

Personality Disorders- Histrionic

DSM-IV-TR Diagnostic Code: 301.50 Histrionic Personality Disorder

Diagnostic Guidelines:

1. Establish Diagnostic accuracy as defined in DSM-IV-TR/ICD-9.

Identify differential diagnoses and co-morbid problems. Rule out conversion disorders, hypochondriasis, dissociative disorders, and affective disorders (Richards, 1993, p246), as well as other Cluster B personality disorders.

2. Establish accurate diagnosis through continued assessment of diagnosis over time and rule out other diagnoses as necessary.
3. Obtain external corroboration of diagnosis when possible through review of past treatment history, legal history, etc.
4. Review previous treatment episodes to determine efficacy of treatment interventions and therapeutic gains.

Treatment Guidelines

1. Approaches which take advantage of matter-of-fact and realistic assessment of situations and problems are useful. Solution-focused therapy is often appropriate with this client. Most therapy approaches should not be focused on the long-term, personality change of the individual, but rather short-term alleviation of difficulties within the person's life. It should be explicitly stated up-front that therapy is not a "magical" cure for this disorder.
2. People who suffer from this disorder are much quicker to seek treatment and exaggerate their symptoms and difficulties in functioning. Because they also tend to be more emotionally needy, they are often reluctant to terminate therapy. This should be addressed by setting an agreed upon length of treatment at the onset of treatment.
3. Women with HPD are described in the literature as self-centered, self-indulgent, and intensely dependent upon others. Emotionally labile, they may show inappropriate and intense anger. They may also threaten suicide as one aspect of generally manipulative behavior (Kernberg, 1992, pp. 58-59).
4. Men with HPD often present with lack of impulse control, antisocial tendencies, an inclination to exploit physical symptoms. They are often promiscuous, indulging in numerous shallow sexual relationships (Kernberg, 1992, p.59; Frances, et. al., 1995, p.373).

5. Parents with HPD may use manipulative behaviors to focus their childrens' attention on parental needs. This allows them to evade parental responsibilities even while appearing loving and involved. Such behavior can result in exploitation of and failure to protect their children from emotional, physical, or sexual abuse (Bornstein, Costello, ed., 1996, pp. 130-132).
6. Therapy should generally be supportive and good rapport will usually be easily established with the client early on. Clinicians may often find themselves placed in a rescuer role, in which the clinician will be asked to constantly reassure and rescue the client from daily problems. Every problem is usually expressed in a dramatic fashion.
7. Suicidal behavior is often apparent in a person who suffers from histrionic personality disorder. Suicidality should be assessed on a regular basis and suicidal threats should not be ignored or dismissed. Suicide sometimes occurs when all that was intended was a gesture, so all such thoughts and plans should be taken seriously. Self-mutilation behavior may also be present in this disorder and should also be taken seriously as an issue of importance to discuss within therapy. However, use of suicidal threats or threats of self harm should not be allowed to become a way for the client to keep him/herself in treatment beyond what is therapeutically valuable.
8. Clinicians should take a skeptical stance with this population due to the level of exaggeration of events and problems the client will convey. By stepping through a line of reasoning to a logical conclusion, the client can usually discover the unrealistic expectations and fears associated with many behaviors and thoughts.
9. Since many people who have histrionic personality disorder will emphasize attractiveness (style over substance) in their lives and relationships, discussing alternatives and having clients try out new behaviors can be helpful. The clinician should also point out when the client is using shallow criteria by which to judge another. The client should eventually be able to do this him/herself.
10. Insight-oriented and cognitive therapy are largely ineffective since people with this disorder are often incapable of examining unconscious motivations and their own thoughts. Helping the client to examine interactions from a more objective point of view and emphasizing alternative explanations for behavior is more effective. Examining and clarifying a client's emotions are also important components of therapy.
11. Many times the clinician will be perceived as sexually attractive to the client. Therapists should be wary of finding themselves emotionally or sexually attracted to such clients (Kubacki & Smith, Retzlaff, ed., 1995, p.171). Boundary issues in relationships and a clear delineation of the therapeutic framework are relevant and important aspects of therapy.
12. Clinicians should be aware of the client's potential to become intensely angry if they see others—including the therapist—as withholding (McWilliams, 1994, p310).

13. Group and family therapy approaches are generally not recommended, since the individual who suffers from this disorder often draws attention to themselves and exaggerates every action and reaction. People with this disorder often come across as fake or shallow in their interpersonal relationships with others.
14. Medications are not indicated except for the treatment of specific, concurrent Axis I diagnoses. Care should be given when prescribing medications to someone who suffers from this disorder because of the potential for abuse or dependence due to a need to quickly alleviate negative feelings. In addition, such clients may use medications to contribute to self-destructive or otherwise harmful behaviors (Ellison & Adler, 1990).
15. Individuals may respond to medication side-effects with intense and dramatic overreaction (Ellison & Adler, Adler, ed., 1990, p.59). Drug-seeking behavior is problematic, and a refusal to prescribe may precipitate dramatic emotional outbursts from the client.

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