

Histrionic Personality Disorder

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Glossary

Axis II disorder One of the five axes of the multiaxial system of the Diagnostic and Statistical Manual. Axis II contains information about personality disorders and mental retardation.

Borderline personality disorder Personality disorder that overlaps substantially with histrionic personality disorder; it is characterized by marked instability in mood, interpersonal relationships, impulse control, and identity.

Histrionic From the Latin word *histrionicus*, meaning of or pertaining to actors, acting, or theater.

Hysteria A historically common medical diagnosis in women, marked by excessive emotionality and unexplained physical symptoms. HPD traces its roots to this condition.

Hysterical personality disorder A precursor to histrionic personality disorder described briefly in the DSM-II in 1968. This diagnosis emphasized seductiveness, impressionistic speech, dramatic and emotional displays, and clinging and demanding relationships.

Impressionistic speech Also known as hyperbolic speech. A term used to describe speech lacking in detail and emphasizing emotion.

Description

Histrionic personality disorder (HPD) manifests itself by early adulthood. Like other personality disorders, HPD is associated with enduring abnormalities in emotion, cognition, and interpersonal behavior. According to the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM), the DSM-IV-Text Revision (DSM-IV-TR), published in 2000, individuals with HPD are characterized by excessive displays of emotionality and need for attention. They are often flamboyant and dramatic, frequently earning the reputation of the 'life of the party.' Indeed, this theatrical behavior inspired the name 'histrionic,' after the Latin 'histrionicus,' meaning pertaining to an actor.

Not surprisingly, people with HPD often experience discomfort when not the focus of interest. Their attention-seeking behavior, which often expresses itself as enthusiasm and flirtatiousness, may initially charm a new friend or love interest. Nevertheless, this behavior quickly becomes frustrating once it becomes evident that these dramatic behaviors serve largely as attention-grabbing gestures. Individuals with HPD may also attempt to attract others through inappropriately seductive and sexual behavior. Because they tend to use their physical appearance to draw attention to themselves, they often expend an inordinate amount of resources on fashion and grooming. In addition, they may 'fish' for compliments and become distraught by an unflattering photograph or trivial criticism of their physical appearance.

Individuals with HPD are characterized by exaggerated expressions of emotion that typically strike others as overblown or insincere. Their language often seems vague and generalized (sometimes termed as 'hyperbolic speech'), and is marked by black-and-white opinions lacking in detail or supporting evidence (e.g., "That movie was just wonderful," "He was a horrible, terrible boyfriend"). Individuals with HPD are easily influenced by people and fleeting trends, and may be overly trusting of others. Additionally, people with HPD tend to believe their interpersonal relationships to be more intimate

than they actually are, and may refer to a casual acquaintance as a cherished friend.

Some of the associated features of the disorder, which are not listed as formal diagnostic criteria in the DSM-IV-TR, include persistent difficulties with romantic and sexual relationships. The relationships and friendships of individuals with HPD often lack genuine emotional intimacy, and their sexual seductiveness may coexist with a tendency to find sexual relationships consistently unsatisfying. People with HPD may be manipulative, a tendency that often coexists with pronounced dependency on their romantic partners. Their friendships are often unsuccessful, largely because friends are often alienated by their insistent demands for attention and sexually provocative behavior. Individuals with HPD usually expect immediate satisfaction and may become excessively frustrated when forced to wait for desired rewards, such as a return call from a friend. They frequently seek excitement and novelty, although their interest in new things wanes quickly. Finally, individuals with HPD may make manipulative suicidal gestures and threats to gain attention, although they rarely commit suicide.

History

HPD traces its roots to the broad and poorly delineated condition once known as 'hysteria,' a state of excessive emotionality traditionally linked to females. The origins of hysteria extend at least as far back as 1900 BC to the writings of ancient Egypt and Greece. At that time, hysteria was said to be brought on by a misplaced uterus or 'wandering womb'; indeed, the prefix 'hyster' means 'womb' in Latin. In Hellenic Greece, people often thought of the uterus as akin to a wild animal, free to roam around a woman's body. This wandering occurred when the womb remained barren for an extended period of time. Thus, women with unsatisfactory sex lives, such as virgins and widows, were especially considered prone to hysterical outbursts. In fact, in ancient Greece, sexual behavior was often prescribed as a remedy for hysteria.

By the Middle Ages, theories regarding the causes of hysteria had shifted considerably. Hysteria was then viewed as the result of wanton sexuality, which supposedly predisposed women to the disorder. Hysteria also became increasingly associated with witchcraft and demonic possession. As early as the seventeenth century, doctors began to see what they called 'disorders' in the personality traits of patients with hysteria. These traits included mental dullness, lethargy, egocentricity, and unexplained physical ailments, most of which are not considered relevant when diagnosing HPD today. Other features, such as suggestibility and outbursts of emotion, evolved from the idea of theatricality, and are commonly associated with HPD today.

Following the Middle Ages, hysteria was increasingly recognized as a natural and physical disorder. Eventually, the idea of hysteria as a disease of the brain and mind emerged. Viennese neurologist Sigmund Freud, whose work with hysterical patients in the late nineteenth and early twentieth centuries laid the groundwork for later theories concerning the unconscious, believed that women possessed innate characteristics, most importantly the absence of the penis, which predisposed them to hysteria.

Following World War II, the American Psychiatric Association developed the DSM to standardize the vast array of diagnostic systems used to diagnose mental disorders. Neither HPD nor hysterical personality was listed in the first edition, DSM-I, which was published in 1952. Nevertheless, both conditions resemble the DSM-I entry for 'emotionally unstable personality.' In 1968, 'hysterical personality' was described briefly in DSM-II, with an emphasis on seductiveness, impressionistic speech, histrionic and emotional displays, and clinging and demanding relationships. Finally, HPD, now referred to by the somewhat less pejorative term histrionic personality disorder, appeared in full-fledged form in DSM-III in 1980, with a substantial focus on dramatic and attention-seeking behavior that persists in today's diagnostic descriptions.

Prevalence and Demographics

Studies using standardized interviews suggest that the prevalence of HPD is about 2–3% of the general population. Much higher rates of HPD occur in clinical settings, with rates typically ranging between 10 and 15%. The differences in prevalence across studies are probably due in part to differences in the measures used to diagnose HPD.

DSM-IV warns readers that cultural factors may influence the manifestation of HPD. However, the manual does not delineate these factors or their specific effects on the manifestation of the disorder. In fact, scant research has examined cultural differences in the prevalence or expression of HPD. Some researchers suspect that differing cultural norms affect the rate of HPD across various populations. For example, HPD may be diagnosed less frequently in Asian cultures than North American cultures due to the discouragement of overt sexuality in the former cultures. In contrast, in Hispanic cultures, where overt displays of sexuality are less stigmatized, HPD may be more prevalent. Nevertheless, there is little systematic research on these conjectures.

Historically, HPD has been viewed as a predominantly female disorder, and DSM-IV notes that HPD may occur

more often in females than in males. Psychologist Paula Kaplan has speculated that HPD is a collection of exaggerated behaviors traditionally perceived as feminine. Some authors, like George Washington University psychiatrist Paul Chodoff, have even argued that merely behaving in a highly traditional 'feminine' manner may lead to a diagnosis of HPD, although research evidence for this claim is wanting. Notably, in non-clinical samples, HPD is equally prevalent in males and females. This finding suggests that the apparent sex difference in HPD may be due to a selection bias. Specifically, women with HPD may be more likely than men with HPD to seek treatment, perhaps because they are more likely to suffer from co-occurring conditions, including depression.

Several researchers have examined the potential for sex-bias in the diagnosis of HPD. In 1989, University of Kentucky psychologists Maureen Ford and Thomas Widiger examined psychologists' ratings of a case vignette describing an individual with either HPD, antisocial personality disorder (APD) – a condition marked by manipulateness, dishonesty, and irresponsible behaviors – or an equal number of features of both disorders. The sex of the individual was listed as male, female, or unspecified. For the APD vignette, clinicians diagnosed the disorder more frequently in men than in women, or in those of an unspecified gender. Clinicians tended to diagnose females who exhibited APD features with HPD. When the vignette described an individual with HPD, clinicians diagnosed it at high rates in women and low rates in men. In contrast, when clinicians rated individual diagnostic criteria in the DSM, sex differences disappeared, suggesting that sex bias for HPD exists at the level of the overall diagnosis, but not at the level of individual diagnostic criteria.

Although HPD may be associated with traditional manifestations of femininity, David Klonsky, then at the University of Virginia, and his colleagues also found associations between the disorder and masculinity in a 2002 study. Specifically, people who behaved in a traditional fashion consistent with their biological sex, such as a stereotypically 'masculine' male or a stereotypically 'feminine' female, displayed more histrionic features. Some authors have conjectured that traditionally 'masculine' manifestations of HPD, such as the 'macho' male, may exist, but due to biased diagnostic criteria these people may be overlooked or underdiagnosed.

Co-occurrence and Comorbidity

HPD frequently co-occurs with other personality disorders, which are listed in Axis II of the DSM. This co-occurrence is especially marked for Cluster B ('dramatic, emotional') personality disorders, which in addition to HPD are borderline personality disorder (BPD), APD, and narcissistic personality disorder (NPD). This overlap of HPD with BPD, which is especially pronounced, may be due in part to similarity in the diagnostic criteria of these conditions, including attention seeking and manipulateness. Nevertheless, individuals with BPD tend to be more marked by self-destructiveness, feelings of emptiness, and anger-filled relationships than individuals with HPD. DSM-IV attempted to reduce the overlap between these two conditions by removing the criteria of angry outbursts and manipulative suicidal gestures from the diagnosis of

HPD. Some researchers, such as Emory University psychologists Drew Westen and Christine Heim, have even proposed the existence of a subtype of BPD with prominent histrionic features.

Both HPD and APD are characterized by manipulative behaviors, impulsiveness, and recklessness. However, HPD lacks the pervasive involvement with antisocial and criminal behavior associated with APD. Individuals with HPD or NPD are both known to crave attention; however, those with NPD are more likely to use this attention for validation rather than satisfaction of sexual or interpersonal needs.

HPD also overlaps highly with dependent personality disorder (DPD). Individuals with DPD and HPD are similar in their reliance on others for approval and guidance; however, individuals with DPD typically lack the theatrical quality of those with HPD.

Finally, HPD exhibits moderate to high rates of co-occurrence with Axis I conditions (major mental disorders), such as somatization disorder, dissociative disorders (e.g., dissociative identity disorder, known formerly as 'multiple personality disorder'), major depression, and dysthymic disorder, a form of chronic and low-level depression. Still other Axis I conditions can be confused with HPD. In particular, bipolar disorder, formerly known as 'manic depression,' may superficially resemble HPD because of its high levels of impulsivity, self-centeredness, and extraversion, especially during manic and hypomanic (mild manic) states.

Assessment

There are no published diagnostic instruments for the assessment of HPD per se. As a consequence, clinicians typically use 'omnibus' or broadband measures of personality disorders to diagnose HPD. These measures include the Structured Interview for DSM-IV Axis II (SCID-II) and the Personality Diagnostic Questionnaire, DSM-IV version (PDQ-4), both of which contain subscales for HPD. In the SCID-II, a clinician rates one item per HPD diagnostic criterion on a scale of one to three. A rating of one indicates the criterion is absent, whereas three indicates the criterion reaches threshold or is true. In contrast, the PDQ-4 is a True or False self-report questionnaire. Other broadband measures such as the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and Million Clinical Inventory, 3rd edition (MCMI-III), may be helpful in detecting HPD. For example, on the MMPI-2, individuals with HPD will often display a Hysteria-Psychopathic deviate profile or a Psychopathic Deviate-Hypomania profile. Elevations on the Hysteria scale of the MMPI-2 reflect a Pollyannaish view of the world, along with a propensity toward physical complaints; elevations on the Psychopathic deviate scale reflect a propensity toward antisocial behavior, including dishonesty, manipulateness, and elevations on the Hypomania scale, reflecting a propensity toward high levels of energy, poor impulse control, and grandiosity. Individuals with HPD sometimes also exhibit high scores on the MMPI-2 Psychasthenia scale, reflecting self-doubt and worry.

Most diagnostic measures for HPD rely largely or entirely on self-report. Nevertheless, some authors have questioned the utility of self-report in the assessment of HPD given that people with this condition tend to lack insight into the nature and

extent of their symptoms. As a consequence, the use of informants, such as coworkers or friends, may offer fresh opportunities for the assessment of HPD and related personality disorders. In a pioneering study of the effects of maladaptive personality traits on military discharge, University of Virginia psychologist Thomas Oltmanns found that peer nominations of HPD were substantially superior to self-reports of HPD in predicting early separation from active duty. This study suggests that informant reports can not only provide meaningful information about the maladaptive traits associated with HPD, but also help to circumvent some of the limitations of self-reports in detecting this condition.

Another potentially fruitful avenue for the assessment of HPD stems from rapid perceptions of small pieces of interpersonal behavior, sometimes termed 'thin slicing.' In another study by Oltmanns' team, participants viewed the initial 30 s of a videotaped interview of individuals diagnosed with personality disorders, including HPD. Even from this brief clip of behavior, observers blind to participants' diagnoses judged people with HPD as more extraverted and likeable than other people. These findings suggest that relatively little interpersonal information may be required to detect at least some of the hallmark interpersonal features of HPD.

Etiology

The etiology (causation) of HPD remains poorly understood. Comparisons of monozygotic (identical) and dizygotic (fraternal) twins suggest that HPD is moderately heritable, but as yet unknown environmental factors also play a role in its development. Some authors have argued that early parenting factors play a role in HPD; for example, some have contended that HPD stems from an anxious attachment style. Nevertheless, it is not clear whether the deficits in interpersonal attachment observed in individuals with HPD are causes of the disorder, or merely manifestations of it.

From a personality trait perspective, individuals with HPD differ from other individuals on the dimensions of the five-factor model of personality. In particular, studies show that HPD is associated with elevated scores on some facets of extraversion, such as gregariousness and excitement-seeking; neuroticism, such as impulsivity; openness to experience; and fantasy, and decreased scores on some facets of conscientiousness, such as self-discipline and deliberation. Nevertheless, the extent to which these trait differences shed light on the causes of HPD, as opposed to merely describing its personality features, is unclear.

Treatment

Psychologists and psychiatrists have implemented a variety of interventions with HPD, none of which has been systematically investigated in controlled studies. No studies have examined the potential utility of medications with HPD patients, so most of the attention has been focused on psychotherapies.

Cognitive and cognitive-behavioral treatments are designed largely to alter the underlying assumptions of HPD patients. University of Pennsylvania psychiatrist Aaron Beck and other cognitive therapists have argued that HPD is associated with a

set of core and often unspoken beliefs, such as “I need others to admire me to be happy” or “Unless I am consistently entertaining, people close to me will abandon me.” Their treatment for HPD is centered on challenging this and other core beliefs using cognitive restructuring and behavioral experiments (‘homework’) intended to disprove these beliefs. For example, a cognitive therapist might set up a behavioral experiment in which an HPD person remains quiet at several parties and determines whether her friends actually abandon her.

Other commonly used therapies for HPD include (a) behavioral therapy, which attempts to extinguish maladaptive behaviors, such as manipulateness or excessive seductiveness, and to reinforce adaptive behaviors, such as efforts to achieve attention in socially healthy ways (e.g., appropriate assertiveness); (b) interpersonal therapy, which attempts to improve the social skills of individuals with HPD; and (c) psychodynamic therapies, which attempt to use the therapeutic relationship to resolve childhood conflicts and parenting deficiencies (e.g., insufficient attention from one’s mother, father, or both) that ostensibly contribute to HPD. Without controlled scientific data, however, it is difficult to recommend any of these psychotherapies with confidence. Research is needed to compare the efficacy of competing therapeutic approaches for HPD, and to ascertain whether attempting to alter HPD individuals’ deep-seated personality traits is more fruitful than accepting these traits and attempting to alter their problematic behavioral manifestations.

See also: Antisocial and Narcissistic Personality Disorder; Borderline Personality Disorder; Personality Disorders; Psychopathology: Diagnosis, Assessment, and Classification.

Further Reading

- Alam CN and Merskey C (1992) The development of the histrionic personality. *History of Psychiatry* 3: 135–165.
- Blagov PS, Fowler KA, and Lilienfeld SO (2007) Histrionic personality disorder. In: O’Donohue WT, Fowler KA, and Lilienfeld SO (eds.) *Personality Disorders: Toward the DSM-V*. Thousand Oaks, CA: Sage.
- Bornstein RF (1998) Implicit and self-attributed dependency needs in dependent and histrionic personality disorders. *Journal of Personality Assessment* 71: 1–14.
- Chodoff P (1982) Hysteria and women. *American Journal of Psychiatry* 139: 545–551.
- Ford MR and Widiger TA (1989) Sex bias in the diagnosis of histrionic and antisocial personality disorders. *Journal of Consulting and Clinical Psychology* 57: 301–305.
- Hamburger ME, Lilienfeld SO, and Hogben M (1996) Psychopathy, gender, and gender roles: Implications for antisocial and histrionic personality disorders. *Journal of Personality Disorders* 10: 41–55.
- Pfohl B (1991) Histrionic personality disorder: A review of available data and recommendations for DSM-IV. *Journal of Personality Disorders* 5: 150–166.
- Shapiro D (1965) *Neurotic Styles*. New York: Basic Books.

Relevant Websites

- http://my.clevelandclinic.org/disorders/Personality_Disorders/hic_Histrionic_Personality_Disorder.aspx – Cleveland Clinic.
- <http://www.mentalhealth.com/dis/p20-pe06.html> – International Mental Health.
- <http://www.nlm.nih.gov/medlineplus/ency/article/001531.htm> – Medline Plus.
- <http://www.webmd.com/mental-health/histrionic-personality-disorder> – WebMD.