Many patients have histrionic features in their makeup, and in general, histrionic patients are attractive people who add much to their surrounding environment through their imagination and sensitivity. Consciously, the histrionic patient wants to be seen as an attractive, charming, lively, warm, intuitive, sensitive, generous, imaginative person who enhances the lives of others and who does not waste time on the trivial details and mechanics of life. However, to those around them, the histrionic patient can appear exhibitionistic, attention seeking, manipulative, superficial, overly dramatic, given to exaggeration, easily hurt, impulsive, inconsiderate of the feelings of others, demanding, and readily given to scenes of tears or anger. Histrionic patients possess a capacity to experience one emotional state after another in very rapid order. In this sense, their affective experience resembles that of the small child who can quickly turn from laughter to tears.

Histrionic personality disorder occurs equally in both sexes. The common transgender features are those of wishing to be seen as glamorous and sexually exciting. The histrionic patient is frequently charismatic and charming. The histrionic patient elicits different responses in other people dependent on their gender. The female histrionic patient is frequently found appealing by male clinicians but is often disliked by female clinicians. Conversely, the male histrionic patient often appeals to female clinicians but not to male clinicians. When a histrionic patient is hospitalized, this gender split is reflected in professional staff discussions. The staff gender polarization that occurs is highly suggestive evidence that the patient's diagnosis is that of histrionic personality disorder.

The histrionic patient presents himself to the world in three domains. One is the dramatic—the exhibitionistic, extravagant, emotion-
ally labile, intense, and overly generous constellation. A second is the manipulative, in which the interpersonal world is controlled and gratification is extracted from it. This is the attention-seeking, demanding, easily hurt, inconsiderate of others, socially promiscuous, and dependent constellation. The third has to do with aspects of ego functions. The histrionic patient is often impulsive, scattered, disorganized, easily bored by detail, rarely punctual, and difficult to rely on. The DSM-IV-TR criteria for histrionic personality disorder focus on a more primitive variant than that described in the older literature (Table 4-1).

### TABLE 4-1. DSM-IV-TR diagnostic criteria for histrionic personality disorder

<table>
<thead>
<tr>
<th>Criteria</th>
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<tr>
<td>A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:</td>
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<tr>
<td>(1) is uncomfortable in situations in which he or she is not the center of attention</td>
</tr>
<tr>
<td>(2) interaction with others is often characterized by inappropriate sexually seductive or provocative behavior</td>
</tr>
<tr>
<td>(3) displays rapidly shifting and shallow expression of emotions</td>
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<tr>
<td>(4) consistently uses physical appearance to draw attention to self</td>
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<tr>
<td>(5) has a style of speech that is excessively impressionistic and lacking in detail</td>
</tr>
<tr>
<td>(6) shows self-dramatization, theatricality, and exaggerated expression of emotion</td>
</tr>
<tr>
<td>(7) is suggestible, i.e., easily influenced by others or circumstances</td>
</tr>
<tr>
<td>(8) considers relationships to be more intimate than they actually are</td>
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Although this describes one end of a continuum that overlaps with the borderline patient, it excludes the well-integrated and better-functioning histrionic patient, who represents a personality type rather than a disorder and tends to be more stable, with better impulse control. The seductiveness is less overt in better-functioning histrionic patients, and they may possess a strict superego, healthier object relations, and higher-level ego defenses in contrast to the more primitive, and hence more disturbed, histrionic patient. In this disorder, clinical attention to underlying dynamics rather than the manifest behavior is crucial in establishing the diagnosis and differentiating the healthier from the sicker.
histrionic patient. The unifying features of the continuum of histrionic patients are emotionality and theatricality, which can be charming in those on the healthier end of the spectrum but unappealing in those patients found at the more disturbed end, who often seem crude in their seductiveness and more dependent, demanding, and helpless.

We agree with Gabbard (2005) that the elimination of the DSM-II diagnosis of hysterical personality disorder and its replacement by histrionic personality disorder in DSM-III essentially removed a clearly identified diagnostic entity and replaced it with the more primitive variant. Gabbard has tabulated the clinical differences between the better-functioning histrionic patient, which he continues to refer to as having “hysterical personality disorder,” and the patient with DSM-IV-TR histrionic personality disorder (Table 4-2). Gabbard’s chart summarizes the

<table>
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<th>TABLE 4-2. Gabbard’s differentiation of hysterical personality disorder from histrionic personality disorder</th>
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<tbody>
<tr>
<td><strong>Hysterical personality disorder</strong></td>
</tr>
<tr>
<td>Restrained and circumscribed emotionality</td>
</tr>
<tr>
<td>Sexualized exhibitionism and need to be loved</td>
</tr>
<tr>
<td>Good impulse control</td>
</tr>
<tr>
<td>Subtly appealing seductiveness</td>
</tr>
<tr>
<td>Ambition and competitiveness</td>
</tr>
<tr>
<td>Mature, triangular object relations</td>
</tr>
<tr>
<td>Separations from love objects can be tolerated</td>
</tr>
<tr>
<td>Strict superego and some obsessional defenses</td>
</tr>
<tr>
<td>Sexualized transference wishes develop gradually and are viewed as unrealistic</td>
</tr>
</tbody>
</table>

distinction between the primitive, oral, “hysteroid” histrionic patient versus the mature, oedipal, “hysterical” histrionic patient, a clinical distinction first made by Zetzel (1968) and by Easser and Lesser (1965).

In this chapter we use the DSM-IV-TR term histrionic personality disorder but apply it in a wider sense to the continuum of histrionic patients, which includes that subsumed under Gabbard’s definition of hysterical personality disorder.

PSYCHOPATHOLOGY AND PSYCHODYNAMICS

Histrionic Characteristics

Self-Dramatization

The speech, physical appearance, and general manner of the histrionic patient are dramatic and exhibitionistic. Communication is expressive, and descriptors emphasize feelings and inner experience rather than facts or details. Language patterns reflect a heavy use of superlatives; emphatic phrases may be used so repetitively that they acquire a stereotyped quality. The listener finds himself drawn in by the patient’s view of the world. The patient exaggerates in order to dramatize a viewpoint and is unconcerned about rigid adherence to truth if a distortion will better accomplish the drama. These patients are often attractive and may appear younger than their age. In both sexes there is a strong interest in style and fashion, which immediately calls attention to their physical appearance. In the woman there is an overdramatization of femininity; in the man there may be a quality of foppishness or excessive masculinity.

Emotionality

Although the histrionic patient has difficulty experiencing deep feelings of love and intimacy, his superficial presentation is quite to the contrary. This patient is charming and relates to others with apparent warmth, although his emotional responses are labile, easily changeable, and at times excessive. His seeming ease at establishing close relationships quickly causes others to feel like old friends, even though the patient may actually feel uncomfortable. This becomes clearer when further intimacy fails to develop after the first few meetings. Whereas the obsessive-compulsive patient attempts to avoid emotional contact, the histrionic patient constantly strives for personal rapport. In any relationship in which the histrionic patient feels no emotional contact, he experiences feelings of rejection and failure and often blames the other individual,
considering him to be boring, cold, and unresponsive. He reacts strongly to disappointment, showing a low tolerance for frustration. A failure to elicit sympathetic responses from others can often lead either to depression or to anger, which may be expressed as a temper tantrum. His charm and verbal expressiveness create an outward impression of poise and self-confidence, but usually the patient's self-image is one of apprehension and insecurity.

Since it is impossible to objectively measure the depth of another person's emotions, it is a quality that one infers from the stability, continuity, and maturity of emotional commitments. A perfectly normal 8-year-old child may change "best friends" with some regularity. Such fickleness in an adult suggests a histrionic character. Relationships with the histrionic patient can be transient and reactive to an immediate event, from loving someone to dismissing them much as a child can move from crying to smiling in a short span of time. There is an underlying instability to the histrionic patient's emotional attachments.

**Seductiveness**

The histrionic patient creates the impression of using the body as an instrument for the expression of love and tenderness, but this stems from a desire to obtain approval, admiration, and protection rather than a feeling of intimacy or genital sexual desire. Physical closeness is substituted for emotional closeness. The attractive and seductive behavior serves to obtain the love or approval of others rather than to give sexual pleasure to the patient. Histrionic patients respond to others of the same sex with competitive antagonism, particularly if the other person is attractive and utilizes the same devices to obtain affection and attention.

**Dependency and Helplessness**

Since Western society has different attitudes toward manifest patterns of dependency in men and women, there are striking differences between the superficial behavior of male and female histrionic patients, but these disappear at a deeper level. The male histrionic patient is more likely to exhibit pseudo-independent behavior, which can be recognized as defensive because of the accompanying emotional responses of excessive fear or anger.

In the interview situation, the histrionic woman presents herself as helpless and dependent, relying on the constant responses of the clinician in order to guide her every action. She is possessive in her relationship to him and resents any competitive threat to this parent-child relationship. The interviewer is viewed as magically omnipotent and capable of solving all of her problems in some mysterious fashion. The
practitioner, as a parent surrogate, is expected to take care of the patient, to do all of the worrying, and to assume all responsibility; the patient's obligation then is to entertain and charm in response. In working out solutions to her problems, she acts helpless, as though her own efforts do not count. This leads to major countertransference problems in the clinician who enjoys the opportunity to enter an omnipotent alliance. Histrionic patients also adopt a particularly helpless posture when in the presence of their mothers. They are frequently regarded by their families as lovable, cute, ineffective, and "still a child." The seductiveness and pseudo-helplessness are used to manipulate others.

These patients require a great deal of attention from others and are unable to entertain themselves. Boredom is, therefore, a constant problem for histrionic patients, because they consider their inner selves to be dull and unstimulating. External stimulation is constantly pursued, and the theatrical, seductive, overly emotional, helpless, and dependent behavior of the histrionic patient is designed to subtly involve others so that their continued interest and affection are assured. "I just don't know what to do about my boyfriend," exclaimed a histrionic patient. "He's fickle and unreliable, but I'm confused because he's so attractive. Tell me what to do; shouldn't I break up with him? You're experienced, knowledgeable. You must have the answer."

The histrionic patient denies responsibility for the plight in which he finds himself, complaining, "I don't know why it always has to happen to me." He feels that all of his problems stem from some impossible life situation. If this were to be magically changed, he would have no complaint. When dependent needs are not met, these patients typically become angry, demanding, and coercive. However, as soon as it becomes apparent that one technique for obtaining dependent care is not likely to succeed, the patient will abandon it and abruptly switch to another approach.

**Noncompliance**

In this important group of character traits, the histrionic patient again appears to be the antithesis of the rigid obsessive character, showing disorderliness, a lack of concern with punctuality, and difficulty in planning the mechanical details of life. This group of dynamically organized traits are frequently flaunted by the histrionic patient in an arrogant or passive-aggressive manner.

Whereas the obsessive-compulsive patient feels anxious without his watch, the histrionic patient prefers not wearing a watch. He trusts that there will be a clock in the window of a jewelry store or on top of a billboard or that he can ask a passing pedestrian the time. Manage-
ment of the time during the session is delegated to the interviewer.

Record keeping and other mundane tasks are viewed by the histrionic patient as burdensome and unnecessary. The obsessive-compulsive patient must always keep his checkbook in order, but the histrionic patient does not bother to do so because the bank keeps a record of the money and will notify him if he is overdrawn. For an obsessive-compulsive person, such an occurrence would be a shameful humiliation.

Histrionic thinking has been described as impulsive, with the patient relying on quick hunches and impressions rather than critical judgments that arise from firm convictions. The patient is often not well informed on politics or world affairs. His main intellectual pursuits are in cultural and artistic areas. He does not usually persevere at routine work, considering it unimportant drudgery. When confronted with a task that is exciting or inspiring and in which the patient can attract attention to himself as a result of his achievement, he reveals a capacity for organization and perseverence. The task can be done particularly well if it requires imagination, a quality that rarely is found in the obsessive character.

**Self-Indulgence**

The histrionic patient's intense need for love and admiration creates an aura of egocentricity. The narcissistic and vain aspects of his personality are manifested in a concern with external appearance and with the amount of attention received from others. His needs must be immediately gratified, a trait that makes it difficult for the histrionic patient to be a good financial planner, because he buys impulsively. Whereas the histrionic patient is extravagant, the obsessive-compulsive patient is parsimonious.

**Suggestibility**

Although it has traditionally been said that histrionic patients are overly suggestible, we agree with Easser and Lesser that the histrionic patient is suggestible only as long as the interviewer supplies the right suggestions, those that the patient has subtly indicated that he desires but for which he wants someone else to assume the responsibility.

**Sexual and Marital Problems**

The histrionic patient usually has disturbed sexual functioning, although there is considerable variation in the form this takes. In the woman, partial frigidity is a reaction to the patient's fear of her own sexual feelings. Also, sexual excitement interferes with her use of sex to control others. This fear is reflected in her hostile, competitive relation-
ships with women and her desire to achieve power over men through seductive conquest. She has great conflict over these goals, with resulting sexual inhibition. Other patients are sexually responsive, but their sexual behavior is accompanied by masochistic fantasies. Promiscuity is not unusual, because the patient uses sex as a means of attracting and controlling men.

The man whom the histrionic woman loves is quickly endowed with the traits of an ideal, all-powerful father who will not make demands on her. However, she always fears losing him as she lost her father, and consequently, she selects a man whom she can hold because of his dependent needs. She may marry "down" socially or marry a man of a different cultural, racial, or religious background, both as an expression of hostility to her father and as a defense against her oedipal strivings. In this way she substitutes a social taboo for the incest taboo. The group who marry older men are also acting out oedipal fantasies but have a greater need to avoid sex. Another dynamic mechanism that often influences the choice of a mate is the defense against castration fear, expressed by selecting a man who is symbolically weaker than the patient.

The male histrionic patient also has disturbances of sexual functioning. These include potency disturbances and Don Juanism. In each of these, there is often an intense neurotic relationship with the mother. Like the female patients, they have been unable to resolve their oedipal conflicts.

It is often observed that the histrionic patient and obsessive-compulsive patient marry each other, seeking in the partner what they are lacking in themselves. The histrionic patient provides emotional expressiveness; the obsessive-compulsive patient offers control and regulations. Typically, the partner of the female histrionic patient is obsessive, with strong passive-dependent trends. These latter traits are not recognized by either party, and particularly not by the histrionic patient, who sees him as a selfish, controlling tyrant who wants to keep her a prisoner. There is usually some degree of validity in this perception, because the partner views her as a status symbol because of her attractiveness, seductive behavior, and appeal to other men. Unconsciously, he views her more as an ideal mother who will gratify both his sexual and dependent needs while he remains passive. The relationship may be stormy and often soon leads to mutual disappointment. Interpersonal conflicts have a characteristic pattern: The woman is angered by her partner's cold detachment, parsimony, and controlling attitudes. He becomes irritated with her demanding behavior, extravagance, and refusal to submit to his domination. In their arguments, he attempts to engage her through intellectualization and appeals to rational logic. She may initially en-
gage in his debate but soon becomes emotional, displaying her anger or her hurt feelings of rejection. The partner either withdraws, feeling bewildered and frustrated, or erupts in a rage reaction of his own. Both parties compete for the role of the “much-loved child.” Because she has selected a man who will not desire her as a woman and an equal partner, she has no choice but to shift alternately between being his mother and his child.

The female patient usually reports that her sexual life deteriorated after marriage, with loss of desire for her husband, frigidity, or an extramarital affair. The relationship with her husband leads to disillusionment as she discovers that he is not the ideal man of whom she had dreamed. In her frustration and depression, she retreats to romantic fantasies. This often leads to the fear of impulsive infidelity, which, if it occurs, further complicates her life with added guilt and depression. Flirtatiousness and seductive charm are reparative attempts that fail to enhance her self-esteem, leading to additional disappointment. Similar patterns occur with the male histrionic patient who becomes disillusioned with his partner and either develops potency disturbances or pursues new and more exciting partners.

**Somatic Symptoms**

Somatic complaints involving multiple organ systems usually begin in the patient’s adolescence and continue throughout life. The symptoms are dramatically described and include headaches, backaches, conversion symptoms, and in the female, pelvic pain and menstrual disorders. In patients with more serious ego pathology, there may be frequent hospitalizations and surgery; gynecological procedures are common in women. It is unusual for these patients to feel physically well for a sustained period of time. Pain is by far the most common symptom and often involves an appeal for help.

Male histrionic patients may also complain of headaches, back pain, gastrointestinal disturbances, and other somatic symptoms. Frequently, histrionic patients possess the fantasy that they have a disorder that is beyond the ken of ordinary physicians. They will often resort to herbal remedies and alternative medical practices in the belief that their physical distress will only respond to an unconventional or exotic treatment.

**Mechanisms of Defense**

The mechanisms of defense utilized by the histrionic patient are less fixed or stable than those employed by the obsessive-compulsive patient. They shift in response to social cues, which partially explains the
difference in diagnostic impression among different mental health practitioners seeing the same patient. Histrionic character traits and symptoms provide more secondary gains than most other defensive patterns. The derisive attitude that typically characterizes both medical and social reaction to this group of people is related to the fact that the secondary gains and special attention received are not only great but also transparent to everyone but the patient. Successful histrionic defenses, unlike most other neurotic symptoms, are not in themselves directly painful, and therefore they potentially offer great relief of mental pain. However, lack of mature gratification, loneliness, and depression develop as a result of the patient’s inhibition. In the case of conversion symptoms, the secondary loss is reflected in the painful and self-punishing aspect of the symptom.

**Repression**

Histrionic symptoms defend the ego from the reawakening of repressed sexuality. Although repression is a basic defense in all patients, it is most often encountered in pure form in the histrionic patient. Memory lacunae, histrionic amnesia, and lack of sexual feeling are clinical manifestations of repression. Developmentally, the erotic feelings and the competitive rage of both the positive and the negative oedipal situations are dealt with by this mechanism. When repression fails to control the anxiety, other defense mechanisms are utilized. Any therapeutic resolution of the other histrionic defenses is incomplete until the initial repression has been accepted by the patient.

**Daydreaming and Fantasy**

Daydreaming and fantasy are normal mental activities that play an important role in the emotional life of every person. Rational thinking is predominantly organized and logical and prepares the organism for action based on the reality principle. Daydreaming, on the other hand, is a continuation of childhood thinking and is based on primitive, magical wish fulfillment processes that follow the pleasure principle. Daydreaming is particularly prominent in the emotional life of the histrionic patient. The content centers around receiving love or attention, whereas in the obsessive-compulsive patient, fantasies usually involve respect, power, and aggression. Daydreaming and its derivative character traits serve a defensive function. The histrionic patient prefers the symbolic gratification provided by fantasy to the gratification available in his real life, because the latter stimulates oedipal anxiety. The central role of the oedipal conflict in the genesis of the higher-function-
ing histrionic personality is discussed later in this chapter under the heading “Developmental Psychodynamics.”

Most patients consider this aspect of their mental lives particularly private, and it is seldom revealed during initial interviews. The histrionic patient is no exception as far as the conscious disclosure of his fantasies is concerned. However, the content of the histrionic patient’s daydreams is revealed indirectly. His infantile fantasies are projected onto the outside world through the use of dramatic behavior. Emotionally significant persons in the patient’s life are involved as participants. (These phenomena are ubiquitous, however, and can be observed in obsessive-compulsive, narcissistic, paranoid, and masochistic patients as well.) When the histrionic patient is successful, these persons interact with the patient so that his real world conforms to the daydream, with the patient as the central character in the drama. The self-dramatization and the overt daydreaming defend the patient against the imagined dangers associated with mature involvement in the adult world. At the same time, the patient is assured that his narcissistic and oral needs will be supplied. By acting out daydreams, the patient reduces the loneliness of the fantasy world and yet avoids the oedipal anxiety and guilt associated with mature adult behavior. The dissociative reaction is an extreme example of this process.

Misrepresentation or lying also defends against real involvement in the world by attempting to substitute the fantasy world. Elaborate falsehoods often contain factual elements that have psychological significance in terms of the past and reveal both the oedipal wish and the defense.

A young woman frequently exaggerated or confabulated experiences concerning her cultural and artistic activities. She reported a feeling of elation while recounting such stories. She would begin to believe the story herself if it were told often enough. In the attempt to turn her daydreams into reality, fact and fantasy had become interwoven. In analyzing these stories, it was learned that the patient’s father was a patron of the arts and that her most frequent and intense contact with him in childhood involved discussions of music and art. In acting out the mother’s role, she feigned knowledge and understanding in order to better please her father. The present-day confabulations symbolized past experiences of closeness to her father, while repression and denial blocked her awareness of the erotic feelings. This elation was the affectual residue that escaped into consciousness and represented the feeling of magical rapport that she had achieved with her father. In daydreams, the patient symbolically defeated her mother by sharing her father’s interests to a greater degree than her mother did. At the same time, she avoided real competition with her mother.
When the interviewer attempts to challenge such confabulations, the patient will often indignantly cling to the distortion and even confabulate further to escape detection. Intense emotional reactions of guilt, fear, or anger may occur when the falsehood is finally acknowledged. The nature of the emotional response will tell the interviewer how the patient has experienced the confrontation. In this example, responses of guilt or fear would reveal the patient's expectation of punishment, whereas a response of anger would indicate that she was enraged at the thought of having to relinquish her fantasized relationship with her father or possibly narcissistically humiliated by being caught.

Daydreaming assumes its greatest psychic importance during the oedipal phase of development and may be associated with masturbatory activity. Because histrionic patients often come from families in which sexual activity is associated with great anxiety, it is no surprise that they often recall either real or imagined maternal prohibitions against masturbation during childhood. The child, striving to control his masturbatory temptations, utilizes daydreaming as a substitute means for obtaining pleasurable self-stimulation. In the oedipal phase, the child's sexuality is focused on his erotic desire toward his parents. This desire cannot be directly gratified and is displaced to the masturbatory activity. Therefore, the fantasies that accompany or substitute for masturbation offer a symbolic gratification of the child's oedipal wishes. In other situations, the parents are exhibitionistic and seductive themselves, overstimulating their child. Depending on the culture, this behavior may lead to sexual precocity, thus incurring negative reactions from peers or other authority figures.

Emotionality as a Defense

The histrionic patient utilizes intense emotionality as a defense against unconscious, frightening feelings. Seductiveness and superficial warmth with the opposite sex permit the avoidance of deeper feelings of closeness, with consequent vulnerability to rejection. Affective outbursts may serve as a protection from sexual feelings or from the fear of rejection. These dramatic emotional displays also relate to identification with an aggressive parent. Playacting and role-playing ward off the dangers inherent in a real participation in life. This explains the quick development of transference as well as the pseudo-intensity and transience of the relationships that these patients develop. This mechanism also leads to the self-dramatization and labile emotionality that are so readily observed. Similar mechanisms are involved between homosexual partners when one or both has prominent histrionic traits.
Identification

Identification plays a prominent role in the development of histrionic symptoms and character traits. First, the histrionic patient may identify with the parent of the same sex or a symbolic representative in a wishful attempt to defeat that parent in the competitive struggle for the love of the parent of the opposite sex. At the same time, this identification also maintains the child’s relationship to the parent of the same sex. An example of identification with a symbolic representative is the man who developed cardiac conversion symptoms after seeing a man his own age collapse with a heart attack. Although this person was a complete stranger, the patient imagined that the heart attack had occurred because the man was driving himself too much in his work. The patient’s father also had succumbed to a heart attack at a young age, and he identified with his father and feared punishment by death for his competitive oedipal desires. The patient had unconsciously made this equation when his mother explained to him, “Your father died because he aggressively drove himself. He was too competitive.”

Second, the histrionic patient can identify with the much-desired parent of the opposite sex or his symbolic representative. This occurs when the patient feels less chance of success in the oedipal competition. Although on the surface the patient relinquishes the parent of the opposite sex, he unconsciously maintains the attachment through identification. In either of these two cases, the symbolic representative of the parent could be an older sibling.

A third type of identification is based on competitive rivalry and envy. Here the other person’s significance to the patient lies in the fact that some experience in this person’s life stimulates envious feelings in the patient. A common example occurs at any rock concert. One young woman will scream ecstatically, and immediately several others will emulate her as they unconsciously seek the sexual gratification symbolized by her behavior, in addition to attracting attention.

Identification is as important a mechanism as conversion in the production of histrionic pain. The identification through pain includes both preoedipal and oedipal components. The pain provides the symbolic gratification of the oedipal wish as well as the compromise of healthy functioning and punishment for the associated feelings of guilt.

Identification is a complex mechanism that is utilized by everyone. Although many persons may identify predominantly with one parent, there are always partial identifications with the other parent as well as with other significant figures. In the mature adult, these partial identifications have fused, but in the histrionic patient this does not occur.
This lack of fusion is particularly important in understanding the histrionic patient. Through successful treatment, the patient's partial identifications become fused into a new self-image.

**Somatization and Conversion**

Histrionic patients often express repressed impulses and affects through somatic symptoms. Conversion is not merely a somatic expression of affect but also a specific representation of fantasies that can be retranslated from their somatic language into their symbolic language. Conversion symptoms are not confined to histrionic patients, however, as was once thought, but can occur in a whole range of patients, including borderline and narcissistic individuals.

The process of conversion, although it is not thoroughly understood, has its origin in early life and is influenced by constitutional factors as well as by the environment. The fundamental step in this mechanism can be briefly explained as follows: Thinking represents trial action and, later, abortive action. For the young child, acting, feeling, thinking, and speaking are all intertwined. Gradually, with development, these become distinct, and thinking and speaking—communicating in symbols—become separate from feeling and acting. However, the potential for expressing thoughts and fantasies through action persists and is reawakened in conversion. In the beginning, thinking is mental talking accompanied by communicative behavior. Gradually there is a less fixed relationship between mental talking and the related motor activity. The child thereby learns that both his behavior and his thoughts have symbolic as well as concrete meanings. When the child’s actions are prohibited or rewarded by his parents, he equates this with prohibition or reward for the related thoughts and affects. Therefore, the inhibitions of action that result from parental restriction usually are associated with repression of the accompanying thought and affect. In the infant, affect expression is directly accompanied by motor, sensory, and autonomic discharge. Since the parental prohibitions involve both the sexual and aggressive feelings of the child, it is the conflicts over the expression of these impulses that are dealt with through the conversion process.

Later, partial repression leads to a separation, so that the affect may remain repressed but the motor, sensory, or autonomic discharge may break through. The term *conversion symptom* refers to the selective malfunction of the motor or sensory nervous system, whereas the persisting abnormal autonomic discharge has been called *somatization*. The impairment has features of inhibition as well as pathological discharge,
the relative proportion varying with different symptoms. For example, conversion paralysis reflects a greater degree of inhibition, and a “hysterical seizure” manifests a greater discharge of the unacceptable impulse. Blushing demonstrates both inhibition and release through the autonomic nervous system.

The affected organ is often an unconscious substitute for the genital. For example, a woman developed hysterical blindness when exposed to the temptation of an extramarital affair. During the course of treatment, she revealed that as a child she had been caught watching her parents’ sexual activities. A traumatic confrontation ensued, with the result that the patient repressed both her visual memory and the accompanying sexual arousal. For her, visual perception and genital excitement were equated, with the result that the conversion symptom had served as a symbolic compromise for sexual gratification and punishment for that forbidden pleasure.

In another instance, the sexual excitement is repressed but the accompanying cardiorespiratory discharge breaks into consciousness, or perhaps an itching sensation affects the genital area. The protracted nature of these symptoms is explained by the fact that a vicarious means of discharge has a limited value in contrast with more direct expression.

The patient’s particular choice of symptoms is influenced by many factors, including both physical and psychological determinants. The physical factors include organic predispositions or the direct effect of illness or injury on a particular organ system. Psychological factors influencing organ choice include historical events, the general symbolic significance of the affected organ, and the particular meaning it has to the patient because of some traumatic episode or because of identification with persons who have had a related physical symptom. Conversion symptoms tend to reflect the patient’s concept of disease. Gross symptoms are, therefore, more common in individuals with less medical sophistication. Patients who are in a health profession may simulate complex syndromes, such as lupus erythematosus, on a conversion basis. Conversion operates with varying degrees of effectiveness in binding the patient’s anxiety, which accounts for the controversial opinions concerning the classic *la belle indifférence* or apparent lack of concern. In our experience, this attitude is relatively uncommon, because depression and anxiety usually break through the defense. The exception would be patients with a gross conversion reaction, and even then, depression soon becomes apparent. *La belle indifférence* may be seen with those minor somatic complaints that form part of the character structure of the histrionic, or in persons with primitive character structure, for whom the secondary gain of dependent care is of great importance.
Regression

In the histrionic patient there is a selective regression by which the patient abandons adult adaptation in favor of the period of childhood during which his inhibitions were established. The conflicts over his emotional experiences caused him to treat certain aspects of his body and its sensations as ego-alien. The selective regression from conflicts over genital sexuality may lead to an oral or anal level of adaptation, although the same conflict will be expressed in the regressed symptom. Features of primitive incorporation are common, as has been shown by the prominent role of identification in the histrionic patient. This can be seen directly in one patient who had globus hystericus, in which there is an unconscious wish to perform fellatio. As treatment progressed, the pregenital incorporative aspect became clear in the patient’s associations of a penis with her fantasy of oral impregnation by her father—and, ultimately, with her mother’s breast. Regressive behavior is particularly common when the patient is confronted by powerful authority figures of the same sex.

In another example, the patient began the third session stating, “I had a dream last night but I can’t tell you about it.” This was followed by an extended silence. The patient remained quiet, and the clinician, responding to the patient’s coyness and curled-up “little-girl” posture, commented, “It feels like you are teasing me.” “My father always teased me. I guess I want to do it to you,” replied the patient, changing her posture and attitude and reverting to adulthood. This patient had illustrated through her childlike posture and behavior a dramatic and regressive linkage between body and mind.

Denial and Isolation

Histrionic patients deny awareness of the significance of their own behavior as well as the behavior of others. This unawareness is greatest in the areas of seductive and manipulative behavior and the secondary gain associated with their symptoms. They also deny their strengths and skills, further contributing to the façade of helplessness. These patients also deny painful emotions, with the result that isolation develops as a defense against depression, and if it is unsuccessful, they will resort to distortion and misrepresentation to escape facing their unhappiness.

Externalization

Externalization, the avoidance of responsibility for one’s own behavior, is closely related to denial. The patient feels that his own actions do not
count and views both success and suffering as being caused by other people in his life.

Developmental Psychodynamics

The developmental patterns of histrionic patients are less consistent than those of obsessive-compulsive patients. One common feature is that the patient occupied a special position in the family, perhaps with the prolonged role of “baby,” as sometimes happens with the youngest child. Physical illnesses that led to special indulgence are often described, and frequently another family member suffered from ill health, which offered the patient an opportunity to observe and envy the privilege accorded to the sickly.

When the future female histrionic patient enters the infantile struggles with her parents over sleeping, feeding, and being held, she discovers that crying and dramatic scenes lead to getting her own way. Her mother gives in, albeit with some annoyance. Her father is more likely to withdraw, often criticizing the mother’s behavior and occasionally intervening with even more indulgence “because the poor child is so upset.” The child is soon aware of the conflict between her parents, and she learns to play each against the other. This pattern interacts with the normal development of conscience, as she learns to escape punishment by indicating that she is sorry or “feels bad.” The mother responds either by making no attempt to punish the child or by not enforcing the punishment. The child escapes the consequences of misbehavior and is left with unresolved feelings of guilt as a result of avoiding punishment.

The typical mother of the female histrionic patient is competitive, cold, and either overtly argumentative or subtly resentful. She unconsciously resents being a woman and envies the masculine role. Overprotection and overindulgence of her daughter compensate for her inability to give real love. Her most tender warmth is expressed when the child is depressed, sick, or upset, which helps to establish depression, physical illness, and tantrums as means of obtaining dependent care. The patient’s need to maintain a dependent relationship with her mother makes it difficult for her to mature. She fails to develop an internalized ego ideal, as is clinically evidenced by the histrionic patient’s continued reliance on the approval of others in order to maintain her own self-esteem.

In families in which special privileges and status are still accorded to men, the little girl becomes sensitive to this sexist prejudice. The female histrionic patient reacts with competitive envy that may be expressed through symbolically castrating behavior, through imitation as
expressed by being a tomboy, or through competing directly with men while retaining her feminine identity. The tomboy pattern is more likely if older brothers provide a readily available model. The histrionic patient may emulate her mother during childhood, but in early adolescence their relationship is marked by open strife. At that time she does not like or admire her mother as much as she does her father, and this also furthers her identification with men.

Since the histrionic patient is unable to obtain adequate nurturant warmth from her mother, she turns to her father as a substitute. He is most often charming, sensitive, seductive, and controlling. Mild alcoholism and other sociopathic trends are common. During the first 3 or 4 years of her life, she and her father are usually close to each other. If he feels rejected by his cold and competitive wife, he turns to his daughter as a safe and convenient source of gratification for his failing masculine self-esteem. He thereby rewards and emphasizes his daughter's flirtatiousness and emotionality. During her latency period, he becomes increasingly uncomfortable with her femininity and may therefore encourage her tomboyish behavior. As she becomes older, she finds her father a difficult man to please because he is easily manipulated on one occasion but may capriciously dominate her on another. At puberty, the romantic and erotic aspects of their relationship are denied by both father and daughter, because both are threatened by their incestuous feelings.

Her transient rejections by her father leave the patient feeling that she has no one, since she already feels alienated from her mother. She may express her rage with emotional outbursts and demanding behavior or she may intensify her seductive and manipulative efforts. Self-dramatization, hyperemotionality, simulated compliance, seductiveness, and physical illness serve to reestablish control in her relationship with her father. She is unwilling to relinquish her attachment to him, and consequently all sexuality must be inhibited. Her oedipal fantasies make her unable to experience sexual desires for any other man.

At puberty, as her sexuality unfolds, trouble begins. The father moves away from his daughter, sometimes finding a mistress but at the same time jealously guarding his daughter from young suitors. The girl feels that she must inhibit her sexuality and remain a little girl in order to retain Daddy's love and at the same time to ward off threatening, exciting impulses. In the healthier patient, the defense against the oedipal conflict is the most significant factor. Fear of maternal retaliation for her success with her father and the fear of incestuous involvement lead to regression to a more infantile level of functioning. The less healthy patient, with more prominent conflicts at an oral level, already views her father more as a maternal substitute.
Variant patterns of histrionic development exist in which the daughter has a greater degree of overt dependence on the mother as well as a father who is more aloof and less seductive. At puberty, the mother makes a strong bid to keep her daughter dependent on her and thereby defeats the child in the struggle for her father's love. These girls inhibit their basically histrionic character traits, and this personality organization may only emerge later in life or during the course of psychotherapy.

In some patients, the real mother is absent, and maternal deprivation may stem from a foster mother who fails to provide closeness. The child learns to simulate emotionality. The father, although erratic, often provides the genuine experience that offers the child a chance at further development.

Beginning in the teenage period, the less well-integrated female histrionic patient has poor relationships with other girls, particularly attractive girls. She is too jealous and competitive with them to be accepted. She is not comfortable with her budding femininity and fears sexual involvement. Therefore she may have only platonic relationships with boys. Everyone in the high school knows who she is, but she is not usually popular. She is often pretty herself and is preoccupied with her appearance. Unattractive girls are less likely to develop histrionic patterns, because they are less successful in using them. The histrionic woman prefers girlfriends who are less attractive and masochistic—an arrangement that offers mutual neurotic gratification. As she progresses through the teen years, she shifts her attention to men but classically overvalues them and selects men who are in some way unattainable. Disappointment, frustration, and disillusionment are inevitable, and she reacts with depression and anxiety.

In the case of the male histrionic patient, the situation is somewhat different. In these cases there is a strong identification with the mother, who was obviously the more powerful figure in the family. She typically had many histrionic traits herself, whereas the father tended to be more withdrawn and passive, avoiding arguments and attempting to maintain peace at any price. The father often expressed his own inhibited aggression through being hypercritical and overly controlling with his son. At times the father was relatively absent in the home or was disinterested in his son, or perhaps he was excessively competitive with his son. In either case, the boy fears castration as a retaliation for his oedipal striving. In adolescence he has less masculine self-confidence than the other boys and is fearful of physical competition. His feeling of masculine strength has been acquired through an identification with the personal strength of his mother, and consequently it is more likely to be manifested in intellectual than physical pursuits. The lack of a
strong father figure with whom he can identify leads to faulty superego development and an inadequate ego ideal. When this restriction of oedipal sexuality continues into adolescence, there evolves a predisposition toward homosexuality. Homosexual object choice probably represents a continuum with biological and constitutional factors as determinants at one end. At the other end of this continuum, however, environmental factors, such as those described earlier, are likely to be crucial in determining same-sex preferences. Thus the boy, in his quest for paternal love and affection, adopts techniques utilized by his mother for gaining the admiration, attention, and affection of men. The greater the weakness, disinterest, or absence of the father, the more overtly effeminate the boy will become.

**Differential Diagnosis**

A distinguishing feature of histrionic patients lies in the emphasis they place in their personality, interactional manner, and dress for the transmission of sexual signals. This amounts to a type of self-dramatization through sexuality. Histrionic patients will often seem to exaggerate culture-bound gender symbols. In men and women this can take two disparate forms but with an underlying common theme: the dramatic highlighting of sexual stereotypes. In histrionic men one such form is the hypermasculine "cowboy." This contrasts with the effeminate "interior decorator" type. In histrionic woman one form is the hyperfeminine "charming hostess," which contrasts with the masculine "boardroom director" type.

The phallic narcissist can easily be confused with the histrionic:

In his first interview, a patient exclaimed, "I just flew up here at 80 miles an hour on my brand-new bike, a Harley-Davidson of course, leaving all those nerds in their pathetic little cars in the dust." This middle-aged man entered the office armored in black leather. He proceeded to deposit his formidable, dark-tinted motorcycle helmet on the floor and proclaimed: "This felt like the right Wagnerian overture to my psychiatric treatment, the power of the bike, my obvious superiority to everyone else."

At first sight this patient's clinical presentation seemed to be histrionic—dramatic, exhibitionistic, hypermasculine. However, the true diagnosis—phallic narcissism—became apparent in the patient's wish to dominate and feel superior to everyone else combined with a sadistic desire to pound his "inferiors" into the dust. He wanted to be feared rather than loved, and the exhibitionism was directed toward that end. Furthermore, this behavior was not personally focused on a particular person or group. His targets were randomly chosen, and his behavior was anonymous.
Differential diagnosis with the histrionic patient can be difficult, as this example demonstrates. Not only is there disagreement among professionals about whether a given patient is histrionic initially, but the clinician also may change his own diagnosis on different occasions in response to changes in the transference/countertransference paradigm. An example would be the young female histrionic patient who is hospitalized for suicidal threats. Such a patient, dramatically using gender signals of seductiveness, dependency, and infantile “little girl” behavior, can split the ward staff along countertransference gender lines. The male professionals may find her sympathetic and “histrionic,” whereas the female professionals may dislike her and regard her as “borderline.”

The major differential with the histrionic patient is thus with the higher-level borderline patient. Both types can be manipulative and demanding. The histrionic patient is more likely to begin the clinical encounter with charm and flattery, whereas the borderline patient more quickly resorts to threats. If charm is unsuccessful, the histrionic patient may also have temper outbursts and use threats to try to manipulate the person they seek to control. Both types of patients may find a real or imagined abandonment a threat, and both patients crave to be the center of attention.

Histrionic interaction with others is often characterized by inappropriate sexual or other provocative behavior. This can be confused with borderline impulsivity, which involves at least two behaviors that are potentially self-damaging (e.g., excessive spending, promiscuous sexual encounters, reckless driving, binge eating). Histrionic patients can be impulsive buyers to an extent that may approach spending binges. Differentiating this from a hypomanic spending binge requires an understanding of the patient’s thoughts and affective experiences. The hypomanic patient is in an elated mood state and believes he can afford anything he desires. He has lost touch with reality. In contrast, the histrionic patient is most likely depressed or is angry with a spouse, and the spending is accompanied by a desire to feel better immediately. The interviewer inquires, “What were you feeling when you went on this shopping spree, and what was going on before you decided to shop?”

Although both histrionic and borderline patients are subject to affective instability or emotional lability, the borderline patient is more negative and vacillates more between fear and rage than between love and anger. The histrionic patient remains connected to significant others and does not have the feelings of emptiness that characterize borderline patients.

In all likelihood, lower-functioning histrionic patients and higher-functioning borderline patients represent much the same group. The dif-
ferential is best made when the patient is functioning at his highest level rather than his lowest level. The level of psychological organization is the crucial variable. In all personality disorders there exists a dimension of relative health versus relative sickness, a quantitative measure. In the borderline patient there is a qualitative boundary that, when breached, is of greater clinical gravity and indicates the diagnosis through relentlessly self-destructive and “out-of-control” behavior that is not typical of the average less-disturbed histrionic patient.

The second most difficult differential diagnosis is with the narcissistic patient. Like the narcissistic patient, the histrionic patient desires excessive admiration and believes that he or she is special and unique and can only be understood by other special or glamorous people. The histrionic patient also possesses a sense of entitlement, may be envious of others, and in moments of stress, may display haughty behaviors and attitudes. Both types of patients may have romantic fantasies, but the narcissist is more concerned with power and admiration than with love. The narcissistic patient cannot fall in love, which is a key diagnostic element. The narcissistic patient possesses a more grandiose sense of himself that can be confused with the histrionic patient’s fantasies of royal birth. Many histrionic patients have prominent narcissistic features, but the histrionic patient is more attached to significant others than the narcissist, is able to fall in love, and cares about the feelings of other people. The histrionic patient likes people who like him. The narcissist has no compunction in dismissing those who like him if they do not acknowledge his special status.

Finally, there is a type of “hypomanic” personality that can be confused with the histrionic patient. Such individuals can be charismatic, constantly “on,” and live in a world of intense affect. They are more vivid than life, never bland, and can be quite charming and charismatic, although they are exhausting with their relentless enthusiasm, energy, and need for constant stimulation. This ill-defined personality type is probably constitutional, a type of low-level, contained hypomania, and its expression is not dynamically determined as it is in the histrionic patient.

**MANAGEMENT OF THE INTERVIEW**

The female histrionic patient usually arrives at the clinician’s office after being disappointed or disillusioned by her husband or lover, resulting in an intensification of fantasy and the fear that an impulsive loss of control of sexual urges will occur. The clinician is unconsciously used as a safe substitute and an inhibiting force. Chief complaints involving depression or generalized anxiety occur in patients of either sex. On
some occasions, particularly with male histrionic patients, somatic symptoms may be in the foreground, and the patient is referred for psychiatric help when no adequate organic basis can be found to explain his suffering. The somatic symptoms often screen depressed feelings, particularly if pain is prominent. Suicidal gestures may lead to the initial psychiatric contact in other cases.

Concern over sexual symptoms is expressed early in treatment. The patient may quickly acknowledge some degree of frigidity or impotence, although this did not lead to seeking treatment until it threatened a love relationship. In healthier patients there are also complaints of social anxiety and inhibition. These are discordant with the patient's actual performance in social situations. This same phenomenon occurs during the interview, in which the patient may conduct himself with apparent poise and composure but feels subjective discomfort.

An attractive, stylishly dressed, professional woman, a veteran of a number of previous unsuccessful therapies, began her initial consultation by saying, "I have to tell you this dream I had last night. It will reveal much more about me than just relating my boring life history." Without waiting for the clinician's response, she launched into a description of a colorful dream that involved her presence at the opera, first as a disgruntled, overlooked member of the audience accompanied by her despised boyfriend and then magically transformed into the star of the performance, the beautiful courtesan Violetta in Verdi's *La Traviata.* "This was a happy dream. I hate being just an uninteresting member of the audience, passively watching." The clinician responded by saying, "What does the dream tell you beyond your life history?" The clinician recognized the patient's transference craving for center stage and her underlying fear that she was really of no interest to others. From the beginning, her exhibitionism and need to seduce by being a famous prostitute, yet unconscious fear of sexuality (Violetta is doomed to die, prematurely), all characteristic of the histrionic patient, were dramatically produced in the first 10 minutes of the session.

The beginning mental health practitioner finds the histrionic patient one of the easiest to interview; the experienced clinician finds him one of the most difficult. This is because it is so necessary for the patient to elicit a favorable response from the clinician. The beginner is reassured by the patient's eager compliance; the more experienced interviewer recognizes the inauthenticity of the affect and role-playing. The interviewer is usually pleased with his new patient, especially if the patient is young, attractive, and of the opposite sex. He may experience the vague aura that accompanies a new romance. Attempts on the part of the interviewer to explore the patient's role in his problems will
threaten the patient's feeling of acceptance because of his strong need to feel that the clinician likes him. Focusing on this issue prematurely will drive the patient away, and yet he cannot be helped unless his role in his difficulties is explored. The interviewer must develop a relationship that will permit the patient to continue in treatment as well as encourage the unfolding of his problems.

The Opening Phase

Initial Rapport

The histrionic patient establishes "instant contact" at the beginning of the interview. He quickly develops apparent emotional rapport, creating an impression of a strong commitment to the interviewer, although feeling little involvement. The patient's first comments are frequently designed to please and flatter the interviewer, complimenting the clinician's office or remarking, "I'm so glad you were able to see me" or "What a relief finally to have someone I can talk to." A reply to such comments is unproductive, and instead the interviewer can shift the focus by asking, "What seems to be the problem?"

Dramatic or Seductive Behavior

The histrionic patient is obviously relieved by the opportunity to describe his suffering and does so with a dramatic quality. Before the interviewer can inquire about the chief complaint, the patient may begin by asking, "Shall I tell my story?" The drama unfolds as he describes his difficulties in vivid, colorful language, using many superlatives. The patient's behavior is designed to create an impression, and the interviewer begins to feel that the scene has been rehearsed and any questions will be an intrusion.

The histrionic patient usually prefers a clinician of the opposite sex. The female histrionic patient often is disappointed if she finds that her new interviewer is a woman. The disappointment is concealed, although the patient may remark, "Oh, I didn't expect a woman therapist!" There is no point in exploring the patient's disappointment in the first part of the interview, because it will only be denied. If the patient has already had a failed treatment with a therapist of the opposite sex, the patient may seek a same-sex therapist the second time around.

Even the inexperienced interviewer quickly recognizes the most common stereotype of the female histrionic patient. The patient is stylishly and often colorfully dressed and has a seductive manner, ranging from social charm to overt sexual propositions. Body language pro-
vides clues in understanding the patient. The patient who dresses up when coming to see the clinician employs a form of body language that lends itself to exploration early in treatment. The most frequent example of the use of the body is the female patient who sits in a provocative posture, exposing a portion of her anatomy in a suggestive way. This behavior is designed to engage and distract the interviewer sexually. It is an unconscious mechanism to equalize the power balance with the interviewer.

Self-dramatization can be interpreted relatively early in treatment, although not in the first few sessions. Premature interpretations cause the patient to feel rejected and are usually made because the clinician is anxious. When the male interviewer comments on the female patient’s seductiveness and her tendency to sexualize every relationship, she will protest that her behavior is not sexual. She might say, “I just want to be friendly, but they always have other ideas.” The interviewer should maintain his opinion without getting into an argument with the patient, who has difficulty accepting the idea that a pretty woman cannot initiate a casual conversation with strange men.

Early interpretations are often useful when the patient directs the interviewer’s attention to her behavior in the initial interview. For example, an attractive young woman pulled up her dress and asked the clinician to admire her suntan. He replied, “Are you more confident about your appearance than about what you are telling me in regard to yourself?” This general, but supportive, interpretation is preferable to silence early in treatment because it is less of a rejection for the patient.

The dramatization of roles that are less obviously sexualized is more difficult to recognize.

A young woman arrived for an interview in tattered jeans and a dirty sweatshirt. The interviewer asked about her problem, and she replied, “Well, I’ve been depressed for months, and a week ago I had a big fight with my husband, and got furious, and that’s when I took the pills.” The patient did not appear to be depressed, and she related her story with dramatic flourish. When the interviewer inquired about the pill episode, the patient answered, “First I started popping the Advil, and then I went for the Valium pills, and that’s when he hit me and I got this lump on my head.” The interviewer requested further details about the fight, and the patient said, “Actually he did not hit me, he shoved me against the wall and I bumped my head.” Rather than the result of a depressive spell, the episode was the culmination of a dramatic free-for-all involving the patient, her husband, and her children.

On several occasions this patient casually, but abruptly, introduced highly charged material, which is typical histrionic behavior. Early in the interview, she gave the ages of her five children as 12, 10, 6, 5, and 1.
No explanation was given when, in the next sentence, she indicated that she had been married only 7 years. Later in the interview, she was asked about her relationship to her in-laws, and she replied, "Well, it is not too bad now, but at first they were not happy about Bill marrying a divorcée with two children."

Dramatic remarks are made frequently during the interview. For instance, the same patient, when volunteering that she was a housewife, added, "That's a glorified term." In the case example above, we can easily identify the patient as histrionic because the features of diagnostic significance have been abstracted from the interview. However, many interviewers do not recognize this behavior when it is mixed with non-histrionic material and the patient is not the stereotypic pretty, seductive young woman.

Another patient may dramatize indifference upon arriving 10 minutes late, showing no awareness of the time. This patient, unconcerned about small amounts of time, will feel that the clinician is being pica-yune in terminating the session on time even though the patient is in the middle of his story. The patient remarks with annoyance, "Can’t I finish what I’m saying?" or "I had so much to tell you today." The interviewer can reply, "We had a late start" and let the matter drop. The interviewer wants the patient to become responsibly interested in the lateness and the motivation behind it.

Some histrionic patients will dramatize obsessiveness in the initial interviews, leading to errors in the clinician’s understanding of the patient. An example would be the patient who brings a pad to the session and jots down notes about the clinician’s remarks, but then loses the notes or never reads them. Beginning interviewers often mistake the patient’s remarks that involve performance or competitiveness as evidence of an obsessive character. Although the histrionic patient can be just as competitive as the obsessive-compulsive patient, the goal of the histrionic patient’s struggle is love or acceptance, whereas the obsessive-compulsive patient is more concerned with power, control, and respect. The histrionic patient may express anger over the doctor’s fee or some other issue, but the subject is dropped when the emotional tone changes; the obsessive-compulsive patient remains inwardly angry for a much longer time, using intellectualization or displacement in order to keep his anger out of consciousness. The histrionic patient will often pay late, offering the excuse that he lost the bill.

Distortions and Exaggerations

When the first interview is almost over, the interviewer may realize that he has little historical data and almost no chronological sense of the pa-
tient's development. Instead, he has become immersed in the interesting and lively details of the present illness and dramatic episodes from the past and senses that he has already lost his neutrality. At some point in the first or second interview, the clinician must intervene in order to obtain more factual information. As he succeeds in getting behind the rehearsed facade, the patient will reveal feelings of depression and anxiety that can then be explored empathically.

Initially, the histrionic patient ascribes his suffering to the actions of others, denying any responsibility for his own plight. He tells what was said and done by the other person but leaves his own behavior a mystery. Rather than interpret these defenses in the initial interview, the clinician can simply ask the patient what he himself said or did in each situation. The patient's response to these confrontations will usually be vague and expressive of his lack of interest in his own role. The interviewer must be persistent if he is to obtain the information he seeks. In addition to gathering information, he subtly communicates that he considers the patient's role important and that the patient has the power to influence his human environment rather than merely being influenced by it. After the first few interviews, the clinician can comment, each time the patient leaves his own behavior a mystery, “You don’t tell me what you contributed to this situation—it is as though you consider your own behavior unimportant” or “In describing each situation, you emphasize what the other person does, but you leave yourself out!”

Frequently the patient will contradict details of his own story or add further exaggeration when telling the story for the second time. The therapist should be alert to these occurrences because they provide excellent opportunities to interpret the patient's defensive misrepresentation. Usually it is the patient's desire for extra sympathy that underlies such distortions. The interviewer can then comment, “It appears that you feel you must dramatize your problems or I won’t appreciate your suffering.” It is through these openings that the therapist encourages the patient to share feelings of sadness and loneliness.

Early Confrontations

Exploration of the Problems

It is common for a histrionic patient to complete the initial interview without revealing the major symptoms that caused him to seek help. The patient frequently uses generalizations in describing his problems. These are accompanied by expressive emotionality, but specific difficulties are not defined. Intense affect conceals the vagueness of what is
said. The interviewer finds that his questions are answered superficially and that the patient seems mildly annoyed when asked for further details. For example, a patient described her husband as a “wonderful person.” The interviewer replied, “Tell me some of the ways in which he is wonderful.” The patient hesitated briefly and then said, “Well, he is very considerate.” The interviewer, realizing that he had actually learned nothing, asked for some examples. What emerged was that her husband never tried to force his attentions on her when she was not in the mood for sex. The interviewer could now ask the patient if she had difficulty with her enjoyment of sex. Without this step, it would have been easier for the patient to deny that she had a sexual problem.

Often the histrionic patient will discuss feelings of depression or anxiety without any outward manifestation of these emotions. The interviewer can indicate to the patient that he does not appear to be depressed or anxious. This must be said tactfully and in an empathic tone, or the patient will feel criticized. An example is, “You prefer not to allow your pain to show while describing it?” This confrontation invites the patient to share his true feelings rather than merely enlist the interviewer’s sympathy with a sad story. The patient’s fear of rejection leads to his attempt to gain sympathy without really sharing himself.

The relative prominence of physical symptoms in the interview to some extent reflects the patient’s belief concerning the interests of the interviewer. It is a rare histrionic patient who does not have some mild physical complaints such as fatigue, headaches, backaches, and menstrual or gastrointestinal symptoms. The patient does not consider such symptoms to have important psychological determinants, and the interviewer should avoid challenging this view early in treatment. He can best inquire about the patient’s physical health as part of his interest in the patient’s life, without implying that he is seeking to find a psychological basis for such symptoms.

With the patient who has an extensive history of physical complaints, the interviewer must not interpret the secondary gain in the first few interviews, even though it may be quite transparent and is seemingly acknowledged by the patient. For example, a patient says, “My family certainly suffers because of my frequent hospitalizations.” The interviewer can reply, “Yes, I’m sure that it is very hard on all of you,” thereby emphasizing the patient’s secondary loss rather than his secondary gain. The histrionic patient will occasionally state early in treatment that his physical symptoms are psychosomatic or are “all in my mind.” The experienced interviewer recognizes this as a resistance, since the patient is making a glib statement that really has little meaning, trying to appeal to what he assumes the interviewer must believe.
The Denial of Responsibility

Responsibility for the patient’s feelings. The histrionic patient attempts to avoid responsibility for his emotional responses and to elicit the interviewer’s support and validation for doing so. The female histrionic patient finishes describing a fight with her husband and then asks, “Wasn’t I right?” or “Wasn’t that a terrible thing for him to say?” The patient will not be helped to better understand herself if the interviewer merely agrees with her. These questions are direct attempts to manipulate the clinician into taking sides with the patient against some other important figure in the patient’s life. The therapist who participates in these enactments is assuming the parent role, which defeats the aim of treatment. The clinician who ignores these attempts at manipulation seems insensitive and uncaring in the patient’s mind. It is for these reasons that exploratory questions are indicated. Examples include, “I’m not sure I understand what underlies your question”; “I feel I’m being put in the middle. If I say yes you are right, I am supporting a part of you but then I am critical of your husband. If I say no, then I don’t appear to be sympathetic to your feelings”; or “Is there some element of self-doubt in this situation that we should explore?” The patient’s desire for an ally is understandable, although underneath the patient has the feeling that she is not entitled to what she seeks. In the transference, the patient has reconstructed the triangular relationship that once existed with her parents, except that the therapist and the spouse now represent these parental objects in the patient’s unconscious.

Frequently the patient will create a very negative picture of someone close to him. If the interviewer attempts to be supportive and comments that the patient’s relative seems to be unfair or selfish, the patient will often repeat the interviewer’s remark to the other person, stating, “My therapist says that you are unfair!” This can be minimized by remarking, “From your description, your mother sounds like quite a selfish person,” or if the patient’s remarks are sufficiently critical, “That is quite an indictment.”

Responsibility for decisions. The histrionic patient will, whenever possible, attempt to have the clinician assume responsibility for his decisions. The wise clinician will not accede to these helpless appeals. Instead, he suggests that the patient explore the conflict that prevents him from making the decision for himself. The patient responds by seeming not to understand what factors are involved in making a decision. Even if the histrionic patient explores the psychological meaning of the decision, when all the discussion is over, he is likely to confront the practi-
tioner with, "Now, what should I do?" If he is pressed to decide for himself, after doing so he will ask, "Is that right?" It is as though the discussion were something quite separate from the actual decision. In other situations, the patient has already made the decision in his own mind, but he wants the practitioner to share the responsibility for the consequences.

An example of one patient's helplessness occurred when the clinician changed the hour of an appointment. The patient made no record of the change and came at the wrong time. Then he said with annoyance, "How do you expect me to remember these things?" The clinician replied, "You are right, it is difficult, and I could never manage either if I hadn't written it in my appointment book!" The clinician should refrain from writing the time down for the patient, because this will only indulge his helplessness and reinforce the pattern. One patient telephoned to inquire if she had missed an appointment on the previous day. When the interviewer replied that she had, the patient sounded distraught and said, "I had so much to talk about; isn't there anything you can do?" The patient hoped that the therapist would take pity on her and find some way to squeeze her into his schedule. When he replied, "We can talk about it next time," she insisted, "There must be something you can do!" The interviewer answered, "No, there isn't." At this point it was clear that the manipulative effort had failed, and the patient said with a tone of resignation, "All right, I'll see you at the regular time tomorrow."

Another way in which the histrionic patient manifests attitudes of helplessness is the use of rhetorical questions. He exclaims, "What should I do about this problem?"; "Can't you help me?"; or "What do you think my dream means?" Stereotyped replies such as "What do you think?" are of little help to the patient. Often no reply is necessary, but early in treatment the interviewer could remark on the patient's feeling of helplessness. A different approach is for the clinician to demonstrate his honesty and humility with a statement such as "I don't know."

**Interpretation of the Patient's Role**

As the therapy progresses, the unconscious role that the histrionic patient lives out in life will emerge. The role that is most common and closest to consciousness is that of the injured party or the victim. Although the origins of this role lie in the distant past, the patient perceives it as a reflection of his current life situation. Other roles, such as that of Cinderella or a princess, are typically related to the patient's narcissism and grandiosity. The patient may elevate her self-esteem through exaggera-
tion of her social status. The achievements of her more successful relatives or friends are inflated to create an overall impression of greater culture, romance, or aristocracy than is accurate. This attitude may manifest itself as a feeling of superiority to the clinician or a veiled reference to the lesser intellectual backgrounds of other people with whom she is involved.

This defense is not interpreted during early interviews. As the interviewer pursues the origin of these grandiose fantasies, he will find that they are oedipal. The female patient's father led her to believe that she was his little princess, and she dared not grow up. She compensates for her apparent helplessness in the adult female role through her pride in being a more feeling and sensitive person than those on whom she is dependent and who symbolically represent her mother. The histrionic patient feels that she has subtler tastes and finer sensibilities and appreciates the better things in life. She feels that it is herself, rather than her husband, whom their friends see as the interesting and attractive person. This attitude toward her husband also defends against sexual involvement with him. He is considered a crude and insensitive person who merely responds to basic animalistic drives. The male patient, on the other hand, is inclined to portray himself in the roles of hero, clown, or "macho," using some distortion of fact.

During therapy, there are shifts in the role that the patient dramatizes. These shifts reflect changes in the patient's current self-image as well as her style of re-creating part-object identifications from the past. Often, the changes in role are in response to the patient's attempts to elicit the interest of the interviewer.

**The Patient Responds**

*Hyperemotionality as a Defense*

Hyperemotionality, one of the histrionic patient's most important defenses, occupies a prominent position in the treatment. The emotionality influences the interviewer to empathize with the patient's feeling; however, the clinician is unable to gratify all of the patient's demands and instead offers interpretations, which serve to block some of the gratifications that the patient receives through his symptoms. As a result, the patient inevitably experiences frustration and may respond with anger to conceal his hurt feelings.

A male histrionic patient elicited a feeling of sympathetic understanding while describing the "impossible situation" of a family business in which he was constantly put in the position of the baby. He went into
considerable detail describing his father’s tyrannical and excitable behavior. As the interviewer persisted in his questions, it became apparent that the patient had temper outbursts at work. At such times, his family would cater to him because he was upset. The patient’s need to play the role of injured child because of his fear of the adult male role was interpreted. As would be expected, the patient reacted with an outburst of anger and depression. At the next session, the patient stated, “I was so upset after our last session, I felt much worse. I couldn’t stop churning inside, but I finally felt better when I ate something on the way back to work.” The interviewer then inquired, “What was it that you felt so badly about?” After the patient described his feeling of unhappiness, the clinician interpreted, “The food seems to provide a form of comfort and security.” The patient revealed that he had been given food and extra privileges during his childhood when he felt badly or had been punished by his parents. The indulgence was associated with feelings of being loved by his parents and having been forgiven for his transgressions. In his adult life, the same experience was unconsciously represented by buying himself food. Rather than gratifying the patient’s bid for love, the therapist offered only an interpretation, which blocked this area of gratification and required the patient to seek a new solution to his injured pride.

In working with this defense, however, the clinician must convince the patient that his traditional solutions offer no permanent resolution of the underlying problem, which is the patient’s feeling of helplessness and damaged self-esteem. The clinician must then show the patient that the hyperemotional response that led to, in this case, the purchase of food also warded off a deeper and more disturbing emotion. At this point, the patient frequently becomes angry and asks, “Why should I have to change?” or “Why can’t anyone accept me the way I am?” No comment is required on the part of the interviewer. Once again the histrionic patient utilizes his hyperemotional anger as a defense against his fear of the adult role.

In due time the patient will recognize that other people have less intense emotional reactions. It is then that the interviewer can point out the pride with which the patient regards his hyperemotional responses. This pride reflects a compensatory sense of superiority to the parent. The hyperemotionality is also a reaction to the emotional response expected by the parents. The reactions of feeling sorry, appreciative, or frightened were expected by the parent and produced by the child in order to gain parental approval. Later, these same processes operated intrapsychically as the ego attempted to obtain approval from internalized objects.

The interpretation of the histrionic patient’s defensive patterns frequently leads to depression. If kept within reasonable limits, this emo-
tion provides the motivation for therapeutic change. A premature urge to prescribe antidepressant medication may convey a message to the patient that the emotion of sadness must be controlled.

**Regressive Behavior**

Those histrionic patients who have more serious ego defects are particularly prone to regressive behavior as the clinician begins to interpret their defensive patterns. The patient may become even more helpless, depressed, and preoccupied with physical illness or may threaten suicide. These symptoms are associated with considerable secondary gain. When such infantile behavior emerges, it should occupy the central focus of the interviewer’s interpretations. Thus it is not appropriate to interpret the female histrionic patient’s fear of oedipal competition while she is depressed and threatening suicide. Instead, the clinician interprets her feeling of deprivation and need for dependent care. After the patient has improved and is experiencing the desire to compete in the adult feminine role, the therapist can explore her oedipal fears as a source of her inhibition.

**Involvement and Pseudo-Involvement**

The female histrionic patient is usually pleased with her therapist during the early phase of treatment. She eagerly anticipates her sessions and is prone to feel romantically involved with the clinician. She sees him as a strong and omnipotent figure who could provide the protection and support that she feels she needs. Similarly, she idealizes the female therapist for having the best of both worlds, a gratifying career as well as a husband and children.

The histrionic patient’s enjoyment of treatment is accompanied by enthusiasm for psychological thinking. The patient is likely to acquire intellectual knowledge about emotional problems from books, friends, or from the clinician himself. Even the most experienced clinician may find himself pleased with the patient’s early interest in treatment and the effort he applies to the work. Because of his emotionality, insights are related with feeling, in contrast to the intellectualization of the obsessive-compulsive patient. The inexperienced interviewer is convinced that this is true emotional insight, as contrasted with intellectual insight. However, after a year or two he discovers that the daily successes do not add up to long-term progress.

It requires experience to recognize when the histrionic patient is not really involved in changing his life and is only playing the role of psychotherapy patient. There are certain clues that are helpful in recogniz-
ing this process. For example, in his enthusiasm for analysis, the patient may bring in material about a spouse, mistress, lover, or friend. He may ask the clinician for advice concerning the other person’s problem, or he might offer his own insights, hoping to win the interviewer’s approval. If the patient receives any encouragement, he might bring in a friend’s dream and request the practitioner’s aid in interpreting it. The interviewer, rather than responding directly, can say to the patient, “What are your thoughts about bringing your friend’s dream to me?”

Another instance is the patient who enlists the aid of auxiliary therapists. This process may take the form of reading books on psychology and psychiatry or it may involve the discussion of his problems with friends. On some occasions, the interviewer can point out that the patient has obtained a contradictory opinion from a friend by not describing the situation in the same way as he had presented it to the therapist. On other occasions, the clinician can interpret the patient’s feeling that the therapist is not providing enough help, and that outside assistance from books and friends is necessary because he feels unable to work out his own answers.

Another example of the histrionic patient’s style of involvement in treatment is his pleasure in watching the clinician “at work” while maintaining an emotional distance from the process. For instance, the patient asks, “Could you explain what you meant last time when you were talking about my mother?” His tone makes it clear that he is not asking for clarification of something he did not understand but that he wishes the clinician to provide sustenance in the form of explanations. When the clinician supplies this gratification, the patient may seem to become interested and involved, but he does not extend the perimeters of the clinician’s explanation. He might even remark, “You seem so wise and understanding,” indicating that he is responding to the clinician’s strength rather than to the content of the interpretation. At these times, the clinician can say, “I get the feeling that you enjoy listening to me analyze you.”

A more subtle clue to the incomplete involvement is provided by the patient’s tendency to omit crucial data from his current life situation, such as the fact that he has started a new romance or that he is in danger of losing his job. When such omissions occur, the interviewer can interpret them as indications of the patient’s partial involvement in treatment.

Recognition of the Patient’s Distress

The histrionic patient’s emotional display is not always a drama. When the interpretations of the defensive pattern are successful, the patient will experience genuine feelings of loneliness, depression, and anxiety.
At such times, it is essential that the interviewer allow the patient to feel that the clinician cares, that he is able to help and will permit some measure of dependent gratification. The mature interviewer is able to accomplish this without abandoning his professional stance. The interviewer who fears being manipulated when the patient genuinely feels badly will miss appropriate opportunities for sympathy, kindness, and understanding. This failure will prevent the development of trust and insight. The interviewer may on occasion have an opportunity to share the patient’s real pain before the end of the initial interview, but with many patients this does not occur for weeks or even months.

**TRANSFERENCE AND COUNTERTRANSFERENCE**

Transference is prominent in the behavior of the histrionic patient from the first interview. The transference is usually positive in the first few interviews and often assumes an erotic quality when interviewer and patient are of opposite sexes. Overtly sexual fantasies about the clinician at the very beginning of treatment often suggest borderline psychopathology.

The following paragraphs refer to the transference and countertransference phenomena seen between a female patient and male interviewer, but a similar relationship also develops between the female interviewer and the male histrionic patient. The patient soon refers to the interviewer as “my doctor,” “my psychiatrist,” or “my therapist.” She may make flattering references to the clinician’s clothing or the furnishings of his office. She is solicitous if he has a cold and takes pains to learn about his interests from clues provided by his office furnishings, books, magazines in the waiting room, and so forth. She is likely to bring newspaper or magazine articles or books that she feels might interest him. She will be particularly interested in the other women patients in the waiting room, with whom she feels intensely competitive. Her traits of possessiveness and jealousy are easily uncovered by exploring remarks that she makes concerning these competitors for the clinician’s love.

Body language often reveals early indications of transference. For example, the female histrionic patient may ask for a glass of water or soda, rummage through her pocketbook in search of a tissue, or put the interviewer in the position of having to help her with her coat. Such behavior is difficult to interpret in an initial interview, although it provides important clues about the patient. On one occasion when the interviewer indicated that he had no soda, the patient responded by
bringing a large bottle to the next interview as a deposit. The interviewer did not accept this offering, because it would have assured the patient that the clinician would provide gratification of her dependent needs on demand. In refusing, the interviewer remarked, “If you are able to bring your own soda today, I think you should be able to manage other times.” Each interviewer must rely on his own personal background and personality style with regard to social formalities such as opening doors, shaking hands, and so on. Behavior that would be natural for a European-born practitioner might be forced for an American.

The histrionic patient makes demands on the clinician’s time. As the treatment progresses, intrusions on the clinician increase. There are requests for extra time or telephone calls to his home. The patient quickly develops an interest in his professional and personal life. Questions such as “Are you married?”; “Do you have children?”; or “Do you live in the city?” are common in the first few interviews. If responded to they will lead to more questions: “What does your wife do?” or “Where do you go on vacation?” If the interviewer gives no reply, the patient will feel rejected or angry at the clinician’s rudeness.

This therapeutic dilemma can best be addressed directly. The clinician might reply, “I appreciate your interest in me as a person, but I can be more helpful to you if we limit our focus to your life and what transpires between us here rather on my outside life” or “Your questions about my outside life are only useful if we explore why you are asking them.” A typical response by the histrionic patient to this rejoinder is, “In other words, I’m not allowed to ask anything about you.” The patient is annoyed by the therapist’s limit setting. This can now be directly addressed: “Are you unhappy with my answer?” or “Do you feel that this will not be a relationship between equals?”

After several months of treatment, a patient related a dream of visiting the therapist and his family at home. She was particularly interested in the therapist’s wife, and in the dream the patient was disappointed that the clinician did not seem as strong in his home as he did in the office. The dream was told late in the session, and the clinician’s comments were limited to the patient’s disappointment in him. A weekend intervened before another session, and the patient became upset and telephoned the clinician at home. In the following session, the telephone call was interpreted as an acting out of the wish in the dream—that is, to compete with the clinician’s wife for his attention. With much embarrassment, the patient revealed that shortly before she had become upset, she had met a woman friend in the park who knew the clinician’s wife and that the patient had made inquiries about her competitor. The patient was soon able to relate this behavior to the situation in her childhood home.
A borderline histrionic patient, having learned from the doorman that the clinician lived in the same building as his office, waited outside all day in order to discover the identity of his wife. If such behavior persists or becomes troublesome to the clinician, it may suggest a countertransference problem, with the patient receiving subtle encouragement from either the clinician's anxiety or his enjoyment of the patient's interest.

The histrionic patient evokes guilt in the interviewer by continually placing him in the position of having to choose between being an indulgent parent and a depriving, punitive one. Even the most skillful interviewer cannot always avoid this dilemma. The clinician can use a combination of sympathy and interpretation. The histrionic patient soon asks, either directly or indirectly, for special privileges. He may request a glass of water or ask to use the clinician's telephone. The female patient might ask to change her clothes in his bathroom or to have her friends meet her in his waiting room. One histrionic patient, who noted that a plant in the clinician's office was dying, brought a new one. Another patient began the session saying, "I didn't have time enough for lunch today. Would you mind if I ate my sandwich?" The interviewer is put in the position of choosing between denying the patient lunch or permitting her to eat during the session. The clinician could remark, "You are asking me to decide whether to accept your interfering with the treatment or to deprive you of your lunch." In general, the interviewer should explore the underlying motivation rather than grant these requests. Histrionic patients with more serious ego defects might be treated more indulgently early in the treatment. The clinician will be more successful if he avoids an unreasonable, rigid approach.

Sometimes the patient will mention that he has discussed his treatment with a friend. On other occasions, the patient may indicate that a friend made some particular comment about the patient's treatment or the patient's therapist, usually reflecting a response of the patient himself that he is disavowing. For example, the patient might say, "My friend does not agree with what you told me last time." The therapist inquires, "What did you tell your friend I said?" In this way, the therapist will learn the nature of the patient's distortions of his remarks. The interviewer can interrupt the patient to ask, "Is that what you thought I said?" Often the patient will be able to recall the clinician's actual statement but then add, "But I thought you meant..." or "What I repeated is almost what you said." It is important to demonstrate the distortion before attempting to analyze its meaning. A series of such experiences with the patient will quickly reveal the nature of the transference. An alternate method is to explore why the patient wants to discuss his treatment with someone else.
When the histrionic patient and the clinician are of the same sex, competitive behavior is more prominent in the transference. The female histrionic expresses feelings of envy about the woman clinician's "stimulating professional life." At the same time she looks for opportunities to imply that the clinician is not a good mother, dresses in poor taste, or is not very feminine. The patient often experiences disappointment that her therapist is a woman, and this can be interpreted quite early in treatment.

Countertransference problems with the histrionic patient vary according to the gender, personality, and degree of experience of the clinician. The less experienced interviewer is afraid of being manipulated by the patient and tends to assume a defensive posture that hampers the development of trust and a therapeutic alliance. Kindness, empathy, and at times, sympathy for the histrionic patient are essential for the treatment to progress. Empathizing with the histrionic patient's unconscious wish for dependent care, rather than reacting with self-righteous indignation, is crucial in this endeavor.

The therapist may allow himself to be set up against the patient's spouse, parents, boss, and so on, thereby assuming the role of key persons from the patient's past who were played off, one against the other. In the extension of this countertransference, the therapist plays the role of parent, protector, or lover in the patient's unconscious, enjoying the patient's quick insights, warmth, emotionality, or even helplessness. Erotic responses in the clinician are very common and may be quite frightening to the therapist. The warmth and seductive behavior of the patient may lead the clinician to be defensively aloof, cold, and business-like, allowing no emotional engagement in the interview. The clinician can look for opportunities to initiate engagement instead of merely responding to the patient's attempts at control.

Awkwardness in dealing with the patient's spontaneity leads the therapist to feel as though he has two left feet. The young clinician's spontaneity is often learned or rehearsed. An example occurred with a histrionic patient's second visit to a female resident. The patient began the session with, "Oh that is the same dress you were wearing last time." This savvy resident smiled and replied, "Well, how about that?" The balance of power was quickly reestablished. The competitive transference was not ready to be interpreted. If the interviewer allows a number of examples to unfold, the interpretation is more effective. A response by the interviewer of "touche" acknowledges, "You caught me off balance." One can then explore the patient's response, and the patient's covert reasons for the aggression will emerge.

Failure to see through the patient's intellectualizations that are de-
signed to impress the therapist misses the fact that the patient is trying to please the clinician. Another common countertransference problem is to miss subtle inhibitions of self-expression. For example, not speaking up at a meeting or fear of asking questions in a class are examples of blind spots that allow the patient to remain a child.

Gratifying the patient excessively to avoid the patient's emotional storms or to keep the patient in treatment is obvious countertransference. Feeling guilty at being either too depriving or too indulgent is the rule, and errors on both sides should be analyzed in the transference. The errors on both sides tend to balance each other out.

There is the histrionic patient who brings gifts to the therapist. It might be a plant to replace one that is dying, or it may be something to eat. Then there is the patient who has a friend meet her in the clinician's waiting room or redoes her makeup in the bathroom or leaves a suitcase in the clinician's closet. Such behaviors by the histrionic patient have the capacity to make the interviewer feel gauche or petty about his response of annoyance. These obvious transference enactments provide countertransference traps. The easiest way of addressing this is when the patient brings it up, even if it is not until the following session, with a comment such as, "I hope you didn't mind that...?" It requires tact and comfort with one's own feelings to ask, "Did you have any reservations about it?" or "How did you think I felt about it?"

As the interviewer acquires experience and professional maturity, he finds it easier to be firm with the histrionic patient and at the same time to be kind and understanding. The histrionic patient always responds to the clinician's understanding by feeling loved. This feeling is followed by unreasonable demands. The clinician cannot gratify these demands, and the patient then feels rejected. The treatment of the patient typically alternates between these two extremes.

One of the easiest ways to avoid being manipulated in the matter of decisions is to admit to the patient that the interviewer does not know what would be best for the patient. At the same time, this challenges the patient's image of the clinician as an omniscient figure of authority. If the patient does succeed in manipulating the clinician, it is possible to use the experience constructively instead of becoming angry with the patient. The interviewer could ask, "Do you feel that this is the way that I can best help you?" or "Why is it so important to manipulate me in this way?" The patient will often misinterpret the firmness or control on the clinician's part as a rejection and as an attempt to inhibit the patient's spontaneous feelings. This misperception stems from the patient's inability to experience a subjective sense of emotional freedom and at the same time successfully regulate and control his life.
CONCLUSION

The histrionic patient is one of the most rewarding patients to treat. Although there are many stressful periods for the patient and the clinician, the experience is rarely boring. As treatment progresses, the patient will eventually develop his capacity for genuine emotional responses and also to manage his own life. His emotional swings will become less marked as he gradually is able to understand and accept his deeper feelings and repressed sexual wishes. The clinician will usually feel some personal enrichment from this therapeutic experience in addition to the satisfaction customarily derived from helping a patient.