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Understanding Histrionic Personality Disorder: A Guide for APRNs

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Introduction

Personality disorders are considered a mental health priority around the globe, yet little is known about these disorders [1]. Advanced Practice Registered Nurses (APRN) can play a vital role in the treatment of personalities disorders, providing increased access and evidence-base treatments. To accomplish this, APRNs should be familiar with the various classifications of personality disorders. This article will introduce Histrionic Personality Disorder (HPD) and will explain its clinical features, describe a thorough assessment, discuss comorbidities and management options, and provide practice recommendations for APRNs.

Definition

HPD is defined as a clinical syndrome in which individuals assume an interactional style that is marked by seductiveness, emotional shallowness, and dramatic behavior [2]. Diagnostic criteria for HPD is a pervasive pattern of excessive emotionality and attention seeking that typically begins in early adulthood [2]. It presents in a variety of contexts as indicated by having five or more of the following: extreme discomfort in situations where he or she is not the center of attention; interactions with others that are often characterized by inappropriate, sexual seductiveness, or provocative behavior; rapidly shifting and shallow expression of emotions; consistent use of physical appearance to draw attention to self; speech that is excessively impressionistic and lacks detail; and exhibits self-dramatization, theatricality, exaggerated expressions of emotion, and suggestibility [2].

HPD is categorized as a “Cluster B” personality disorder, along with Narcissistic Personality Disorder (NPD), Borderline Personality Disorder (BPD), and Antisocial Personality Disorder (ASPD) [2]. Cluster B personality disorders all share erratic, dramatic, and impulsive characteristics, but are nonetheless distinct from one another [3]. Patients with HPD often put significant time and energy into their attire in an attempt to impress others and gain

their attention [2]. They may speak in a vague style that is lacking in detail, and the dramatics in behavior may cause embarrassment for those around them [4]. Additionally, people with HPD can be impressionable, gullible, highly suggestible, and easily influenced by those that they admire [4].

Assessment

A core aspect of the Cluster B personality disorders is maladaptation in response to past traumatic events or lack of emotional development during sensitive periods in their life [5]. It has long been shown that personality disorders can be influenced by parenting style and by the patient’s attachment with their parents during infancy [6]. Thus, it is believed that the upbringing of those with HPD, combined with a natural inclination to a Personality Disorder (PD), can predispose them to HPD [6]. For this reason, the patient’s childhood, infancy, relationships with parents and close family members should be explored by the APRN. Specific parenting styles that influence HPD may be those that lacked boundaries or were emotionally inconsistent [6]. Individuals whose parents exhibited dramatic, erratic, volatile, or inappropriate sexual behavior also put their offspring at high risk for the development of HPD [6].

An assessment should also include a more in-depth assessment of the individual’s current interpersonal relationships, as they may still have notable difficulty in achieving intimacy within romantic and sexual relationships as well as within friendships [2]. Relationship losses are common in HPD because their partners feel overwhelmed with the emotional manipulation of seductiveness and dependency, demands for constant attention, insensitivity to others’ feelings with regards to provocative interpersonal style, and poor insight into their personal role in the termination of relationships [2]. Overall, a psychoanalytic approach is suggested in patients with HPD, as helping them clarify their own inner feelings can bring understanding to their maladaptive and self-defeating behaviors [3].

Screening of HPD should be aimed at deciphering it from other co-occurring psychiatric disorders & personality disorders including BPD, NPD, Antisocial Personality Disorder (ASPD) and Dependent Personality Disorders (DPD) [2]. Not being the center of attention and loss of relationships can trigger depression in HPD. Features shared by BPD and HPD include attention seeking, manipulation and rapidly shifting emotions. Features seen in BPD and not in HPD include rage and reactivity, chronic feelings of emptiness/abandonment and identity disturbance. HPD and ASPD share common features of impulsiveness, superficial, seductive, manipulative and excitement seeking, but HPD exhibits exaggerated emotions, but does not distinctly engage in antisocial behaviors (Disregard for and violation of rights of others, deceitfulness, lack of remorse, engages in acts that are illegal or show disrespect for social norms). The differentiator between HPD and NPD is that individuals with HPD are willing to gain attention not just by being dramatic, provocative or seductive, they are also willing to be seen as fragile if it serves their purpose, whereas individuals with NPD are only willing to gain admiration by portrayal of a grandiose sense of self-importance, power, and entitlement. In DPD individuals crave attention via seeking praise and guidance and go about this by exhibiting a clingy, submissive, and inhibited dependent traits, while individuals with HPD seek the same praise and attention and will accomplish this by either being manipulative, flamboyant and seductive or subdued, fragile and dependent. In individuals with DPD there is no display of disinhibition, or flamboyance [2].

Currently, there is not a stand-alone clinical measure for histrionic symptoms. The Millon Clinical Multiaxial Inventory is the only major clinical test to include a specific histrionic scale, whereas the Minnesota Multiphasic Personality (MMPI) does not include a specific HPD scale although histrionic personality traits might be inferred from other scales [7]. According to a 2016-2017 study that compared the Millon clinical multiaxial inventory to the Brief Histrionic Personality Symptom Scale (BHPS), the BHPS was shown to have good psychometric properties when used as a tool for assessing individuals with HPD [8]. Additional tools such as the Hamilton Depression Rating inventory may be useful in identifying existing depression being that the presence of any PD diagnosis has been associated with higher rates of persistent depression and/or decreased remission rates [9].

Comorbidities

HPD has been associated with a high comorbid presence of other psychiatric disorders including major depressive disorder (MDD), somatic symptom disorder, and conversion disorder (Functional neurological symptom disorder) [2]. Other personality disorders including borderline, narcissistic, antisocial and dependent personality disorders may also co-occur with HPD [2]. Depression can occur in HPD as a result of alienation from friends and loss of relationships due to pressures for attention.

Somatic symptom disorder and conversion disorders can occur in HPD whereby they may use physical symptoms and complaints to gain attention from others [2]. Somatization behavior may also be apparent during their interaction with an APRN when they provide dramatic descriptions of physical and psychological symptoms that are replaced by new symptoms each visit [2]. Screening for HPD should aim at differentiating these psychiatric disorders and personality types that have features in common with HPD. Anxiety disorders are also seen at a higher prevalence with a rating of 35% to 52% in those with personality disorders [10]. Eating disorders have been reported to co-occur in a small proportion of those suffering from various PDs. Cluster B PDs, which includes HPD, have a higher co-occurrence of Bulimia Nervosa (BN) when compared with Anorexia Nervosa (AN) [11].

Substance use disorders (SUD) can co-occur with personality disorders with an overall prevalence of 10% to 14% in the normal population and from 34.8% to 73.0% in those treated for addictions [12]. The prevalence of any PD is higher among patients with drug use disorder than Alcohol Use Disorder (AUD). Comorbid PD among patients with SUDs is a predictor of poor prognosis in terms of poorer treatment response and outcome [12].

Management

Historically, HPD is the only surviving illness designation that resembles the ancient term hysteria - a term used as long ago as Ancient Egypt and Greece - and was later termed neurosis or hysterical neuroses by Freud [13]. Despite this illustrious history, and the seeming familiarity of dramatic and superficial attention-seeking behavior, proper treatment remains elusive and understudied [7]. The overlap of personality disorders not only with each other, but also with a variety of other psychiatric diseases contributes to the difficulty of pharmacologic treatment. As with other personality disorders, there are no specific pharmacologic interventions for the treatment of HPD. Selective Serotonin Reuptake Inhibitors (SSRIs) and mood stabilizers are often used in clinical practice to regulate mood dysregulation and treat depression and anxiety in BPD [14]. Generally, pharmacologic therapy should focus on targeted symptoms, such as anxiety or depression [3]. This could include neuroleptics or mood stabilizers, but basic management in outpatient settings would most safely be initiated with SSRIs of standard dosing as they present a low risk of overdose [15].

Pharmacotherapy should be used only as adjunctive treatment in patients with HPD, with long-term psychotherapy being the primary intervention for the patient [16]. The presentation of a patient with HPD can be intimidating and overwhelming for the APRN to manage, but the outward provocation, sexualization, and attention-seeking behavior stem from low self-esteem, poor coping skills, and significant emotional distress [4]. This unstable sense of self is often masked by their projective performance [4].

In this regard psychodynamic psychotherapy can generally benefit these patients, as it can help connect implicit and maladaptive behaviors with their underlying mechanisms. More specifically, Dialectic Behavioral Therapy (DBT) may also be helpful for those with HPD [16]. DBT utilizes personalized, skills-based training to help manage emotions and change behavior [17]. Psychodynamic therapy may also be helpful for HPD patients in recognizing pathology as a result of arrested development [16].

While a primary care provider may not be able to provide direct therapeutic treatment to a patient with HPD, they may be the first professional that can form a therapeutic relationship with the patient, as patients with HPD often have chronic somatic complaints. But utilizing this relationship to identify the patient's goals, while making a point to maintain clear professional boundaries and expectations, may provide a stepping stone for the patient to enter into beneficial psychotherapy later with a Psychiatric Mental Health Nurse Practitioner, a Psychiatric Mental Health Clinical Nurse Specialist, or another clinician who provides psychotherapy.

Practice Recommendations

Treating patients with personality disorders can be challenging due to encountering manipulation, seductiveness, demanding, dependent, angry, and aggressive behaviors. Implementing practice strategies and using clinical recommendations can help build a therapeutic relationship and improve treatment outcomes. Patients with personality disorders can present with several interaction and regulation problems, that may illicit counteractive reactions, emotions, and feelings from some APRNs [18]. Implementing strategies and practice recommendations can minimize challenges and create a therapeutic environment. Recommended strategies include providing patients with a structured approach to problem-solving, encouraging patients to practice self-control, helping patients connect feelings to events and actions, being active, responsive, validating, and recognizing countertransference issues [19].

Other recommendations include being prepared to manage the maladaptive defense mechanisms used by patients with personality disorders. Effective defense mechanisms minimize anxiety and depression on the conscious level [3]. Repression and dissociation are dominant defenses used by patients with HPD [3]. Dissociation or denial is the replacement of unpleasant affects with pleasant ones, and patients who frequently dissociate appear as dramatic and emotionally shallow. The APRN should remain calm, firm, and use displacement with these patients by talking with them about the issue of denial in a non-threatening way [3]. Empathizing with the denied affect without confrontation may allow the patient to raise the original topic themselves [3]. Acting out, throwing tantrums, aggressive behaviors, and pleasureless promiscuity are other defense mechanisms used by patients

with personality disorders [3]. The APRN should be mindful of escalating behaviors, recognize that the patient may have lost control, and try to focus the patient's attention or leave the room to maintain safety when defense mechanisms present a threat [3].

Ritter, et al. [19] also recommend the therapeutic use of self through proper communication. This intervention involves being empathic but firm, maintaining a positive tone but exhibiting firmness when needed, and recognizing negative countertransference that interferes in building therapeutic relationships [19]. Combs, et al. [20] offer the following guidelines when managing patients with cluster B personality disorders:

- Maintain clear, unambiguous communication;
- Explore treatment options optimistically;
- Work in an open, engaging, nonjudgmental manner to build a trusting relationship;
- Remember that people with cluster B diagnoses usually come from a traumatic history;
- Cultivate calmness when facing emotional volatility;
- Be supportive, compassionate and calm in finding solutions for life problems;
- Encourage manageable short-term goal setting.

A final recommendation to APRNs would be to ensure individualized treatment of patients with suspected personality disorders. The DSM-V contains an alternative method of diagnosing personality disorders, which does not cluster personality disorders, but characterizes them based on their individual impairments in functioning and pathological traits [2]. HPD is not specifically included in the alternative model as it has overlap with other Defined Personality Disorders in this model such as BPD and NPD. This alternative model emphasizes the individualizing of care because assessment, treatment, and patient-APRN relationship will also vary accordingly.

The goal of these practice recommendations is to establish and maintain a useful and therapeutic APRN-patient relationship. Patients with personality disorders have an increased risk of suicide, substance abuse, injury, depression, and homicide [20]. A therapeutic APRN-patient relationship should help improve treatment goals and decrease risks for patients diagnosed with HPD.

Conclusion

HPD is a prevalent disorder around the globe, and those suffering from the disorder need specialized care. PMHNPs and PMH-CNSs are trained and ready to care for these patients, many of which provide various psychotherapeutic techniques that are efficacious in HPD. However, it is important for APRNs working in

all settings to be able to identify individuals with HPD early. With early identification, APRNs will be able to intervene, accurately diagnose, explain the illness and provide education to the patient, and quickly refer them to receive appropriate care.

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