings of individual diagnostic criteria, however, did not differ by sex. One possible alternative to a "sex bias" interpretation of these findings is that clinicians may have correctly taken into account the base rates of APD (higher among men) and HPD (which may be higher among women in clinical settings) when making overall diagnoses.

Other studies have yielded inconclusive results concerning sex bias in HPD diagnosis. Belitsky et al. (1996) asked 96 psychiatric residents (45 women) to rate Ford and Widiger's (1989) case histories described above.

Participants who received the APD history were more likely to diagnose APD correctly if the patient was a man and to underdiagnose it when the patient was a woman. The sex of the patient did not influence HPD diagnosis in this study, although it may have influenced ratings of prognosis (HPD received a more favorable prognosis if the sex of the patient was female, but female sex of the patient also led to more favorable prognosis overall).

Bias may be present not only in clinician's judgments but also in the extent to which HPD criteria reflect feminine versus masculine gender roles. Sprock (2000) compiled lists of HPD behavioral examples for the DSM-III-R and DSM-IV criteria by asking 120 undergraduates (60 women) to read the criteria and provide examples for each. Counterbalancing for student gender, one third of the undergraduates received instructions to write behaviors that would typify men with HPD, one third wrote about women, and one third received gender-unspecified instructions. Sprock then sent subsets of behaviors to 157 clinicians (58 psychiatrists and 97 psychologists) and asked them to rate the extent to which the behaviors were representative of either the diagnostic criteria or their own overall conceptualization of HPD. Masculine behaviors received significantly lower representativeness ratings when compared with feminine or gender-unspecified behaviors in both the HPD criteria condition and the overall conceptualization of HPD. Following this, bias concerns may be addressed by writing diagnostic criteria thought to capture masculine manifestations of HPD (e.g., bragging or hypermasculinity), or as suggested by some (e.g., Sprock, 2000), criteria that have been found empirically to represent HPD equally well in men and women (e.g., dramatic exaggeration in speech or jealousy at inattention). Some researchers have voiced concerns, however, that such an approach may lower the validity of the construct (Widiger, 1998).

Antisocial Personality Disorder and Psychopathy

The description of histrionic personality, especially in men (e.g., Luisada et al., 1974), shares a resemblance with APD. Warner (1978) demonstrated that various mental health professionals are likely to label a patient description as hysterical personality if the patient's sex was said to be female, but to diagnose APD and hysterical personality at nearly equal rates if the sex was said to be male. Thus, Warner suggested that APD and hysterical personality could be gender-typed forms of the same condition. Indeed, APD and HPD appear to co-occur in individuals more often than would be expected if they each occurred by chance (Lilienfeld, VanValkenburg, Larntz, & Akiskal, 1986), and histrionic men report high rates of antisocial acts (Luisada et al., 1974). APD overlaps moderately with the construct of psychopathy (Cleckley, 1941/1982), as do certain features of HPD, such as shallow expression of emotion, seductiveness, manipulativeness, and dishonesty. Hart and Hare (1989) reported a significant correlation between HPD and scores on an interview-based psychopathy measure.

Standage, Bilsbury, Jain, and Smith (1984) predicted that histrionic women, like psychopathic individuals, may have low perspective taking abilities. They compared 20 female inpatients meeting DSM-III criteria for histrionic personality with 20 depressed female inpatients matched for age, expressive vocabulary, and depression scores. The groups did not differ significantly on a paper-and-pencil measure of perspective taking, but the histrionic women scored significantly lower on the Socialization scale of the California Psychological Inventory and higher on the Psychoticism and Lie scales of the Eysenck Personality Questionnaire. Thus the histrionic inpatients scored high on measures that may be expected to relate to psychopathy and APD, either due to overlap between these constructs and HPD or due to co-occurrence of APD and HPD features in the sample. Additionally, the histrionic women in Standage et al.'s (1984) study had greater rates of features often associated with APD, such as attempted suicide, drug and alcohol abuse, unemployment, and first-degree relatives with a criminal history, than did depressed controls.

In a group of 180 undergraduates (90 women; 64% Caucasian), Hamburger, Lilienfeld, and Hogben (1996) tested the hypotheses that psychopathy underlies both APD and HPD and that the relationship of APD and HPD with psychopathy is moderated by both biological sex and gender roles. Scores on the Psychopathic Personality Inventory (PPI; Lilienfeld, 1990) predicted scores on measures of both APD ($r = .48$ and .59) and HPD ($r = .16$ and .49) with an alpha of less than .05. Furthermore, the relationship between PPI scores and APD scores was stronger among men than it was among women, whereas the relationship between PPI and HPD scores was stronger among women. The classification of participants as masculine, feminine, androgynous, or undifferentiated, however, did not emerge as a moderator of the relationship between psychopathy and APD or HPD.

Cale and Lilienfeld (2002) examined the hypothesis that APD and HPD could be behavioral manifestations of psychopathy moderated by biological sex in a nonclinical sample of 75 actors (36 women). The authors sampled actors because they deemed it likely to find high levels and a wide range of HPD symptoms such as emotionality, attention seeking, and dramatization. Correlational analyses of self-report and peer ratings revealed that psychopathy was more strongly associated with HPD in women and with APD in men.

Thus, even though the association between HPD, APD, and psychopathy has been replicated, the extent to which HPD and APD are gender-typed manifestations of the same latent construct or simply co-occur remains unclear and calls for further study.

Theoretical Conceptualizations

Psychodynamic and cognitive conceptualizations of HPD have been the most influential in the clinical field and have had the greatest impact on treatment. Therefore, we address these conceptualizations in the section on psychotherapy

below. The dynamic and cognitive theories have met with increasing competition from neurobehavioral, trait, and attachment conceptualizations among researchers.

Neurobehavioral Model

According to Depue and Lenzenweger's (2001) neurobehavioral dimensional model, PDs are combinations of extremes on orthogonal traits of emotion, affiliation, and control. The ratio of agentic extraversion (or positive emotionality, mediated by the neurotransmitter dopamine in the ventral tegmental area) and neuroticism (or negative emotionality/anxiety, mediated by the central amygdala and the neurotransmitter norepinephrine) comprises one emotional dimension. Harm avoidance (fear, mediated by the stria terminalis and norepinephrine) comprises a second emotional dimension, whereas impulsivity (nonaffective constraint, mediated by serotonin) and affiliation (mediated by oxytocin and other gonadal steroids) are the nonaffective traits. In this model, HPD is characterized by a high ratio of agentic extraversion to neuroticism, low nonaffective constraint, and moderate to high affiliation. Theoretically, the high dopamine and low serotonin in these individuals predispose them to gregariousness and emotional lability. In a related evolutionary neurochemical model, Klein (1999) hypothesized that a noradrenergic primate regulatory mechanism responsive to social cues of interest or rejection may become dysregulated in some individuals.

Trait Models

Trait theorists conceptualize PDs as constellations of maladaptive or extreme variants of otherwise normative personality dispositions (Widiger & Bornstein, 2001). According to Widiger and Frances (1994), the five-factor model (FFM) may be useful in describing and diagnosing PDs. As part of a larger study, Lynam and Widiger (2001) asked 19 experts on HPD to think of and rate a prototypical person with HPD on a scale of 1 to 5 along items used to measure dimensions of the FFM. Ratings for the five broad domains, neuroticism (N), extraversion (E), openness (O), agreeableness (A), and conscientiousness (C), were neither high nor low, suggesting that clinicians thought that patients with HPD tended to be average or unremarkable on these dimensions. Ratings comprising the facets within each domain were more informative. On average, clinicians rated HPD as low on self-consciousness and high on impulsiveness (within the N domain); high on gregariousness, activity, excitement seeking, and positive emotions (within E); high on fantasy, feelings, and actions (within O), and low on self-discipline and deliberation (within C). In contrast, Brieger, Sommer, Bloink, and Marneros (2000) reported that, in a sample of 229 former patients and controls, high N, high E, and low C predicted dimensional scores on a histrionic personality dimension based on the criteria of the tenth revision of the International Classification of Disorders

(ICD-10; World Health Organization, 1993). Given such heterogeneous findings, application of the FFM in conceptualizing and diagnosing HPD may be premature.

Attachment Model

From an attachment perspective (Bartholomew, Kwong, & Hart, 2001), HPD is consistent with what is referred to as a preoccupied attachment style. Such individuals are theorized to hold a positive mental model of others (predisposing them to approach others) and a negative model of the self (predisposing them to feel vulnerable, especially to rejection). People with this attachment style are thought to have strong relational needs and actively seek relationships, but may be so hypervigilant that they respond to the slightest interpersonal stress or disappointment with increased attachment behaviors, which can overwhelm and scare away potential partners. Attachment theorists see the emotionality and need for attention in individuals with HPD as evidence for attachment anxiety, whereas they see the extraversion and perhaps sexualization as evidence of intense relational needs.

Assessment and Differential Diagnosis

No specialized instrument exists for the screening and assessment of HPD. However, two commonly used broad PD measures include HPD scales. The general psychometric properties of these instruments as well as those of their HPD scales are outlined below.

The Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997) has one item per criterion for each of the PD diagnoses, to be rated during the interview on a scale from 1 ("absent or false") to 3 ("threshold or true"). Most research on the SCID-II was conducted using its previous version, the DSM-III-R SCID-II (e.g., Dreessen & Arntz, 1998; Renneberg, Chambless, Dowdall, Fauerbach, & Gracely, 1992; Spitzer, Williams, Gibbon, & First, 1990), and indicates acceptable levels of interrater reliability and internal consistency. At least one paper (Maffei et al., 1997) reports adequate levels of interrater reliability (kappa = .92; intraclass correlation [ICC] = .95) and internal consistency (Armor's theta = .87) for HPD using the DSM-IV version of the SCID-II.

The Personality Diagnostic Questionnaire 4+ (PDQ-4+; Hyler & Rieder, 1994) is a self-report measure that (as the SCID-II) assesses DSM-IV criteria for the 10 primary PDs and the two designated for further study. Correlations among all PDQ-4+ and SCID-II scales were low to moderate, but significant (r = .19–.42), and PDQ-4+ scales exhibited mediocre internal consistencies. Only two scales (antisocial and dependent) showed strong powers of discrimination.

A larger concern in evaluating HPD is its differentiation from other disorders, and common comorbid conditions.

Treatments for HPD

With the exception of Linehan's (1993) study of dialectical behavior therapy for BPD, the literature offers little rigorous research on the treatment of Axis II disorders. What follows is a description of the extant research, which varies greatly in scope and quality.

General Characteristics of Treatment

A panel of three experts nominated and elected by the psychiatric community in Australia (Quality Assurance Project, 1991) concluded that long-term psychotherapy would be beneficial to HPD patients and also likely be cost-effective by minimizing adverse economic outcomes of the disorder. Nevertheless, it should be noted that they were not citing research evidence specific to HPD to buttress this assumption. They conceptualized DSM-III-R HPD as a variant of BPD and asserted that the dramatizing and sexualizing behavior of HPD patients is a way of asserting a false sense of identity to counteract the feelings of emptiness and lack of identity underlying borderline pathology. The limited empirical record (primarily single- and multiple-case reports) suggested that three or more years of relatively intense (e.g., twice-weekly) therapy may be needed for good outcomes in one half to two thirds of patients. This panel recommended outpatient individual, group, or combined therapy with hospitalization and medication only during crisis.

While acknowledging that brief therapy for HPD may not be optimal, Dorfman (2000) recommended increasing its effectiveness in the context of managed care by taking an integrative stance and maintaining a specific focus on short-term goals (dealing with acute distress) and long-term changes in interpersonal behavior. He related the case of a 49-year old woman who at the start of treatment communicated in vague and self-dramatizing ways, experienced herself as a victim and others as unsympathetic, suffered from turbulent abusive relationships, and complained of feelings of anxiety, depression, emptiness, and inadequacy. The sessions focused initially on creating a working alliance, then on helping the client label beliefs about dependency and abandonment in order to help her understand their impact on her relationships, and finally on replacement of dramatic manipulations with alternative interpersonal behavior. Dorfman conducted 13 biweekly sessions with this patient and gave her the option of boosters. Several months after termination, she reported only occasional dysphoria, avoided abusive relationships, and maintained some insight into her need for attention, but she continued to be emotionally reactive under stress and overly concerned with her appearance. The efficacy and cost-effectiveness of such brief treatments remain largely unexplored using formal methods.

Other researchers have investigated the influence of HPD on treatment characteristics such as termination. Hilsenroth, Holdwick, Castlebury, and Blais (1998) reviewed literature suggesting that PDs are common in psychiatric patients and adversely affect the outcome of treatment for Axis I disorders, and

sought in particular to examine the links between Cluster B PDs and psychotherapy termination. In 90 patients with different PDs, the number of DSM-IV criteria for HPD met did not correlate significantly with the number of psychotherapy sessions. In a stepwise regression, HPD criterion 8, "considers relationships to be more intimate than they really are," predicted the number of therapy sessions independent of other significant predictors, such as the BPD criterion "frantic efforts to avoid real or imagined abandonment" and the NPD criterion "requires excessive admiration." Unfortunately, stepwise regression tends to capitalize on chance findings, and these findings may be difficult to replicate. Their generalizability may also be limited by the atypical nature of the sample, which included patients meeting criteria for only one PD, which is not usually the case in the community. Other researchers (Tyrer, Mitchard, Methuen, & Ranger, 2003) have found patients with HPD not particularly likely to either seek or reject therapy.

Expressive Psychodynamic Therapy

From a psychodynamic perspective, HPD is a hysterical character style (McWilliams, 1994; Shapiro, 1965) presenting at the borderline level of dysfunction (Kernberg, 1970, 1975). The hysterical style is characterized by diffuse, global, and impressionistic cognition that makes motivated inattention easy and self-understanding difficult. It can present at a neurotic, borderline, or psychotic level of severity (see also Pollak, 1981; Zisook, DeVaul, & Gammon, 1979), with borderline implying that the person has difficulty establishing a stable sense of self. Kernberg (2004) considers most histrionic patients to be in the high (meaning healthier) borderline range (see Kernberg, 2004, for the distinction between BPD and borderline personality organization.) Because patients' representations of the self and others are split into all-good and all-bad fragments, under conditions of stress and negative emotion the experience of self as all bad may lead to intense suffering and self-harm, whereas projective identification and the experience of others as evil may lead to rage. Yet the patient may depend on relationships with others to feel whole. Thus, manipulativeness and acting out may be self-defeating ways to maintain the attention of others. This psychodynamic conceptualization has a phenomenological appeal but remains wanting for empirical validation.

Psychodynamic therapists are likely to view such pathology as arrested development rather than conflict (Mitchell, 1988; Mitchell & Black, 1995; Quality Assurance Project, 1991). Therefore, they recommend modifications to the classical technique of therapist neutrality. Instead, they suggest more directive and expressive approaches (McWilliams, 1994, 2004) in which the therapist shows empathy, helps the client label and understand his or her dreaded feelings, promotes tolerance for anxiety and ambiguity, and helps establish a complex and realistic understanding of the self, others, and relationships. Because of these patients' fragile sense of identity and the dramatic shifts in how they feel about themselves and the therapist, firm boundaries and clear, consistent conditions of therapy are essential. For similar reasons,

psychodynamic therapists often work with such patients face-to-face instead of using the couch, and they see them only once or twice a week. Research has not yet addressed the efficacy of the above recommendations.

The therapist attempts to promote healthy maturation by responding to elements of the patient's expression that are likely to be genuine and ignoring those that are impersonal or mendacious (Quality Assurance Project, 1991). Early in the treatment, the therapist focuses on building the alliance. Inevitably, the patient's unstable representations begin to create disruptions in the relationship due to idealization or devaluation, at which point the therapist points them out to the patient and links them to past and recent experiences. Patients learn to reflect on their feelings and interactions and realize that they can share negative aspects of the self with the therapist without falling apart or being abandoned, which is intended to help build self-esteem. The therapist gradually challenges the patient to link different aspects of his or her ways of experiencing the self and others to establish a sense of identity, continuity, and authenticity. Patients may use pseudoinsight, or superficial insights that are quickly forgotten and primarily aim to please and flatter the therapist, posing a challenge in later phases of treatment (Chodoff, 1978).

In a meta-analysis of controlled studies of psychodynamic ($n = 14$) and cognitive ($n = 11$) therapy outcome for PDs employing measures such as the Beck Depression Inventory, the Symptom Checklist–90 (SCL-90), the Health-Sickness Rating Scale, and the Global Adjustment Scale, Leichsenring and Leibing (2003) found large effect sizes for both kinds of therapy on self-report as well as observer ratings of outcome. More recently, Svartberg, Stiles, and Seltzer (2004) reported similar results. In addition, some evidence emerged for the long-term effectiveness of psychodynamic therapies (Leichsenring & Leibing, 2003). Nevertheless, the effectiveness of psychodynamic therapies has not yet been demonstrated in controlled studies for HPD per se. Similarly, the question of whether these therapies work by means of their hypothesized mechanisms needs to be addressed empirically.

Cognitive Therapy

Cognitive therapists conceptualize PDs as attributable to dysfunctional schemas that develop out of people's tendencies to cope in certain ways with interpersonal challenges (Beck & Freeman, 1990). A person who develops HPD may have had strong dependency and rejection sensitivity tendencies as a child and may have received strong reinforcement from others for attention seeking behavior or the exaggerated display of gender-typed behaviors. The former tendencies may result in a core belief that "I am basically unattractive," and the reinforcement history may lead to a core belief that "I need others to admire me in order to be happy." The individual compensates by believing "I am lovable, entertaining, and interesting," "I am entitled to admiration," and "People are there to admire me" (Beck & Freeman, 1990, p. 50). Thus, according to this framework, persons with HPD view themselves as deserving of unfaltering attention and view others positively as long

as they provide it. Their overt cheerfulness conceals underlying anxiety and rejection sensitivity. People with HPD deal pragmatically with the belief that they are unattractive by seeking minute-to-minute interaction and attention in an attempt to counter this fear. They quickly act on their frustration if a person contradicts their compensatory beliefs by ignoring them. Thus, the person with HPD operates on conditional beliefs such as "Unless I captivate others, I am nothing," "If I can't entertain people, they will abandon me," and "If people don't respond, they are rotten." An associated belief is "I can go by my feelings," which gives one the freedom to express immediate feelings of affection or aggression toward others in exaggerated ways, regardless of their appropriateness. Thus, the histrionic approach to life is based on global, impressionistic, and fleeting cognitions that are at odds with the problem solving and focused set that cognitive therapy teaches.

Work in the cognitive approach begins by gradually helping the patient identify feelings and thoughts and then challenging irrational thoughts, first in relation to specific symptoms and gradually at a more global level. Patients with HPD may find homework assignments boring, which is why Beck and Freeman (1990) suggest that therapists encourage patients to use vivid imagination when working on homework (e.g., by phrasing their rational thoughts in dramatic ways). It may be helpful to clarify to patients that treatment will not eradicate the strong emotions they value but will make them more constructive. Emotional outbursts can be dealt with by clarifying the goal (e.g., to receive positive attention), listing the pros and cons of an outburst in relation to the goal, and coming up with alternative ways of reaching it. Such interventions may help stabilize the patient's relationships, but ultimately the therapy must help patients address their sense of identity and core beliefs. Patients may gradually write down things that describe themselves as a way of building a stable identity, and they may engage in small behavioral experiments to challenge their belief that they depend on others' care and attention. A rational argument has been made that this work could last for up to 3 years. However, the specific formulations and treatment recommendations of cognitive therapy for HPD, like those of psychodynamic therapy, have not been investigated extensively.

Cognitive therapy for PDs has been described in several volumes (e.g., Beck & Freeman, 1990; Beck, Freeman, & Davis, 2004; Young, 1999), but its empirical support still comes primarily from case studies (e.g., Bernstein, 2002; Morrison, 2000) and a small number of clinical trials (Leichsenring & Leibing, 2003; Svartberg et al., 2004), in which its effectiveness was comparable with that of psychodynamic therapy. The field is still wanting for empirical evaluations of the effectiveness of cognitive therapy specifically for HPD.

Other Therapies

A few other proposed therapies for HPD are worth mentioning, although they will not be discussed at length for brevity's sake. Horowitz (1997) described a rationally derived cognitive/psychodynamic approach that starts

with a configurational assessment of symptoms, states of mind, defense styles, person schemas, and the level of severity. This approach involves three primary phases, one focusing on attainment of emotional and behavioral stabilization, one focusing on improving communication, and one focusing on modifying defenses. Horowitz did not specify treatment duration, but his framework implies that it would depend upon the level of severity. A related cognitive/analytic approach proposed by Ryle (1997) has received limited research support in Europe for the treatment of BPD (Garyfallos et al., 2002; Kerr, 1999).

The application of functional analytic therapy with histrionic patients as described by Callaghan, Summers, and Weidman (2003) may appeal to proponents of both interpersonal and behavioral approaches. They apply functional analysis principles within the therapeutic relationship by extinguishing or punishing interpersonally problematic behaviors and reinforcing desirable behaviors idiosyncratic for the patient. For example, therapists may share with clients the way their behavior made them feel, acting under the assumption that the client enacts the same maladaptive behaviors that occur outside of therapy and that their modification through feedback in therapy will generalize to other relationships. Although descriptive case studies implementing this approach with histrionic patients have been cited (e.g., Callaghan et al., 2003), sufficient empirical support for its effectiveness is still lacking.

While no clinical trials of pharmacotherapy for HPD currently exist, Kool, Dekker, Duijsens, De Jonghe, and Puite (2003) report some potentially relevant findings regarding pharmacotherapy for personality pathology in general. They compared two groups, one receiving pharmacotherapy only for depression (a selective serotonin reuptake inhibitor, a tricyclic antidepressant, or a reversible monoamine oxidase inhibitor for 6 months; $n = 25$), and one receiving pharmacotherapy and brief psychodynamic therapy ($n = 47$). Using a self-report inventory to measure personality pathology before treatment and 40 weeks later, they found that overall personality pathology (including histrionicity) decreased in the combined treatment group regardless of their improvement on depression, while only those patients who improved on depression in the pharmacotherapy group scored lower on personality pathology. The authors reported that patients with Cluster B pathology showed the least reduction in PD scores, but the role of HPD in this was unclear, as was the proportion of patients who had HPD. Other authors (e.g., Grossman, 2004) have suggested that, given the emotional regulation difficulties of patients with HPD, medications such as selective serotonin reuptake inhibitors, mood stabilizers, and anticonvulsants deserve research consideration.

Questions for Future Research

Many research questions remain pertaining to the conceptualization, etiology, and treatment of HPD. We will highlight four that we consider most significant as we move toward DSM-V:

1. **What are the real-world outcomes of HPD?** As noted earlier in this chapter, little is known about the clinical predictive power of HPD for outcomes such as relationship satisfaction and stability, employment history, general health, and life satisfaction. Furthermore, empirical studies should examine the degree to which factors such as Axis I comorbidity and severity of HPD presentation affect the degree to which negative life outcomes are experienced. Relatedly, some researchers (e.g., Svanborg et al., 2000) have cited preliminary biological evidence that histrionic features may be adaptive for some individuals. The conditions under which features of HPD can serve an adaptive function are another interesting direction for further research.

2. **Can endophenotypic markers of HPD help elucidate its degree of differentiation from allied conditions?** Continued overlap between HPD and other Axis II conditions such as BPD, NPD, and DPD calls for an examination of the degree to which these disorders can be differentiated as well as their incremental validity over and above each other in predicting clinically relevant outcomes. Endophenotypic markers, as assessed by laboratory measures, are an as of yet relatively unexplored but potentially interesting avenue for doing so.

3. **What is the current status of cultural differences in the presentation and course of HPD?** Not only is there a lack of empirical literature regarding the nature of cultural differences in HPD, but theoretical writings pertaining to this topic are likely outdated by now. For example, changes in the cultural and economic conditions in different global regions may have changed hypothesized prevalence rates of HPD. Furthermore, the degree to which HPD is more or less prevalent or may have distinctive features within cultural enclaves in nonnative countries (e.g., the U.S.) is also an unexplored question.

4. **What is the best course of treatment for HPD?** While the proposed treatments for HPD reviewed in this chapter are appealing from a phenomenological standpoint, it is clear that more rigorous treatment outcome research must examine these and other proposed therapies. Additionally, it is important to compare proposed treatments with one another on well-operationalized outcome variables in order to examine the possible differences in efficacy. When selecting targeted outcomes, in keeping with suggestions regarding personality considerations in treatment planning (see Harkness & Lilienfeld, 1997), clinicians and researchers should consider selecting some reflective of "characteristic adaptations" (behaviors arising from maladaptive traits) in addition to reduction of trait levels themselves. Such an approach is implied in therapies utilizing functional analytic (Callaghan et al., 2003) and interpersonal components (Dorfman, 2000) and awaits large-scale empirical validation.

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