

The so-called “good hysterics” revisited

*A study of histrionic personality disorder based on its low
prevalence in a large Norwegian psychiatric sample*

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Abstract

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Title of article: “The so-called good hysterics revisited. A study of histrionic personality disorder based on its low prevalence in a large Norwegian psychiatric sample.”

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Background: To the knowledge of this author, no known studies with equally large sample sizes have shown as low prevalence (0.4%) for histrionic personality disorder (HPD) as that of this one. As a literature review indicates that HPD suffers from low construct validity, this article will shed light on the low prevalence by analyzing the construct validity of HPD.

Methods: Data was obtained from twelve different Norwegian day treatment centres, comprising 2289 patients treated for personality disorders. Information on personality disorders was gathered by Structured Clinical Interview for DSM-IV Axis II Diagnoses (SCID-II), in addition to measures on dysfunction, distress and interpersonal problems. The author did not participate in data gathering.

Results: Although only 10 (0.4%) patients obtained HPD diagnosis, certain findings aided analysis of construct validity; (1) HPD diagnosis and fulfilment of HPD criteria indicated distress and dysfunction, (2) the HPD criteria were interrelated, but only marginally more related to HPD than to borderline personality disorder and to narcissistic personality disorder diagnoses, and (3) the eight HPD criteria were, by of exploratory and confirmatory factor analysis, divided into two factors.

Conclusions: The HPD diagnosis in its current form seems to suffer from low construct validity, with implications for prevalence rates. Different possibilities as to which latent structures underlie the eight HPD criteria are discussed, and a tentative suggestion as to the shared properties between these structures is offered.

Preface

I am greatly indebted to the following persons, with whose help I have paved my way through a substantial amount of literature, critically evaluated my results, and gradually evolved towards an understanding of what research and personality disorders are all about:

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1. Introduction

In all its versions, the construct and diagnosis histrionic personality disorder (HPD) has been subject to debate for more than 50 years. This debate has largely been due to the sustaining disagreement and uncertainty as to its true nature (Chodoff, 1974, 1978, 1982; Chodoff & Lyons, 1958; McWilliams, 1994; Millon, 1996; Pfohl, 1995). Comorbidity studies have been relatively consistent, showing significant co-occurrences with borderline (BPD) and narcissistic personality disorder (NPD) (Dahl, 1986; Ekselius, Lindstrom, von Knorring, & Bodlund, 1994; Grant, Stinson, Dawson, Chou, & Ruan, 2005; Marinangeli et al., 2007; Nurnberg, Raskin, Levine, & Pollack, 1991; Pfohl, 1995; Pfohl, Coryell, Zimmermann, & Stangl, 1986; Widiger & Rogers, 1989; Widiger et al., 1991), and to a somewhat lesser degree co-occurrences with antisocial (ASPD) and dependent personality disorder (DPD). Studies have shown conflicting prevalence rates, with some showing a complete lack of patients with HPD (see table 1). Furthermore, the levels of psychopathology for those diagnosed with (previous versions of) HPD have frequently been identified as either benign or malignant (Easser & Lesser, 1969; Kernberg, 1975, 1992; Knapp, Levin, McCarter, Wermer, & Zetzel, 1960; Zetzel, 1968), and as representing higher and lower developmental levels of defenses. This has resulted in confusion as to exactly which patients this diagnosis has been aimed at identifying. As HPD is a construct¹, in the sense that its criteria are operationalizations of domains of behaviour specific to those who are meant to be described by this diagnosis (Livesley & Jackson, 1991), the recurrent comorbidity patterns, conflicting prevalence rates and differences among patients within the same construct indicate that the construct validity of HPD is questionable.

¹ Throughout this article, the term “construct” will refer to the constructed and manualized HPD diagnosis. The term “latent structure” (Widiger, Simonson, Krueger, Livesley and Verheul, 2005) will refer to the underlying structure, that being the structure(s) in real life that are identified by the HPD criteria. Latent structure is not equivalent to, but an indicator of a nosological entity.

Table 1: Prevalence rates across studies*Community samples*

Author	Diagnostic	Country	Sample size	HPD (%)
Black et al. (1993)	DSM-III	USA	247	(3.2)
Coid et al. (2006)	DSM-IV	UK	626	(0.0)
Crawford (2005)	DSM-IV	USA	644	(0.9)
Klein et al. (1995)	DSM-III-R	USA	229	(1.7)
Lenzenweger et al. (1997)	DSM-III-R	USA	258	(1.9)
Lenzenweger (2007)	DSM-IV	USA	214	(0.0)
Maier et al. (1992)	DSM-III-R	Germany	452	(1.3)
Moldin et al. (1994)	DSM-III-R	USA	302	(0.3)
Samuels et al. (2002)	DSM-IV	USA	742	(0.2)
Torgersen et al. (2001)	DSM-III-R	Norway	2053	(2.0)
Zimmermann & Coryell (1989)	DSM-III	USA	797	(3.0)

Psychiatric samples

Author	Diagnostic	Country	Sample size	HPD (%)
Keown et al. (2002)	ICD-10	UK	166	(6.0)
Posternak & Zimmermann (2002)	DSM-IV	USA	530	(1.1)
Ranger et al. (2004)	ICD-10	UK	73	(3.0)
Zimmermann et al. (2005)	DSM-IV	USA	859	(1.0)

1.1 Background for this study

When the author's preliminary research on patients with personality disorders in Norwegian day treatment units revealed that merely 10 (0.4%) out of 2289 patients with personality disorders were above threshold for HPD diagnosis, this seemed to follow the jinx of histrionic personality disorder.

Undeniably, 0.4% was an alarmingly low prevalence for patients with HPD.

Although prevalence studies have found conflicting prevalence rates (table 1), the findings from this study can be considered robust. Several reasons can support this:

First, the data were gathered from twelve different day treatment centres across Norway. Any idiosyncratic accepted-among-colleagues-as-truths as to understanding of criteria or diagnosis should thus be limited, although these centres are under the same network and participate at the same annual conferences. Second, the means by which these data were gathered have been nothing but the most thorough (see 2.1 Methods, p.23). Third, the sample consisted exclusively of patients with personality disorders. One should therefore expect to find higher rates of any personality disorder among this sample than in the normal population. Fourth, whereas different community and psychiatric samples show conflicting prevalence patterns, some have found curiously low prevalence rates. In addition, the on-going Norwegian Multisite Study of Process and Outcome in Psychotherapy, comprising 530 outpatients with axis II disorders, have found no patients with HPD (von der Lippe, personal communication, 2007).

Upon researching PSYCinfo, MEDLINE, PUBMED and even the local academic library to understand this low prevalence, it seemed as if the low prevalence was proportional to the relatively little research previously published on histrionic personality disorder, especially when compared to that of BPD, NPD, and ASPD personality disorders; the probands of HPD in cluster B. However, the literature that did exist on HPD revealed a historical development with unresolved questions that had potential for providing insight into the low prevalence of this study.

1.2 Literature review

When reading the literature on HPD from the perspective of the low prevalence in this study, the following issues raise questions as to the construct validity of HPD. Poor construct validity can result in low and differing prevalence rates, and is thus a reasonable starting point for research.

1.2.1 Evolution from hysteria to histrionic personality disorder

Histrionic personality disorder has not always been a nosological entity. Rather, there has been a gradual development, originating in the symptomatic disorder hysteria, and oriented towards identifying a hysterical personality (Chodoff & Lyons, 1958). The result of this development has been a personality disorder no one really knows what is.

When studying hysteria, Freud found his Galapagos in 19th century Vienna. At that time, sexual morality was confounded with severe restrictions and hypocrisy (Veith, 1993). The degree of inhibition of sexual urges in women was only superseded by society's fascination with the same topic. As women's sexual urges or desires were prohibited by social standards, Breuer and Freud (1893-95) believed this ultimately would lead to suppression of the same urges, although later traceable through hysterical symptoms such as conversion, heightened emotionality etc. Albeit not an isomorphic relation, Freud (1931) later linked hysteria to erotic personalities or types, namely those whose major goal in life was "the desire to love or above all be loved" (p. 250). Kraepelin (1904), working on this field about the same time as Freud, further developed the understanding of hysteria based on clinical data, but focused on the character and dynamics behind the hysterical symptoms; namely "to secure the sympathy of those around her, she has to recourse to (...) histrionic exaggeration" (p. 253). However, Freud's interest lay in describing how hysterical symptoms could be explained as dammed-up energy representing drives (libido), rather than the character under which regime the histrionic exaggeration could take place (Silverstein, 2007).

The further transition from hysteria to hysterical personality has left something to be desired as to clarity and linearity. It seems plausible that as the study of personality rather than symptoms gained interest in the psychoanalytic arena, attention was focused on the hysterical personality rather than the hysterical symptoms (Chodoff, 1978). Consequently, the study of the symptomatic disorder hysteria lost interest, especially as the hysterical character was only loosely connected to hysteria. The hunt for the common denominators behind the hysterical character had begun. The

German phenomenological school of psychiatry elaborated on Kraepelin's descriptions (1904), as different traits of the hysterical patient were described; Jaspers (1949) focused on their attempt to seem more than they were, as a parallel to Kohut's (1968) later writings on narcissistic personality, but claimed that this was a result of self-deception and loss of contact with genuine feelings. Their "hysterical gift" was their ability to live in the theatre they had created, and be carried away by the moment. Schneider (1923/1950) emphasized the exaggerated or self-aggrandizing manner of drawing attention to oneself. He noted their attempts to seem more desirable by means of constant lying. Kretschmer (1926) wrote on rapidly shifting emotions, a theatrical pathos, their search for greatness and play with suicide. Reich (1933/1949) held forth the coquettish actions and appearance in hysterical patients, as well as their suggestibility and how they reacted to disappointments with devaluation. Fenichel (1945) added to Reich's formulations the inclination to sexualize all nonsexual relations, and inviting others to turn from reality to fantasy. Chodoff and Lyons (1958) elaborated on the sexuality in these patients, noted that frigidity and sexual inhibition lay under the sexual provocativeness, and that their self-presentation masked a childlike dependency. They believed that the patients' emotional outbursts concealed a demand to be taken care of. Shapiro's (1965) writings on hysterical neurotic style gave penetrating insights into how their behaviour came to be as a result of diffuse, impressionistic cognitive functioning. Based on clinical experience and patients' response to Rorschach testing, he developed an integrated explanation of the functioning of those with what he called a "neurotic hysterical style". He described their cognitive style as overwhelmingly impressionistic, focusing on impression rather than detail, being led by sudden emotional resonance and forfeiting the use of the mind as the machinery it was meant to be. Their opinions were thus suggestible, formed by impressions and not reflected upon, making them more susceptible to suggestions from others or the impact of new impressions. A lack of commitment is a weak foundation for holding on to one's opinion. Their emotionality is equally superficial, as they are "struck" by familiarity, vividness, colours or something fascinating upon inspecting facets of the world, which triggers their enthusiasm, rage, sadness or similar evoked emotions. As new experiences

emerge, their emotions vanish, and in retrospect they rarely acknowledge those emotions as “theirs”.

Upon formalizing the criteria for HPD in diagnostic manuals, the historical evolution of HPD has been the ground out of which a personality disorder diagnosis emerged.

1.2.2 Rationale behind criteria

Although the HPD diagnosis is (heuristically) recognized mainly by dramatic flamboyance and attention-seeking, the eight criteria in *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (*DSM-IV*; American Psychiatric Association, 1994) (see box 1) constituting HPD do not easily come together as a whole. For example, the DSM-IV criterion 7 (“is suggestible”) and criterion 2 (“interactions with others is often characterized by inappropriate sexually seductive or provocative behaviour”) are not immediately recognizable as two co-occurring features of a unitary syndrome. By comparison, criterion 1 (“is uncomfortable in situations in which he or she is not the centre of attention”) and 4 (“constantly uses physical appearance to draw attention to self”) reflect different attitudes or behaviours that seemingly sample the same domain; attention-seeking. Criterion 7, criterion 5 (“has a style of speech that is excessively impressionistic and lacking in detail”) and criterion 3 (“displays rapidly shifting and shallow expression of emotions”) seem to be the “odd criteria out”. They are frequently applied in case examples (Millon, 1996; Spitzer, Gibbon, Skodol, & Williams, 1994; 2002) but no rationale is given for their inclusion with the other criteria, and one is left to speculate why they fall in under the same construct. It seems as the HPD criteria are not as seamlessly connected as those of for example APD (avoidant personality disorder) or OCPD (obsessive-compulsive personality disorder). As DSM-IV is (postulated as) atheoretical (Millon, 1996), one will find it hard to explain why these criteria are describing the same prototype, lest one could use steps of inferences and theory. Reliability statistics as to the HPD criteria are rare (Pfohl, 1995), and the observational criteria for HPD are in distinct lack of more comprehensive and

elaborate descriptions. In order to further understand the combination of these criteria, a historical perspective on the manualized nosological development of histrionic personality disorder in DSM-IV (1994) is necessary.

HPD made its first official categorized appearance in *Diagnostic and Statistical Manual of Mental Disorders*, 2nd edition (*DSM-II*; American Psychiatric Association, 1968), then under the label hysterical personality disorder. Excitability, emotional instability, over-reactivity, attention-seeking, self-dramatization, immaturity, self-centeredness, vanity, and dependence described the full prototype. (The diagnosis emotional unstable personality in *Diagnostic and Statistical Manual of Mental Disorders*, 1st edition (*DSM-I*; Mental Hospitals Service, 1952) covered some of the criteria for the current version of HPD, but at that time the hysterical personality was probably too closely connected to conversion hysteria to facilitate a separate diagnosis.) Usage of the term “histrionic² personality disorder” was suggested in DSM-II, and first applied in *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition (*DSM-III*; American Psychiatric Association, 1980), quite possibly due to a desire to further remove the construct from its roots in hysteria (Chodoff, 1974) and to soften its connotations as to gender. DSM-III introduced criteria on manipulative use of suicide (attempts or gestures) and irrational, angry outbursts, but the same criteria were later removed in *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition revised (*DSM-III-R*; American Psychiatric Association, 1987, largely due to overlap with BPD (Pfohl, 1995). Two more criteria were thus added; “is inappropriately sexually seductive in appearance and behaviour”, and “has a style of speech that is excessively impressionistic and lacking in detail”. When preparing DSM-IV, low specificity participated in the removal of the criterion “is self-centred, actions being directed toward obtaining immediate satisfaction; has no tolerance for frustration of delayed gratification”. To keep the number of criteria at eight, a new criterion was introduced; “considers relationships to

² Histrionic er derived from the Greek word “histrionicus”, meaning “pertaining to an actor”

be more intimate than they actually are”. The DSM-III-R criterion “constantly seeks or demands reassurance, approval or praise” was also considered too unspecific, as it tended to overlap with other personality disorders. It was therefore reworded into “is suggestible, i.e., easily influenced by others or circumstances” in DSM-IV.

Furthermore, five criteria were now necessary to obtain diagnosis, as compared to four criteria in DSM-III-R. Not surprisingly, this led to a decline in the number of patients diagnosed with HPD (Blais & Baity, 2006). HPD is now defined as depicted in Box 1.

Box 1

Diagnostic criteria for histrionic personality disorder (DSM-IV, 1994)

- (1) is uncomfortable in situations in which he or she is not the centre of attention
 - (2) interaction with others is often characterized by inappropriate sexually seductive or provocative behaviour
 - (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.
-

It seems as if the development of the HPD construct in DSM moved towards easily identifiable criteria referring to attention-seeking, and withholding criteria referring to sexual inhibitions, dependence, immaturity etc, as were descriptive of previous understandings of HPD. Thus, the aforementioned criteria 3, 5 and 7 still stand out. However, based on the previously mentioned work of Shapiro (1965), a rationale for criteria 3, 5 and 7 is suddenly given. The inclusion of these criteria under the histrionic category can thus be explained as an adoption of classical understandings of the hysterical character. Several reasons can be suggested for this, but one

possibility could be that the DSM Task Forces included these as an homage to the psychoanalytic establishment and the clinically appealing works of Shapiro (1965).

The attention-seeking seems to have been the common denominator found by different nosologists, whereas other descriptions have been more sporadic in appearance. As the descriptions diverged, the editors of DSM at one point had to choose one out of several possible combinations of criteria to constitute the HPD construct. The attention-seeking has been the most agreed-upon (as well as easily identifiable and heuristically easy), whereas the inclusion of criteria referring to an impressionistic cognitive style quite possibly reflected the ambiguity and uncertainty as to what latent structures this diagnosis referred to. This topic was paralleled in a related debate arose around the 1960's. At that time, clinicians and theorists were concerned with divergent descriptions of the hysterical personality, as well as the discrepancy between the somewhat benign understandings and descriptions of hysterical personality, and the severity of psychopathology found among some of the patients who fell under the same diagnosis.

1.2.3 Unitariness of diagnosis

Based on a review of one hundred different psychoanalyses, Knapp and colleagues (1960) stated that; "our reports tend to indicate that hysterical patients are, to put it simply, very good or very bad patients" (p. 460). Easser and Lesser (1969), following this line of thought, differentiated those they called hysterical and those they called hysteroid. The hysterics were seductive, competing with same-sex peers to gain the interest of the other sex, and dreamt of the ideal romantic love that one day would be theirs. Although they tended to function quite well socially, they usually experienced a vague discomfort upon subconsciously expecting shame or humiliation in the face of rejection or failure. They were warm and to be found at the centre of attention, but could use anger instrumentally to achieve their interpersonal goals. When visiting their childhood homes, they regressed to dependent and inhibited children. Their parents were ever-present in their mind and fantasies, especially regarding sexuality.

Their other-sex parent usually applauded their charm, but reacted negatively to their sexuality. These patients' sexuality dominated and scared them side by side. Their defence mechanisms were usually suppression, denial and substituting reality with fantasy. As to hysteroids on the other hand, Easser and Lesser described them as lying somewhere between the infantile dependent and the borderline or psychotic. Their exhibitionism was one of latent aggression, and their competitive mentality beyond that of the hysterics. They were described as self-and-other-absorbed and at times functioned in an insisting or bizarre manner. They could change their hair colours on a weekly basis to keep up with their changing emotions. As hysterics at times had problems in relations, the hysteroids had problems forming relations. They started relations with enthusiasm, but ended in bitterness and rage when their expectations of rescue, care and nurture were not fulfilled. As to environmental influences, Easser and Lesser found that their mothers usually died early, or did not provide affective nurturance. Their fantasy life was richer than that of hysterics, and they partially lived within these fantasies, as a substitute for relations.

Equally impressed by the apparent differences within those unitarily diagnosed as hysterics, Zetzel (1968) wrote the intriguing article "The so-called good hysterics" where she questioned whether hysterics could be subsumed under the same diagnosis. She introduced the term "good" and "bad" hysteric, where she delineated the bad hysteric as something close to what is now known as borderline personality disorder. Zetzel divided hysterics into four groups, based on their level of pathology and analysability. The true hysteric had, in Zetzel's opinion, experienced a triangular conflict, but paid a too heavy price. She argued that a child usually will have an ambivalent relationship with at least one of the parents, but defend against these feelings by reaction formation. The groups were not described very detailed, but the third group composed of depressive patients whose depressions were hidden under a masque of hysteria. The fourth group, the bad hysterics, were described as all to ready to express intense sexualized transference fantasies, and tended to regard these fantasies as areas for realistic gratification. The intensity of their acting-out was "...like the obsessional defenses of the borderline or psychotic, they are directed

towards ensuring their perception and control of certain aspects of external reality” (p. 260).

Lazare, Klerman, & Armor (1970) and Marmor (1953) suggested distinguishing between different levels of severity and pathology by means of identifying their fixations as oedipal and oral. Lazare et al. (1970) portrayed the healthier oedipal hysterical personality as being seductive, competitive, buoyant, experiencing guilt and obsessional traits, as well as being sexually inhibited, but otherwise rather well-functioning when not under stress (mainly when in fear of rejection or as aging comes into play). Criteria concerning suggestibility and dependency were debated upon, reflecting their impressionistic cognitive style and covert dependency needs. The sicker oral hysterical personality was described as more pronounced in its dysfunction; sexually promiscuous or troubled, self-absorbed, impulsive, disturbingly unstable affectivity, manipulative behaviour, poor differentiation of internal and external reality, and inability to tolerate separation from love objects. Their dependency was thus described as either covert or intense, in line with Zetzel’s (1968) who questioned their differences as to ego development and subsequent difference in suppression or impulsivity in expression of needs.

Kernberg (1975, 1991) sought to distinguish even more elaboratively between the classical hysterical personality, which he termed healthier, and the modern histrionic personality, which he termed sicker. In his line of theory, he attempted to distinguish patients as to their structural level of psychopathology. He separated the neurotic, borderline and psychotic structural level of psychopathology, each level consisting of development-specific defenses and problems. He considered hysterics to be organized at a neurotic structural level, but his experience with the difference among patients participated in his separating those from those he called histrionic. Furthermore, he separated the female from the male hysteric or histrionic. The main distinction between hysterical and histrionic personality was the loss of control and function, which was a general feature of the histrionic, but for the hysterical this only happened when in conflict with close persons. They shared some core dependency

problems, but used defenses from different levels of maturity and level of organization.

In the sense that patients diagnosed with the same diagnosis (HPD) have been described as either two groups of patients with different psychopathological profiles³, the over-inclusiveness of the HPD diagnosis testifies to problematic construct validity. The comorbidity with other personality disorders has highlighted this problem even further.

1.2.4 Delineation of diagnosis

Aspects of the co-occurrence of HPD and severe personality disorders, especially NPD and BPD (Dahl, 1986; Ekselius et al., 1994; Grant, 2005; Marinangeli et al., 2000; McCormick et al., 2007; Nurnberg et al., 1991; Pfohl, 1995; Pfohl et al., 1986; Widiger & Rogers, 1989; Widiger et al., 1991) have been troublesome, as hysteria (Breuer & Freud, 1893-95), hysterical style (Shapiro, 1965) or hysterical personality (Horowitz, 1971) have traditionally been understood as neurotic styles, whereas BPD and NPD are usually understood as manifestations of severe developmental disorders (Silverstein, 2007). As to the conflicting prevalence rates of HPD, inpatient samples usually have higher rates of cluster B personality disorders (particularly borderline and histrionic; Black, Bell, Hulbert, & Nasrallah, 1988; Charney et al., 1981; Friedman et al., 1983; Pfohl et al., 1984), whereas outpatient samples tend to have more cluster C personality disorders (e.g., obsessive–compulsive, avoidant, and dependent; Pilkonis & Frank, 1988; Shea et al., 1987; Tyrer et al., 1983). If HPD is connected to both extreme ends on a continuum of severity, one could argue that its properties should be distributed across the same continuum. Some criteria could reflect the healthier end of the continuum (understood as a conflict level (Killingmo, 1989), more mature defenses, or less serious dysfunction), and some could reflect the

³ For fluency of reading and historical reference, these types will henceforth be called “good hysterics” and “bad hysterics”, respectively.

severe end of the continuum (understood as developmental arrest or deficit (Killingmo, 1989), immature defenses, or severe dysfunction). In which case, the benign and malignant HPD could be sharing some traits or underlying structures, but otherwise be unrelated. Otherwise, all HPD criteria could be manifest at all levels of pathology, but to different extents of intensity. It seems as if this debate has ended on the discussion on whether two versions of HPD exist, rather than commenting on why the criteria of the same personality syndrome are pointing in two different directions.

The comorbidity with other personality disorders could either point to a lack of discriminating criteria, namely those specific to HPD and not shared with other personality disorders, or a too great overlap between latent structures. The discriminating features of HPD are important in the sense that they give a rationale for the necessity and existence of histrionic personality disorder for HPD as a diagnostic category, as DSM attempts to identify as few independent diagnoses as possible, lest the manual be miles thick. For example, HPD will most likely share some features with similar personality disorder constructs, such as NPD. Their interpersonal behaviour will be similar to some extent, as they both have a grandiose, exhibitionistic display of themselves. However, unless there is something unique about HPD, one should be aware of the danger that this diagnosis would lose its necessity. Those who obtain this diagnosis should have a pattern of something unique that will be lost if it were to be subsumed under NPD. On the other hand, overlap with other personality disorders can reflect level of severity, and give important clinical information. The comorbidity between HPD and BPD is an example of the former (Widiger & Rogers, 1989), and the comorbidity between HPD and DPD is an example of the latter.

Comorbidity of personality disorders has been an ongoing dilemma when discussing the construct validity of personality disorder diagnoses. Comorbidity usually affects prognosis (Millon, 1996), clinical picture and treatment planning. Furthermore, the very conceptualization of personality disorders is closely connected to exactly how

independent they are from each other. If certain personality disorders often co-occur, can we then maintain that these PDs are separate entities? The full debate on comorbidity would be beyond the scope of this article, but interested readers are referred to Millon (1996) and Oldham (1991) for thoughts on the matter. For this article, suffice it to say that comorbidity is the rule rather than the exception for personality disorders in general. Comorbidity could be the result of confusion among diagnosticians as to diagnostic criteria or shared fundamental psychopathological disturbances (Oldham et al., 1991). Co-occurring diagnoses may be causally related, or the comorbidity could reflect a shared definitional artefact resulting from shared diagnostic criteria (Widiger et al., 1991). Widiger and Rogers (1989) suggested that the three clusters represent three different manifestations of fundamental disturbances, and intra-cluster correlation should thus be high, which has found support in research (Kass et al., 1985; Sanislow et al., 2002).

In settings where persons with severe personality disorders reside, one will often find higher rates of comorbidity (Boyd et al., 1984; Fyer et al., 1988). In a review of studies from 1983-1990, Gruenreich (1992) found that HPD was the personality disorder most frequently comorbid with BPD. As noted by Widiger et al. (1991), co-occurrence must be held up against the base rate of the personality disorders in question. A comorbidity of 6 BPD-HPD when $n_{HPD}=10$, is significantly higher than a comorbidity of 6 DPD-BPD when $n_{BPD}=300$. Different studies have conflicting findings, but on an overall basis, HPD seems to be most usually comorbid with NPD, BPD, ASPD and/or DPD (Dahl, 1986; Ekselius et al., 1994; Marinangeli et al., 2000; McCormick et al., 2007; Nurnberg et al., 1991; Pfohl et al., 1986; Widiger & Rogers, 1989; Widiger et al., 1991).

As there seems to be genetic influence with regards to all common personality traits studied (Torgersen, 2005), and common personality traits share approximately half the variance with personality disorders (Costa & McCrae, 1990; Soldz, Budman, Demby, & Merry, 1993), one can expect personality disorders to be genetically influenced as well. A twin study by Torgersen and colleagues (in press) have recently

found a modest level of total heritability for HPD (0.31), and, maybe more importantly, that the common genetic factor among all cluster B diagnoses had the strongest effect on HPD. The high common variance shared by the cluster B personality disorders has been found elsewhere (Zimmermann & Coryell, 1989, 1990; Moldin, Rice, Erlenmeyer-Kimling, Squires-Wheeler, 1994; Grilo & McGlashan, 2000; Fossati et al., 2000; Zimmermann, Rothschild, & Chelminski, 2005). HPD and BPD had the lowest disorder-specific genetic variance, which could imply that these disorders represent the overall genetic liability to cluster B. When considering comorbidity within cluster B, one would have to reflect on the possibility of shared genetic material. Stress or adverse experiences could accentuate already existing predispositions within individuals, and trigger a pattern of histrionic behaviour, thought and emotions.

The de-delineation of HPD as a construct has probably not increased its desirability as a subject for theory or research. When the latent structure underlying a personality disorder can not be distinguished from that of another personality disorder, the construct validity of either is problematic, as their being separated is hard to explain.

By these areas of historical development, research and questions as to HPD, questionable construct validity seems to be evident. By analyzing the construct validity of the HPD diagnosis this article will shed light on HPD as a construct, and in doing so provide reasons for the low prevalence of HPD, as these quite possibly are related.

1.3 The present study

There is no gold standard for analyzing construct validity (Kendell & Jablensky, 2003; Oldham, 1991). However, the procedure proposed by Robins & Guze (1970) is one of the most usually referred to as to validation of constructs of psychopathology (Widiger, 1993; McDermut, Zimmerman, & Chelminski, 2003). Robins & Guze (1970) suggested five areas for analyzing construct validity; (1) clinical description

(identifying core symptoms and features), (2) laboratory studies (data on biological markers), (3) delimitation from other disorders and unitariness of diagnosis, (4) follow-up study (showing that individuals with the same disorder follow a similar course to one another), and (5) family study (demonstrating increased prevalence among close probands). However, their article reflected an understanding of diseases as discrete entities, as if psychiatric illnesses did not share genetic variance. This must of course be considered as a result of the time this article was written. Kendell and Jablensky (2003) maintain that it should be sufficient to demonstrate that the defining features of a syndrome should be demonstrated to be an entity, and separated from neighbouring syndromes and normality. Arntz (1999) made a similar argument, principally relying on exploratory and confirmatory factor analysis and reliability statistics to evaluate the construct validity of personality disorders. Upon analyzing the construct validity of personality disorder not otherwise specified (PDNOS), Verheul, Bartak, & Widiger (2007) primarily used comorbidity statistics, in addition to assessing the severity of those diagnosed with PDNOS, to indicate their rightful place among the DSM-IV clusters.

The purpose of this article will be to analyze selected properties of the aforementioned sample of 2289 patients with personality disorders, with the intent to study histrionic personality disorder. The first step of this study will be to analyze the construct validity of the HPD diagnosis, as the literature review indicates that the HPD construct suffers from low construct validity. This will be done by investigating to which extent the HPD diagnosis is an indicator of psychopathology, if it is sufficiently separated from other personality disorders, and if it can be demonstrated to be a unitary entity of psychopathology. The next step will be to suggest different possibilities as to which latent structure(s) the HPD criteria refer to, as the literature review also speaks of a conglomerate of diagnoses, criteria and intentions melted together into HPD. The different possibilities offered will in turn provide different answers as to the low prevalence found in this study. These possibilities are based on the statistical procedures in this article, in addition to clinical information as provided in the literature review. This part is therefore tentative.

Questions as to gender-bias will not be raised in this article, even though a substantial amount of literature has been written on the topic. As Pfohl (1995) stated, “there appear to be important sex-related differences in the application of the diagnosis, but the clinical implications of this are not clear” (p. 186). For more information on this, the interested reader is encouraged to read Chodoff (1982) and Horowitz (1971).

2.0 Materials, methods and statistics

2.1 Materials and methods

Patients treated in the Norwegian Network of Psychotherapeutic Day Hospitals from 1996 to 2006 were used as data material ($n = 2289$). Treatment units within this network are specifically designed for patients with PDs, and comprise of Day Unit (Ullevål Universitetssykehus), Group Unit (DPS-Lovisenlund), Group Therapy Unit (Drammen DPS), Unit for Group Treatment (DPS Skien), Clinic for Group Treatment (Psykiatrien i Vestfold HF), Bergenhus Day Unit (DPS Klinikken), Unit for Group Therapy (Lillestrøm DPS), Clinic Unit for Group Psychotherapy A6 (HF-Sanderud), Group Therapy Unit (Ringerike psykiatriske senter), Årstad Day Unit (Fjell og Årstad DPS), Section for Group Treatment (Lovisenberg DPS) and Day Unit (Furuset DPS). Being part of the Norwegian Network of Psychotherapeutic Day Hospitals requires each unit to adhere to clearly described diagnostic procedures (Karterud et al., 1998). These are according to the LEAD-principle (Longitudinal, Expert, All Data; Spitzer, 1983).

To assess distress, symptoms and interpersonal problems, all patients are scored upon admission and discharge on Global Assessment of Functioning (*GAF*, axis V in *DSM-IV*, 1994), Global Severity Index (*GSI* from Symptom Checklist-90-R, Derogatis, 1994) and Circumplex of Interpersonal Problems (*CIP*; Pedersen, 2002), a 48-item version of the Inventory of Interpersonal Problems-Circumplex by Alden, Wiggins, & Pincus (1990). These scores are subjected to staff consensus. Both SCL 90-R and CIP consist of a 5-point Likert Scale (0-4), in which high scores indicate more symptomatic or interpersonal problems. *GAF* is scored on a scale from 0-100, where higher scores indicate better functioning at work, home or in social life, as well as somatic well-being. A separate study estimated the intra-class correlation of this *GAF* procedure as 0.96 (Pedersen, Hagtvét, & Karterud, 2007).

Structured Clinical Interview for DSM-IV Axis II Diagnoses (*SCID-II*; First, Spitzer, Gibbon, Williams, & Benjamin, 1994) and Mini International Neuropsychiatric Interview (*M.I.N.I.*; Sheehan et al., 1994) are undertaken within 2 weeks of admission. (Both these are translated into Norwegian by highly experienced researchers and clinicians.) These result in tentative diagnoses, which are discussed among team members at a case conference. The obtained data are compared with other relevant information (e.g. letter of referral, written patient narratives and evaluation interviews). Two weeks after discharge (each patient is treated for 18 weeks), the tentative axis I and II diagnoses are discussed at a new case conference, this time taking into consideration clinical observations from the 18 weeks of treatment.

2.2 Subjects

71.2% of all patients were women ($n = 1629$), and the mean age was 35 years ($SE = 0.19$). Upon entering treatment, the mean score on GAF was 44.9 ($SE = 0.11$), GSI was 1.5 ($SE = 0.01$) and CIP was 1.7 ($SE = 0.01$). Mean number of fulfilled personality disorder criteria was 12 ($SE = 0.14$).

10 (0.4%) out of 2289 patients fulfilled the criterion numbers for an HPD diagnosis. Mean age was 32.8 ($SE = 1.41$). Among these, the average number of HPD criteria was 5.3 ($SE = 0.15$), whereas average number of BPD criteria was also 5.3 ($SE = 0.63$). One patient with HPD had five other axis II diagnoses, while two patients had only the HPD diagnosis.

Of the 10 patients with HPD diagnosis, 8 were female. By reference, 1629 (71.2%) of all the 2289 patients were female. By computing Fisher's exact test, the gender difference among HPD patients was not significantly different from the gender difference in the entire dataset (two-tailed Fisher exact $p = 0.733$).

All patients in the study participated with informed consent, and the study was approved by the Regional Committee for Medical Research Ethics.

2.3 Statistics

Separation from non-pathology

GAF, CIP and GSI scores, as well as comorbidity with axis I disorders, were used to evaluate the level of dysfunction and distress experienced by the patients. By computing partial correlations between GAF, CIP and GSI scores on the one side, with the number of HPD criteria fulfilled on the other side, a correlation coefficient will inform as to how these are related. Differences between mean scores for those with and without a histrionic personality disorder diagnosis were assessed by applying a t-test.

Delineation from other disorders

Cronbach's α (Cronbach, 1951), item-total correlations, as well as the correlations between the HPD criteria and the different Axis II diagnoses were evaluated to evaluate internal consistency and level of specificity for the HPD criteria. As the total number of subjects was high, Pearson's correlation coefficient was used instead of Spearman, to decrease probability of ties.

To study diagnostic co-occurrence with other personality disorder diagnoses, χ^2 square statistics and calculation of θ coefficients were used. θ coefficient is the Pearson correlation coefficient for dichotomous data, and is therefore a legitimate effect size indicating the strength of association.

Unitariness of diagnosis

To check for unitariness of diagnosis, the factor structure of HPD was measured with an exploratory factor analysis, performed with Principal Component Analysis as the extraction method and Kaiser Normalization as the rotation method. The first PCA included all PD criteria, excluding the juvenile conduct disorder criteria for antisocial PD. The second PCA included the HPD criteria only. Factor loadings lower than 0.40 were suppressed, due to high n . The selection of factors was based on eigenvalues higher than 1.0, clinical coherence and the place of the elbow in the scree plot. To

control for limitations in PCA (not separated error and specific variances), a principal axis factoring was performed. All loadings lower than 0.40 were suppressed. By applying a principal axis factoring for control, similar structures were found. KMO measures sampling adequacy, and is recommended to be above 0.60 (Kaiser, 1970, 1974). Bartlett's test of sphericity is used to verify the assumption that variances are equal across groups or samples, and recommended to be below 0.50. (Bartlett, 1954).

A confirmatory factor analysis (using Amos 6) was performed to further test bidimensionality of the construct versus a 1-factor solution. For comparing goodness-of-fit for the different models, several indices were used. The normative fit index (*NFI*; Bentler & Bonnett, 1980), comparative fit index (*CFI*; Bentler, 1990), the Tucker–Lewis Index (*TLI*; Tucker & Lewis, 1973), and the Root Mean Square Error of Approximation (*RMSEA*; Steiger, 1990) were used to assess how well the specified model fitted the data. The CFI, NFI and TLI assess the magnitude of fit between the sample and model covariance matrices. CFI and NFI estimate the relative reduction in the lack of fit, and TLI estimates the relative improvement per degree of freedom. The CFI and NFI are both derived from chi-square statistic, and are supposed to lie between 0 and 1. The CFI score is less affected by sample size than that of NFI. Cut-off values above 0.90 have been suggested to indicate “acceptable” fit, and values close to 0.95 as “adequate” fit for NFI, CFI and TLI (Hu & Bentler, 1999). Using chi-square as a central statistic is based on the assumption that the model will hold exactly in the population, although this may be unreasonable in this kind of research, as it may imply that such models will be rejected in large samples (Jöreskog, 1996). Browne and Cudeck (1989) proposed a number of measures accounting for the error of approximation and for the precision of the measure itself. One of these population discrepancy functions is the RMSEA, which measures discrepancy per degree of freedom. A RMSEA of .05 or below indicates a good fit. The Akaike Information Criterion (*AIC*; Akaike, 1987) attempts to balance goodness of fit and model complexity. The lower AIC, the better fit. The single sample Expected Cross-Validation Index (*ECVI*; Browne & Cudeck, 1989) measures the discrepancy between the fitted covariance matrix in the current sample and the expected

covariance matrix that would be obtained in another sample of the same size. The lower ECVI, the better fit.

2.4 Additional procedures to increase statistical power

For all analyses, this study used the criteria gradient in the SCID protocol: 1 = criteria absent, 2 = criteria partly fulfilled, and 3 = criteria present. In addition, all scores were dichotomized for re-analyses to check for inconsistencies, as Pearson's correlation coefficient is not optimal for ordinal scales. Furthermore, correlation statistics with Spearman rank correlation coefficient were performed for optimal re-analysis.

Due to the large sample size, 50% of all patients from our total pool of patients were twice randomly selected, thus creating two random sub-samples of 1144 patients, comparable with the initial findings. As for factor analysis, the data file was split into four sub-samples, each comprising 572, 572, 572 and 573 patients respectively. This was done because of how factor analysis can be susceptible to a too easily reached statistical significance when n is high. Factor analysis on categorical data is usually not recommended, and the use of tetrachoric correlations is therefore favourable. However, due to the large n and use of sub-samples for re-analyses, this was not considered necessary. All analyses were performed on the entire sample, except for those specifically referring to patients with HPD.

3. Results

The prevalence for all personality disorders in this sample can be seen in table 2, depicting HPD as the personality disorder with the lowest prevalence (0.4%), and avoidant personality disorder with the highest prevalence (38.8%).

Table 2

Prevalence (percentages) for personality disorders in this study

<u>Personality disorder</u>	<u>N</u>	<u>% □</u>
<i>Cluster A</i>		
Paranoid	236	10.4
Schizoid	17	0.7
Schizotypal	30	1.3
<i>Cluster B</i>		
Antisocial	38	1.7
Borderline	536	23.5
Histrionic	10	0.4
Narcissistic	18	0.8
<i>Cluster C</i>		
Avoidant	884	38.8
Dependent	240	10.5
Obsessive-compulsive	204	9.0
PDNOS*	414	18.1

□The table should be read as follows: 10.4% of all patients in the sample had paranoid personality disorder. As comorbidity occurs, the percentage will not sum to 100.

* PDNOS indicates personality disorder not otherwise specified

Separation from non-pathology

CIP and GSI scores were moderately associated with number of fulfilled HPD criteria, but this was not so for GAF scores. Mean scores for patients with HPD signified more dysfunction on GAF ($M = 44.5$, $SE = 1.36$), GSI ($M = 1.95$, $SE = 0.18$) and CIP ($M = 1.91$, $SE = 0.14$), than the mean scores for all patients on GAF ($M = 44.9$, $SE = 0.11$), GSI ($M = 1.5$, $SE = 0.1$) and CIP ($M = 1.7$, $SE = 0.1$). However, the mean scores on GSI ($M = 1.91$, $SE = 0.14$) were the only ones significantly higher ($t = -2.334$, $df = 2246$, two-tailed $p = .02$) for patients with than without the HPD.

When correlating the number of HPD criteria fulfilled with the scores on distress and dysfunction, GAF scores were not significantly lower ($M = -0.40$, $p = .054$), whereas both CIP ($M = .079$, $p = .000$) and GSI ($M = .094$, $p = .000$) were significantly higher the more HPD criteria fulfilled.

Among all the symptom disorders, the ones significantly associated with HPD were somatoform disorders ($\chi^2 = 9.190$, $df = 1$, $p = .002$) and substance abuse ($\chi^2 = 9.989$, $df = 1$, $p = .002$).

Delimitation of diagnosis

Generally, the HPD items showed low correlation with HPD diagnosis (table 3). Criteria 7 correlated higher with DPD and avoidant personality disorder (APD) than with HPD. Several HPD criteria correlated significantly with other PDs, especially BPD and NPD. As an indicator of internal consistency, a Cronbach's α of 0.65 is acceptable, although 0.70 or higher is recommended (Pallant, 2001). By removing criteria 7; "Is suggestible", Cronbach's will rise to 0.72 (table 4).

Table 3

Correlations between the 8 HPD criteria and personality disorder (PD) diagnoses[□]

<u>HPD criteria</u>	SH	SC	PA	AS	NA	BO	AV	OCPD	DEP	HPD
(1) uncomfortable when not the center of attention	.004	-.033	.067**	.045**	.076**	.147**	-.169**	.089**	.024	.171**
(2) sexually seductive or provocative behaviour	-.002	-.022	.039	.070**	.078**	.182**	-.149**	.021	.001	.237**
(3) rapidly shifting and shallow expression of emotions	-.020	-.002	-.003	.016	.060**	.147**	-.088**	-.012	-.007	.222**
(4) use of physical appearance to draw attention	-.029	-.021	.055**	.048**	.037	.183**	-.068**	.002	.060**	.199**
(5) excessively impressionistic speech	-.015	.031	-.022	.041	.028	.097**	-.065**	.013	.011	.197**
(6) self-dramatization and exaggerated expression	-.021	-.022	.034	-.012	.071**	.159**	-.141**	.050*	.028	.225**
(7) suggestible	-.005	.012	-.015	-.006	-.022	.070**	.132**	.013	.183**	.076**
(8) considers relationships more intimate than they are	-.015	.026	-.007	-.016	-.063**	.119**	-.110**	.060**	.094**	.221**

*p < .05

**p < .01

□ SH = schizoid PD, SC = schizotypal PD, PA = paranoid PD, NA = narcissistic PD, BO = borderline PD, AV = avoidant PD, OCPD = obsessive-compulsive PD, DEP = dependent PD

Table 4*Reliability statistics of the HPD criteria*

<u>HPD criteria</u>	1*	2*	3*	4*	5*	6*	7*	8*	CITC	α
(1) uncomfortable when not the center of attention	1.00	.392	.248	.368	.153	.378	.051	.238	.447	.589
(2) sexually seductive or provocative behaviour		1.00	.341	.375	.206	.382	.067	.256	.489	.582
(3) rapidly shifting and shallow expression of emotions			1.00	.222	.378	.310	.073	.267	.410	.617
(4) use of physical appearance to draw attention				1.00	.108	.354	.045	.223	.417	.603
(5) excessively impressionistic speech					1.00	.175	.073	.149	.279	.642
(6) self-dramatization and exaggerated expression						1.00	.053	.328	.484	.583
(7) suggestible							1.00	.140	.107	.724
(8) considers relationships more intimate than they are								1.00	.385	.611

* HPD criteria 1 to 8

CITC is Corrected Item-Total Correlation, that is the correlation of the criterion with the sum of the other criteria.

 α is Cronbach's alpha if item deleted*Cronbach's $\alpha = 0.651$*

Among all other PDs, the HPD diagnosis correlated significantly ($p < .01$) with dependent (DPD), borderline (BPD) and narcissistic personality disorder (NPD) (table 6). Average number of total PD criteria among patients with HPD was 22.6.

Table 6

Diagnostic co-occurrence of HPD with other personality disorders

	total (n)	HPD n (%)	Association sig. level χ^2	θ coefficient
<i>Cluster A</i>				
Schizotypal	30	0 (0)	1.000	-.006
Paranoid	236	1 (10)	1.000	-.008
Schizoid	17	0 (0)	1.000	-.001
<i>Cluster B</i>				
Antisocial	38	1 (10)	.155	.043*
Narcissistic	18	2 (20)	.003	.114**
Borderline	536	6 (60)	.014	.057**
<i>Cluster C</i>				
Avoidant	883	1 (10)	1.000	-.039
OCD	204	1 (10)	.610	.002
Dependent	240	4 (40)	.015	.064**

The table should be read as follows: 10% of all patients with HPD diagnosis, also had a paranoid personality disorder diagnosis.

χ^2 Chi-square, Fisher's exact test (2-tailed)

* $p < .05$

** $p < .01$

Delineation of diagnosis

A full PCA on all the SCID-II criteria revealed a 19-factor solution, with eigenvalues higher than 1, explaining 51.6% of all variance. HPD criteria 1, 2, 4, 6 and 8 loaded on component 3 (table 7), explaining 3.9% of all variance, also including criteria 4 for NPD ("requires excessive admiration"). HPD criteria 3 and 5 loaded on component 16, explaining 1.4 % of all variance. HPD criterion 7 loaded, as the only, on component 17, explaining 1.3% of all variance.

Table 7*Principal Component Analysis: Factor loadings of the HPD criteria*

		Loadings including all PD criteria			Loadings including HPD criteria only		
		Factor 3	Factor 16	Factor 17	Factor 1*	Factor 2*	Factor 3*
HPD	(1) uncomfortable when not the center of attention	.66	-	-	.72 (.73)	-	-
HPD	(2) sexually seductive or provocative behaviour	.65	-	-	.67 (.69)	-	-
HPD	(3) rapidly shifting and shallow expression of emotions	-	.63	-	-	.73 (.66)	-
HPD	(4) use of physical appearance to draw attention	.71	-	-	.73 (.73)	-	-
HPD	(5) excessively impressionistic speech	-	.70	-	-	.87 (.77)	-
HPD	(6) self-dramatization and exaggerated expression	.62	-	-	.69 (.70)	-	-
HPD	(7) suggestible	-	-	.60	-	-.48	.94
HPD	(8) considers relationships more intimate than they are	.41	-	-	.44 (.44)	-	-
NAPD	(3) requires excessive admiration	.56	-	-			

* factor loadings for a two-factor solution in parenthesis

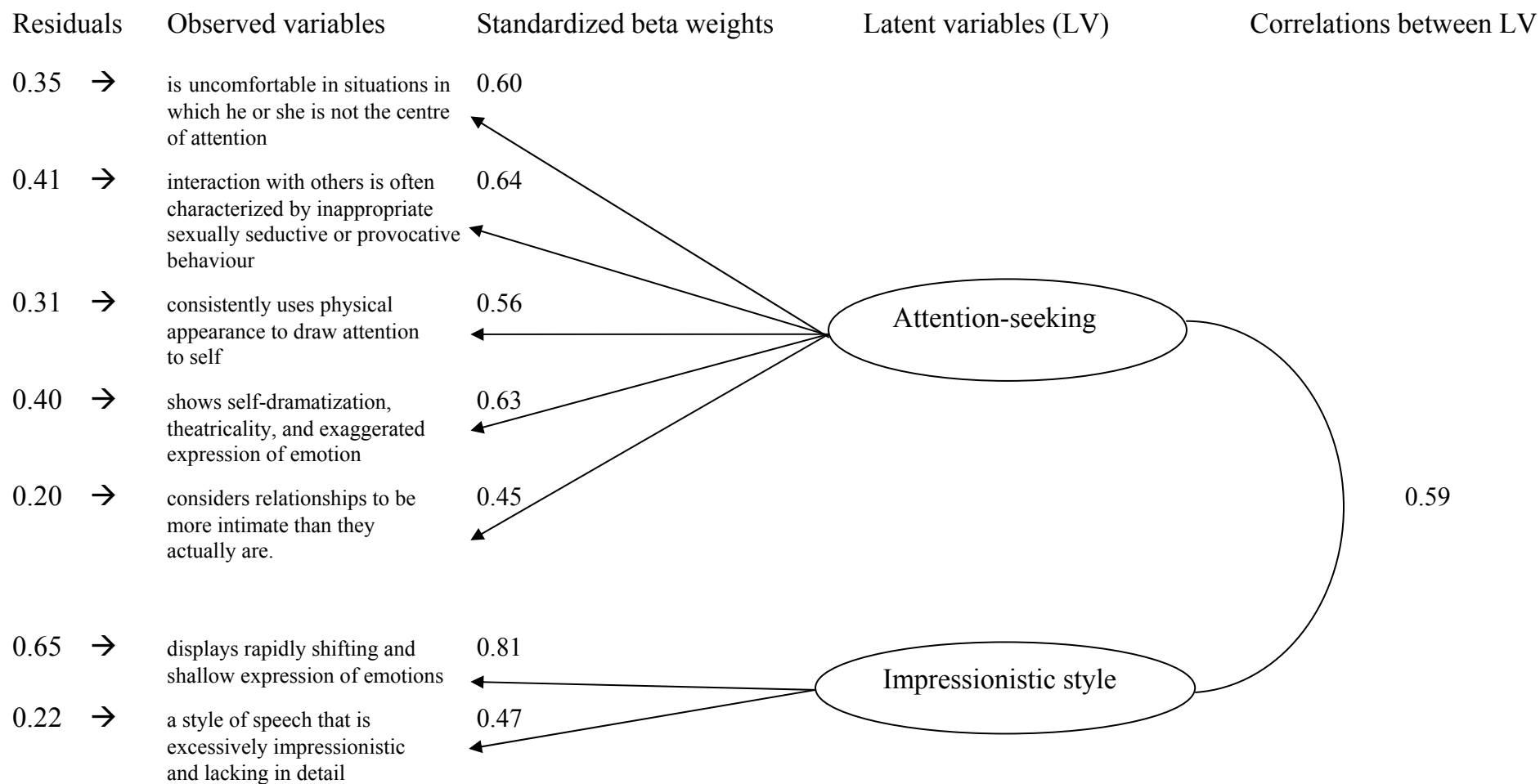
A PCA on the HPD criteria only (table 7), revealed a two-factor solution. Factor 1 consisted of criteria 1, 2, 4, 6 and 8, and factor 2 consisted of criteria 3, 5 and 7. Still, criteria 7 was suspected to be an outlier, as its correlation was low (.44), and a potential third factor had an eigenvalue of .993. Thus a new PCA was performed on the HPD criteria only, demanding a 3 factor solution. Factor 1 consisted of criteria 1, 2, 4, 6 and 8, and factor 2 consisted of criteria 3 and 5. Factor 3 consisted of criteria 7, loading high (.94).

A bi-dimensional model, with criteria 1, 2, 4, 6 and 8 in the first factor, and criteria 3, 5 and 7 in the second factor was explored by means of confirmatory factor analysis (figure 1). This model yielded a better fit ($\chi^2 = 100.2$, $df = 19$, $p < .000$, NFI = .963, CFI = .969, TLI = .942, RMSEA = .043, AIC = 150.2, ECVI = .066) than the unitary model with all criteria loading on one factor ($\chi^2 = 269$, $df = 20$, NFI = .900, CFI = .906, TLI = .831, RMSEA = .074, AIC = 317.0, ECVI = .139). The bi-dimensional model was improved when criteria 7 was removed from the second factor in the analysis ($\chi^2 = 67.5$, $df = 13$, $P < .000$, NFI = .974, CFI = .979, TLI = .955, RMSEA = .043, AIC = 111.54, ECVI = .049).

The confirmation of finding by means of randomly created sub-samples, dichotomizing scores and using Spearman rank correlation coefficient revealed no relevant inconsistencies with the initial findings.

Figure 1

Path diagram from the best fitting two-factor model for the HPD criteria (suppressing criterion 7)



4. Discussion

In this line of research, it is important to accentuate the difference between the nomothetic descriptions of personality disorders in DSM-IV and the ideographic manifestations in real life. The axis II in DSM is neither exhaustive, nor does it comprise internally homogeneous entities. The ambition, then, has been to construct the most common and distinctive prototypes of personality disorders, being as independent from each other as possible. The HPD diagnosis is only that, a diagnosis or construct, designed to enable diagnosticians in identifying the correspondence between a persons emotions, behaviours or attitudes and a latent structure (Widiger et al., 2005) operationalized as behaviours, emotions or attitudes. (See Widiger (1991) for an excellent discussion on this). For this construct to be useful, it must enable diagnosticians to identify patients based on the operationalizations of this latent structure.

4.1 Analysis of construct validity

When prevalence rates are as low as in this study, this is important information for the validity of the diagnosis in question. One way of inquiring into this will be through the analysis of the construct validity of the HPD diagnosis. In this article, the assessment of the delineation and unitariness of the diagnosis, as well as a separation of this construct from the "normal" population, has served as basis for analysis.

4.1.1 Separation from non-pathology

The low GAF and high CIP and GSI scores of those diagnosed with HPD, imply that they were severely distressed and experienced dysfunction. A GAF score below 50 is generally considered the cut-off for severe pathology, where supportive therapy is indicated (McCullough et al., 2003). Additionally, their scores indicated more distress when compared to the rest of the patients in this psychiatric population.

Comorbidity with axis I disorders was not very high, and will be not be further commentated on, apart from the reflection that substance abuse could signal considerable distress. Comorbidity with BPD can be taken as an indicator of severity of psychopathology, and so can the substantial number of other criteria fulfilled as well. In all, the patients diagnosed with HPD seem to be separated from the normal population, in terms of distress and dysfunction. The criteria also seem to indicate distress alone.

4.1.2 Delineation of diagnosis

To suggest that HPD should be completely independent of other personality disorders would be somewhat naïve. Comorbidity is normality, and not a threat to diagnostic work, but a guide into a patient's idiographic clinical picture. However, the high correlations between the HPD criteria and other personality disorders raise a different problem; The HPD criteria did not seem very specific for the HPD diagnosis. This, in combination with comorbidity with other personality disorders, suggests that the HPD construct lacks something unique. If these criteria describe a construct not well enough delineated, one could question if HPD in fact is a personality disorder in its own right. However, first one needs to understand the comorbidity patterns.

The comorbidity with DPD is probably best understood by means of inferences; The suggestibility criterion is quite possibly misconcepted as a sign of dependency akin to the dependency of patients with DPD. The correlation between this criterion and DPD, in addition to this criterion loading on a separate component on factor analysis, adds weight to this argument. Classical psychoanalytical literature suggests a different understanding of the suggestibility. The attention-seeking of HPD implies that they to a great extent depend on the approval of others, in an impulsive way for bad hysterics and a covert way for the good hysterics. This is thought to be a dependency different than that typical of DPD. As described by Easser and Lesser (1969), bad hysterics are more aggressively dependent on others, with the clinging-like features of the BPD. Their dependence is thus more similar to strong narcissistic-

dependent needs, implying an impairment in the earliest experiences of loving and being loved, and in the conditioned expectations arising out of these body experiences with self and others. As to the good hysterics⁴, Blais & Baity (2006) explicitly understand criterion 7 as a covert dependency need, and found partial support for this in Rorschach assessment and clinical settings. A covert dependency is what is thought to lie behind a passive-impressionistic cognitive style, naïvety, and suppression of healthy sexual and aggressive expressivity. One could therefore ask if these patients have a motivation for their passive-impressionistic cognitive style, namely the denial or suppression of a dependence on others. This would reformulate the neurotic hysterical style into a strategy rather than a condition. This would imply that it would be hard for a diagnostician to identify the dependency in an initial interview or after a few weeks of treatment. The dependency would be covered by layers of defenses. However, the data from this study cannot support or reject this understanding, but the literature review and comorbidity with DPD for both HPD criteria and diagnosis suggest the possibility. The comorbidity with DPD is therefore informative, but also potentially misleading as to different understandings of the suggestibility criterion.

The comorbidity with BPD is relevant as an indicator of severity (Widiger & Rogers, 1989), as well as a hint towards questioning whether HPD and BPD are really different from one another. As there were more patients with HPD and BPD than patients with only HPD, this should be further evaluated. One possibility could be that patients with BPD apply histrionic behaviours and accentuate their dependent needs for attention (implying that HPD in fact is a sub-factor of BPD), or patients with HPD could regress to more severe identity disturbances as those manifest in patients with BPD. Otherwise, the two personality disorders could simply share many features, such as impulsivity, difficulties in relationships, intensity in affectivity and

⁴ Although research or literature usually use the term histrionic for all levels of severity, this article will “translate” this into good or bad hysteric, based on how the research or literature describe the patients.

reactions e.g. Again, the question is whether the two diagnoses or their latent structures overlap too much.

The comorbidity with NPD is interesting, as their criteria to a certain degree resemble each other. The need for attention and feeling special, a grandiose display of one self, all these are in the border area between the two personality disorders. An outsider without knowledge of which latent structures the NPD and HPD criteria refer to, could quite possibly imagine them as variations over the same attention-seeking and self-aggrandizing theme. The inclusion of a criterion from NPD in the attention-seeking factor is an example of this. However, there is a “warmer narcissism” within the HPD construct, as manifest in their pleasing attitude towards others. Furthermore, those described as histrionic usually have high empathic abilities, perhaps even too high. Their manipulative sides, as described in literature, are similar to those of NPD, BPD and ASPD, but the literature describes them as distinctly warmer and more directed at affiliation.

4.1.2 Unitariness of diagnosis

The analyses suggested that the HPD criteria did not form a unitary diagnosis. To diagnose a patient with HPD critically rests on the assumption that this diagnosis makes sense by referring to something “out there”, a prototype or construct against which a diagnostician can evaluate each patient. Some of the criteria are easily captured (desire to be at centre of attention e.g.), others are not (impressionistic speech e.g.), and together they seemingly do not form a coherent construct.

Furthermore, one can imagine that it would be difficult to regard one’s emotions as shallow, thus making self-report on this item more difficult. The statistical analyses suggest that two or three different factors are at play (similar results were obtained by Shedler & Westen (2004), although they used an adolescent sample) depending on how one understands the suggestibility criterion. By this, making diagnostic judgements as to caseness will be difficult.

The first factor consisted of criteria 1, 2, 4, 6 and 8 (see box 1, p. 13), thus referring to a way of relating to others, largely by exhibitionism and theatricality, probably guided by the belief that this will increase affiliation. This factor refers to what is similar to a “warm female narcissism”, characterized by a grandiose exhibitionism of oneself and one’s attributes. One can understand this by one’s conflicting aims at pleasing oneself or others. With the danger of over-generalizing, women traditionally learn to please others, and thus more easily develop an HPD state of mind, displaying themselves to be evaluated and accepted by others. On the other side, men learn to please themselves, and are more prone to developing the coldness of NPD or the manipulative sides of ASPD. As the literature describes, a marked competitiveness with same-sex and desire to conquer their opposite-sex should be expected, as those diagnosed with HPD need to “stand out”, to be accepted or taken care of. The constant use of one’s appearance is a child-like way of asking others to approve of them or take care of them, as a substitute for forming firm relations or finding the support they need within themselves. This factor seems to refer to intense and impulsive dependent needs of others that are acted out. As is typical for cluster B.

The second factor referred to criteria 3 and 5. This factor seems to refer to a domain of behaviour where a passive-impressionistic cognitive style dominates the individual’s behaviour, mental processes and emotions. This can be understood as a way to avoid genuine relating to others and one self. This article argues that understanding criterion 7 as described by Shapiro (1965), would result in criteria 3, 5 and 7 loading on the same factor, instead of criterion 7 loading on a separate factor. Whether this factor is connected to attention-seeking, is an open debate and largely determined by how one understands the underlying structure(s).

When two or three factors, that do not seem unitary, appear in the same category, prevalence rates will be lowered as compared to disorders based on one underlying factor or several interdependent factors. This is due to simple statistics: The chances for meeting criteria X are higher than the chances for meeting criteria X and Z. As several of the criteria are reflecting the same underlying latent structure, one could

expect that the chances for meeting criteria 1 and 2 were not critically lower than the chances for meeting criteria 1 alone. By comparison, the fact that criteria 1 and 7 seemingly represent different latent structures will result in a much lower chance for meeting both criteria than for meeting either one alone. As five criteria are necessary for obtaining diagnosis, and the attention-seeking factor contains five criteria, these could be sufficient for caseness. However, none of the patients had all these five criteria. Should we compare this factor to the unitariness of avoidant personality disorder (APD), this would be equivalent to a patient not meeting all 8 criteria for APD diagnosis. In other words, perfectly normal. When the criteria of a diagnosis refer to two different latent structures, obtaining diagnosis is statistically less probable than fulfilling five of eight criteria pertaining to the same latent structure. Prevalence rates will thus suffer.

These analyses support the preliminary conclusions from the literature review in the sense that HPD seems to suffer from low construct validity, although further studies are necessary to follow up and support this. The two-factor model this study has found can also be a reflection of a compromise between different understandings of the HPD construct. As the hysteria diagnosis disappeared from the DSM system, we can imagine that the editors wanted to maintain some aspects of the hysterical style or personality in the diagnostic manual. Whether this was due to politics, theory or research is for the privileged to know. On the other hand, the HPD diagnosis was put in cluster B and constructed to refer to those flamboyant patients that lay closer to a borderline level of functioning (McWilliams, 1994), to capture the patients of more severe psychopathology formerly diagnosed as hysterical. It is therefore probable that criteria 3, 5 and 7 are operationalizations of the good hysteric, so aptly described by e.g. Easser & Lesser (1969), Kernberg (1975), and Shapiro (1965). Criteria 1, 2, 4, 6, and 8, on the other hand, seem to operationalizations of the bad hysteric, as described by e.g. Easser & Lesser (1969), Fenichel (1945), Kretschmer (1923), Lazare et al. (1970), and Schneider (1923/1950). These two factors underlying the HPD diagnosis therefore do not seem to be manifestations of the same latent structure, neither by

factor analysis nor by clinical coherence. This has implications for construct validity and prevalence rates.

4.2 Which latent structure(s) do the HPD criteria refer to?

After having evaluated the construct validity of HPD to be rather poor, a pertinent question subsequently arises; “Which latent structure(s) do the HPD criteria describe?”. This is a very difficult question, as research on HPD has been minimal. After the thorough clinical descriptions of Zetzel (1968), Easser & Lesser (1969) and Kernberg (1975, 1992), there has been a void in psychological literature as to clinical descriptions of the good and bad hysterics. There does seem to me a disequilibrium between the constructed HPD diagnosis and the latent structure(s) identified by the HPD criteria, as the literature review and analyses indicate.

It is possible to posit at least two possibilities that can explain the co-occurrence but seemingly lack of unitariness of the HPD criteria. (1) Either the HPD criteria describe a coherent personality pattern that is organized on a continuum of severity. Or (2), the HPD criteria reflect two different latent structures, which have some features in common, but otherwise are independent. These two possibilities provide different answers to the low prevalence found in this study.

4.2.1 HPD as a continuum of severity

The first possibility would be that the eight HPD criteria constitute a unitary construct that describe shared features of those who fall high and low on a continuum of severity. Kernberg (1975, 1992), Easser and Lesser (1969) and Zetzel (1968) describe their good and bad hysterics as sharing traits, but with different intensity, level of dysfunction and maturity of defenses. They have thus adhered to a shared diagnostic label, and identified two extremes within the same label. Whether they agree to the shared diagnostic label or not, was not a priority in their writings. McWilliams (1994), on the other hand, has been more specific with regard to this. She has argued

for a Kernbergian structuralization of all types of personality disorders, thus enabling a patient to be diagnosed with histrionic personality disorder at a neurotic, borderline or psychotic level of organization. But whereas Kernberg (1975) argued that specific personality disorders were most typical found on certain structural levels, McWilliams (1994) modified this by suggesting that all personality disorders can be found on all structural levels. However, both Kernberg (1975) and McWilliams (1994) argue that the histrionic style is most typically found among the neurotic level of organization, just as the obsessional neurosis. After ended treatment, patients tend to score higher on histrionic and obsessive-compulsive traits (Torgersen, personal communication, 2008), which supports the view that these two personality disorders are organized on a more benign level. With regard to this, the histrionic style can be understood as leaning more heavily to the healthier end of the continuum, but nevertheless being a style descriptive of both ends of the continuum. But interestingly, 204 patients in this study were diagnosed with OCPD, thus indicating severe distress by being in intensive psychotherapeutic day treatment. However, the dysfunction inherent in the rigidity of the full-blown OCPD is quite different than that of a patient fulfilling some criteria of OCPD, which can be quite adaptive (von der Lippe, personal communication, 2008).

When compared to Zetzel (1968), Kernberg (1975, 1992) or Easser and Lesser (1969), this would imply that the neurotic organized histrionic personality disorder is similar to good hysterics. The borderline organized histrionic personality disorder would resemble the bad hysterics. They would share all the HPD criteria, but with differing degrees of intensity, and with a different severity of pathology and maturity of defenses as background.

The high level of comorbidity with borderline personality disorder, the community studies that found high prevalence rates of HPD, and the literature on good and bad hysterics support the possibility that HPD exists on all levels of severity. However, this would not explain the low prevalence of the bad hysterics in this study. If the HPD criteria in fact describe a shared latent structure, one could expect a somewhat

higher prevalence of the bad hysterics than this study found. As personality disorders imply a certain level of distress, one would expect more of those at the extreme end to appear in the data material from this study. Should those who score on the HPD criteria mainly be found in the community, then these criteria do not describe a latent structure pertaining to both extremes on a continuum of severity. The purpose of identifying personality disorder diagnoses in DSM has been to find the most common manifestations of personality disorders, not to describe every possible construct. A personality disorder diagnosis of low prevalence is in jeopardy as to its existence in the DSM system, although no such explicit criteria exist as of now.

By following McWilliams' theory (1994), most of the good hysteric would not be identified in this study, as they would be less likely to seek intensive treatment due to their relatively high level of functioning. This could explain the low prevalence found in this study, as the 10 patients found here then would represent the few occupying the severe end of the continuum. This possibility thus implies the following; (1) that the HPD diagnosis to a certain extent has construct validity, (2) that the reason for the low prevalence of bad hysterics in this study is due to the HPD construct mainly being organized on a neurotic level of psychopathology, and (3) that the eight HPD criteria describe the prototype of the good and bad hysterics, although with different levels of intensity.

4.2.2 HPD as two categorically different disorders

The second possibility would be that histrionic personality disorder in its current form is a combination of two sub-sets of criteria pertaining to two different latent structures. The properties of these latent structures have to be inferred, based on clinical coherence, clinical literature, research and statistical analyses.

Comorbidity with BPD and NPD, strong separation from non-pathology, and the shared genetic material with cluster B diagnoses could be taken as support for the existence of a latent structure referring to more severe pathology than that of the good hysteric. In addition, prevalence studies and clinical descriptions suggest that good

hysterics do exist, or at least that some patients diagnosed with HPD are experiencing less distress than those in this study (Torgersen, personal communication, 2008). Should the eight HPD criteria refer to two different latent structures, the low prevalence would then partially be explained by the low construct validity of HPD this possibility implies. A diagnosis encompassing two disorders or nosological entities can be argued to have low construct validity, resulting in low prevalence as it would be difficult to meet caseness. Furthermore, the good and bad hysterics would be identified according to which understanding of the HPD construct the diagnostician held. A diagnostician who understands HPD as a dominantly benign disorder, will probably identify bad hysterics as BPD. The inclusion of both diagnostic latent structures in one diagnosis will thus severely affect prevalence rates. Furthermore, there will probably be other properties of either latent structure that have been left out from the set of criteria, thus forfeiting the chance to identify the patients by means of better and more comprehensive criteria.

To improve construct validity, the two nosological entities should be identified and delineated from each other with respect to their differences. Should the eight HPD criteria refer to two latent structures that are different nosological entities, one would have to ask what domains they share. As the criteria show internal consistency and most patients seem to be identified by criteria from both factors, there must be some features that connect these two entities, other than historical origin. One such feature could be what Witkin and Goodenough (1975) described as field-dependence. To simplify, field-dependence referred to the habitual use of a global perception, instead of the articulated, detailed perceptive style typical of field-independence. Later research has connected each style to distinct ways of relating to others vis-à-vis one self (Witkin, 1965; Witkin & Goodenough, 1977). Field-dependents define themselves more according to outer sources of information, fusing together the impression of themselves with the field they are in or persons they interact with, and are to a much higher degree socially involved as well. In contrast, field-independents define their opinions, feelings etc. more according to inner sources of information, and to a greater degree psychologically separate themselves from their environment.

The child's perceptual style has been found to correlate with the relationship to the parents (Dyk & Witkin, 1965; Barclay & Cusumano, 1967; Dawson, 1967), which indicated that a child can learn to filter the sensory perceptions from the outside world according to their behavioural attachment style, or at least that these are interrelated. Furthermore, Lewis (1995) found that shame and guilt, resulting from rejection by attachment figures, were significantly correlated with a field-dependent perceptual style. The field-dependents' dependence on others would thus be descriptive of aspects of a good hysteric's style, as well as a foundation for the bad hysteric. Rejection would be managed differently according to their defenses' maturational level. Denial or suppression would work for good hysterics, whereas acting-out or angry outbursts would be the reaction of choice for bad hysterics.

The avoidance of genuine affect by means of shallow emotionality, in context with the fear of being left, has been studied based on children's attachment patterns and Adult Attachment Interview (AAI; George, Kaplan & Main, 1984/1985/1986). Most important for this article were the attachment type described as preoccupied (George & Solomon, 1999; Solomon, George & DeJong, 1995). As Bowlby (1980) wrote, attachment is also a question of perception and information processing, and George & West (2001) found that those with preoccupied attachment used long, vague sentences, as well as unclear differentiations between self and other. They often used generalizations and seem insecure, incoherent and immature in their narrative abilities (West & George, 2002). Furthermore, they had trouble separating themselves from their attachment experiences. They had a strong fear of being left, as well as a general feeling of helplessness. To avoid being overwhelmed by emotions concerning attachment, they disconnect cognitively, thereby detaching affectivity, experience and detail from its source (George & Solomon, 1999; Solomon, George, & DeJong, 1995). This cognitive disconnection can be so intense that they can lose their agency of self (George & West, 2001). There is thus a distinct impressionistic style, equally described as field-dependence, that emerges as a common feature. This style can be understood as a consequence or cause of external events such as (fear of) rejection. For the good hysterics, this would be the name of their impressionistic cognitive

style, use of denial and general sensitivity towards others. For the bad hysterics this would be their constant activation of attachment system, fears of being left as well as intense need for others and their attention. The failure of others to gratify their attachment needs could potentially be disastrous.

Finally, as an experiment of the thought, Baron-Cohen (2003) highlights empathy as an organizing feature of personality. When writing on autism as recognized by extremely systemizing abilities and lack of empathizing abilities, Baron-Cohen then proposed the opposite, namely the extremely empathizing and non-systemizing. An extreme sense of empathy could be one of enmeshment, where one does not only accentuate the other's self-state, but also in some sense has trouble separating oneself from it. They would know what others desire, and take it upon themselves to please. A desire to please others, being outer-directed, and failing to ask one self "Is this good for me?" would characterize this. Both the suppression of the good hysterics, as well as the enmeshment with others' needs typical of the bad hysterics could be linked with this, as this could reflect a dependency on others and subsequent desire to secure attachment. These uncalibrated empathic abilities would distinguish both good and bad hysterics from the cold, empathy-lacking narcissism classically depicted in narcissistic personality disorder.

4.3 Where do we go from here?

So this article ends where it started. Curiously few patients have been diagnosed with histrionic personality disorder, at least among those who seek more intensive treatment. Tentatively speaking, this article leans towards an understanding of the current HPD diagnosis as a set of criteria that pertain to two different latent structures. These latent structures appear to be somehow related, but their differences point to structurally different levels of pathology, thus implying that they should not be part of the same diagnostic category.

Should this understanding be a useful nosological development, then the delineation, delimitation and reconstruction of these two latent structures should be attempted, in order to increase construct validity. One could therefore attempt to understand the differences and equalities between these two levels of functioning more psychologically. This could be a starting point for further research, although clearly understood to be tentative. Even though clinical tradition and theoretical constructs are not equivalents to construct validity, they do function as a starting point: As classical psychoanalytic literature and this article have argued, the core problem of both good and bad hysterics can partly be understood as a “hysterical” dependency on others. However, as they seem to be organized at different structural levels of psychopathology, they will use differently organized defenses upon activation of these needs.

The good hysteric will deny or suppress dependency needs. Their dependency needs will be masked and expressed by a passive-impressionistic cognitive style. In partial accordance with this, Kernberg (1975) understood the emotionality of the good hysterics as pseudo-emotionality, as a defense to reinforce repression, and von der Lippe and Torgersen (1984) found that the hysterical character correlated weakly, although not significantly ($r = .23$, $p < .10$), with repression. This postulated dependency will prohibit all acts of aggression towards others. Aggressive outbursts may erupt, but they will quickly regret or deny ownership to the aggression.

Sexualization of appearance can be found, but this will be less intense, less impulsive, and probably more inhibited than that of the bad hysterics. McWilliams (1994) viewed this sexualization as a counterphobic defense for the good hysteric.

Dependency needs will probably underlie the sexualization, but expressed differently by the good and bad hysterics.

The bad hysterics will be characterized by an impulsive acting out of dependency needs, thus a more primitive defense. Aggression will be turned against those who disappoint, reject or disregard the bad hysteric. There is thus a similarity as to dependency needs, but a difference as to the way it is dealt with. Aggressive and

sexual needs are more impulsively and intensely acted out among the bad hysterics, as typical for cluster B diagnoses. In line with this, Cramer (1999) found that the more criteria for histrionic personality disorder diagnosis patients fulfilled, the more immature their defenses were.

Future research may find interest in focusing more on core problems which are in dialectic relationship to strategies such as avoidance, attention-seeking, narcissism etc. Core problems such as low self-esteem, dependence, or low mentalization are clinically meaningful areas, and a valid area for research as to latent structures underlying the different personality disorders. When maturity of defenses is taken into account, a better and more clinically sound differentiation between diagnoses is possible. In the mean time, the HPD diagnosis seems to partly cover two different latent structures, thereby affecting utilitarian value and prevalence rates.

4.4 Limitations

There are several limitations to this study. First, the number of patients diagnosed with histrionic personality disorder was very low in this study. This will affect the statistical power for all analyses specific to those with HPD. However, due to the large *n* in this study, factor analyses should still be valid, as they are performed on all patients. Second, had there been more patients diagnosed with HPD, a MAMBAC (Means Above – Means Below A Cut; Meehl, 1995) and MAXCOV (Maximum Covariance; Meehl, 1995) could have been performed, thereby using bootstraps taxometrics for further evaluating the latent structure of the HPD diagnosis. Third, ideally, the data should be complemented by the CIP and SCL-90-R profiles on all sub-scores, but this material was not obtainable. These profiles could be informative as to understanding the suggested attention-seeking, dependency or impressionistic domains underlying HPD. Fourth, had the number of patients who fulfilled the HPD diagnosis been higher, a correlation between the two HPD factors and dysfunction, distress and comorbidity patterns could have been helpful in establishing the properties of the HPD factors.

5.0 Summary

The important clinical descriptions by Easser & Lesser (1969), Kernberg (1975) and Zetzel (1968) were the first steps towards deconstructing the HPD diagnosis with respect to its real life equivalents. This article can be seen as an extension of their work.

As clinicians, we are accustomed to ask ourselves how our patients (the empirical terrain) fit the DSM-IV axis II (the theoretical map). The vast majority of mental health professionals in the USA, as well as most of the published research, have used the DSM as a diagnostic tool. Hence, the DSM is the very map by which we navigate, and should thus be taken seriously, whether we approve of its existence or not. As we organize our cognitive activity around categories, we are led to acknowledge categories as (a simplification of) something real “out there”. Consciously or subconsciously, our therapeutic planning, therapy evaluation, expectations, research and communication with colleagues are coloured by the diagnoses we set. Consequently, our map has some precedence over our navigation in the terrain. Should some of the criteria for passive-aggressive personality disorder suddenly subsume under avoidant personality disorder, or should schizoid personality disorder be strongly correlated with paranoid personality disorder, one can only imagine the consequences. It is therefore imperative to scrutinize the personality disorder diagnoses in the DSM system, due to their powerful implications. Should a personality disorder be too enmeshed with another personality disorder, should it be too uncommon, or should its criteria be too uncorrelated or refer to different nosological entities, then it would be wise to rethink the usefulness and appropriateness of this personality disorder diagnosis.

There is something vaguely inconclusive, contradictory and unapproachable about HPD. In the end, most of the literature on HPD seems to reflect a search for one answer; “What is histrionic personality disorder?”. When Zetzel (1968) wrote the intriguing article “The so-called good hysterics” 40 years ago, the entire article was a

comment on the wide usage of the term hysteric as an agreed-upon group of unitarily “good” patients, based on tacit knowledge rather than critical research. 40 years later, the histrionic personality disorder diagnosis suffers from the same bias.

This article suggests further research into the construct validity of this personality disorder, as this has been a neglected area for research. Upon preparing DSM-V, researchers should ask themselves if histrionic personality disorder deserves its place among the other personality disorders in axis-II. And in which case, which aspects of HPD should apply? As of now, there are too many unresolved questions and too little clinical research. In line with Arntz (1999), this article suggests that theory can serve as a humble guide for research on personality disorders, to avoid the personality disorder construct to lose meaning.

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