Problems in Family Practice

The Female Hysterical Personality Disorder

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It is not uncommon in family practice for the family physician to encounter the female patient with a hysterical personality disorder. A case presentation and interview are provided to help the family physician recognize the problem. A formulation of this case stresses psychosexual development, which will provide the reader with insight that can be generalized to other patients. Major emphasis is given to practical guidelines for the clinician for management of this frequently difficult problem in a medical setting.

The hysterical personality disorder is not yet clearly defined by psychiatry. The analytic school stresses a fixation at the Oedipal phase of psychosocial development. Others[1,2] base this diagnosis on a constellation of behavioral traits. Furthermore, the personality disorder must be differentiated from the hysterical neurosis or classical hysterical conversion reaction. The medical profession is often guilty of using the term "hysterical overlay" as a label for those patients who appear to be exaggerating symptoms.

Traditionally, this has been considered an exclusively female disorder. The recent trend to base the diagnosis on observable behavior has led to the recognition that this constellation of traits can be seen in men. Luisada[3] has reviewed a series of males with the diagnosis of hysterical personality. In this paper, the term *female* hysterical personality disorder is used to avoid being sexist and to underscore that we are discussing one specific aspect of a more general problem.

The female patient with a hysterical personality disorder can be a problem patient in family practice. If the physician can recognize such a patient and have some strategy for managing the intrapersonal problems that frequently arise between patient, physician, and paramedical staff, he may avoid feelings of anger and frustration. Furthermore, successfully helping such a patient learn to interact with others in a more appropriate fashion by engendering a mature and stable doctor-patient relationship can be rewarding for the physician.

This paper employs a format that has been used to describe for family physicians other common emotional problems.[4,5] The case presented represents an extreme example in order to emphasize certain points. The reader is asked to keep in mind that many less dramatic variations on this theme are encountered almost daily in a family practice. The interview stresses technique and the formulation stresses developmental psychology. The suggestions for management emphasize the role for the general physician rather than for the psychotherapeutic behavioralist.

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Case Presentation

G.S. is a 20-year-old female who barged into her family doctor's office in the midst of a busy afternoon, complaining that she was nervous and needed help. Although she had tried to commit suicide in the past, she denied having any thoughts or plans for doing so now. After a brief encounter, she was given a small amount of diazepam and arrangements were made for a "long interview" as part of a teaching seminar in a family medicine preceptorship that has previously been described.[6] She promised to call the family doctor if she became desperate before that scheduled appointment in 48 hours.

The entire family had been cared for by the family doctor, and the patient had been seen on one occasion during the past year for a minor problem. The "long interview" revealed that the patient had experienced tremendous emotional turmoil during recent months, including hospitalizations for attempted suicides. The family had very carefully and successfully concealed this information.

According to the patient, the problems all began about a year previously. The patient had a close relationship with a boy named Steve. They enjoyed each other's company and planned to get married. For no obvious reason, she tried to jump off a bridge while Steve was watching. Soon after this, he broke off the engagement. At this point, she became quite despondent and had a series of hospitalizations. During one of these hospital stays she became involved with an attendant who eventually insisted that they stop seeing each other. Two months prior to the interview she fell in love with another boy named Mike. A few days before the interview she realized that she was pregnant with Mike's child.

Interview

The following edited interview details some of the patient's recent behavior. In addition, it contains information on which a formulation was developed and the diagnosis of hysterical personality disorder was made. The footnotes marked "T" are designed to describe interviewing technique.

Doctor: Maybe we can try to figure out what is causing this trouble. Let's go back to your breaking up with the former boyfriend.[T1] That seems to have set off some of your anxiety. Is that right?

Patient: That's when I started to go in and out of the hospitals.

Doctor: Have you ever had any nervous problems or tension before this last birthday?[T2]

Patient: No. The day I turned 20 was the day it all started. I'll never forget that birthday as long as I live.

Doctor: Why did you break up with your boyfriend?

Patient: Because I tried to commit suicide in front of him. He couldn't take it any longer. I don't even know why I did it then. I had no good reason . . . Then, when I broke up with him I really wanted to do it. I really meant business. Before I was hoping that he would save me . . .

Now I've found someone else, Michael. I never thought I could find anybody else. Now I find out I'm pregnant, and he wants me to have an abortion. I don't want him to have me have an abortion so he can take off after. I love this boy very much and he loves me.

Doctor: You believe he does love you?[T3]

Patient: I do. It was so sudden . . . When I try to kill myself, I ask why? I have someone who loves me.

Doctor: Even though you're getting along well with your boyfriend, you still want to kill yourself?

Patient: Yes, I do. Saturday I tried it. I took 20 pills. I was with him. I kept falling asleep. Finally I had to tell him. He made me go to the hospital.

Doctor: We have at least two sets of problems to work on. First is your concern about the pregnancy and second your relationship with this man. How do you feel about him?[T4]

Patient: I love him very much.

Doctor: But you don't trust what he says about his love for you.[T5]

Patient: When I first told him I was pregnant he said we'll have it and work things out. Then after a while he said he didn't want the baby. He wants me to go into Boston and have an abortion. It only takes a few minutes. We don't want to start with a baby. I don't want him to be trapped into marrying me because of the baby.

Doctor: What makes you hesitate to have the abortion? Is it because you're afraid that you'll lose him?

Patient: I don't know. I don't know. It is kind of confusing. I was confused last Saturday when I took the pills.

Doctor: Do you often go into action like that?

Patient: Oh yes. Last time I really felt angry – I have a brand new car – I took a big rock and threw it through the windshield. I only had the car for two days.

Doctor: You really do go into action.[T6]

Patient: I do. I get the urge and I just do it.

Doctor: It is still puzzling why you would go that far. What is it that drives you to do something as desperate as trying to commit suicide? Especially when things are going well, particularly that first time with Steve.

Patient: Well, in my mind I think I was testing him.

Doctor: That's an intriguing idea, what would you be testing?[T7]

Patient: To see if he would say "Don't kill yourself, I love you too much." Mike said that when I tried to kill myself, and he meant it.

Doctor: How did you feel when he said it and meant it?

Patient: I felt hopeless. Now I couldn't kill myself because I'd be hurting him . . . . . and my parents.

Doctor: Your thoughts, then, are that maybe part of wanting to commit suicide is getting proof that someone loves you.

Patient: My mother loves me.

Doctor: Is there any doubt about her love?

Patient: Oh no. She has always helped and supported me. She visited me every day in the hospital. She understands about the pregnancy.

Doctor: Do other people love you?

Patient: It's no secret that my father and I don't get along. My father's cold. He would not say hello to you if you twisted his arm. He's out of it completely. When he learned about the pregnancy he said, "If I had ruined a girl like that, my father would have whipped me." He thinks that I'm ruined now, a ruined woman. My mother accepts it, but my father thinks I'm a ruined woman.

Doctor: Tell me some more about your father. He seems different than the rest of the family.

Patient: My father? He works hard, that's about the only thing I can say. He comes home from work and watches TV. On weekends, he watches TV. He never expresses emotions. My mother and father don't even sleep together.

Doctor: Has your mother ever tried to explain why they don't share the same bed?

Patient: My mother had a nervous breakdown while she was carrying me.

[T1] Exploring the onset of symptomatic behavior can help the clinician to understand it. It is analogous to understanding a physical symptom like chest pain: When did it start? How? Where? etc.

[T2] An attempt to confirm the date on which the symptoms began.

[T3] An attempt to clarify her conscious assessment of this relationship. She believes that he loves her but fears he will leave her.

[T4] This patient presents multiple problems. The clinician tries to sort them out.

[T5] This is an attempt to underscore distrust as a basic problem in her relationship with Michael.

[T6] This delineates her impulsiveness.

[T7] Testing seems to be a technique she employs to attempt to cope with her distrust.

They were going to break up. But she had me and they decided to stay together because of me. That makes me feel small. All their problems are because of me, because I was born.[T8]

Doctor: That's quite a burden.[T9]

Patient: I didn't ask to be born.

Doctor: Does your father love anyone else?

Patient: He loves my younger brother. He does things with him. They're pretty close.

Doctor: How does he feel about you?

Patient: He now thinks that I'm a ruined woman.

Doctor: Does he think that, or is that your interpretation of what he thinks? His reaction to the pregnancy sounds to me more like an indictment against Mike than against you. Has your father ever been close to you?

Patient: Oh yes. When I was four or five he used to take me to the park all the time. He kept calling me "Daddy's little girl."

Doctor: When did that change?

Patient: When I was about 14 or 15. That's when I started having accident after accident. I fell off a horse, I broke my toe, I had several car accidents, I stepped on a needle . . . one accident after another. (laughter)

Doctor: This all started when you were 15?

Patient: Yes.

Doctor: What brought that on? How could you be a careful person until age fifteen?

Patient: I don't know. I'm still clumsy.

Doctor: Is that when you and your father stopped being close?[T10]

Patient: Yes, more or less when I was going into high school.

Doctor: How did this distance develop? You were Daddy's little girl for so many years.

Patient: We just came to the point that he wouldn't talk to me and I wouldn't talk to him. I never tell him anything. I don't talk to him and he don't talk to me.

Doctor: What if something were to happen to make it possible for you to be close to your father again? How would you feel about that?[T11]

Patient: I wouldn't want to be close to him.

Doctor: Why?

Patient: I don't know. I can't make myself. I would feel very uncomfortable if he were to try to be close to me.

[T8] The story of her origin is strikingly similar to that of her fetus.

[T9] This is an attempt to show some recognition of her feeling of guilt.

[T10] This was intended to clarify that her father had been close to her prior to her early adolescence.

[T11] The physician explores the current barriers to closeness.

Formulation

It appears that the patient had a reasonably good home environment until she entered adolescence. She had been "Daddy's little girl." As she matured into a young lady there was probably a resurgence of some natural attraction between father and daughter. There is a variable amount of sexuality involved in the relationship between parent and child, particularly between opposite sexes. This often surfaces to a conscious level. There is an intensification of these feelings at adolescence.

Most people can handle these uncomfortable feelings well. In a healthy family these feelings of sexual attraction can be tolerated. An occasional twinge of physical attraction does not cause panic. However, this patient's father seems to have a rigid sense of right and wrong regarding sex, as manifested by his statement that "if I ruined a girl my father would have come after me with a whip."

It appears that these feelings were not tolerated in this patient's family. One might conjecture that in order to go on living together they reached a parting of the ways. There could be no more hugging and kissing and closeness. This would be too threatening. This could account for the apparent separation that the patient so vividly described at age 14.

The subsequent series of accidents possibly represent a form of self-induced punishment for feelings of guilt that may have been evoked by the unconscious attraction that the patient had for her father. It is a universal reaction that punishment alleviates guilt.

This mixture of attraction and guilt is then transferred to her relationships with other men. This could explain why she seemed compelled to behave in a manner that destroyed her relationship with Steve at a time when things were at their best. When closeness and sexual feelings arose she felt guilty. This guilt was not consciously recognized by the patient. She then tested the relationship and spoiled it by trying to commit suicide in Steven's presence.

When the patient gets into any type of a therapeutic relationship, whether it be with a psychiatrist or with a family physician, the doctor must be aware of these dynamics or he is going to fall into the same trap. As the doctor and patient develop rapport, she is going to feel a closeness in this relationship. This closeness will then become threatening. She will then feel compelled to break it up. The doctor must be prepared for this and realize that she will try to test him to see whether he will reject her as her feelings of closeness develop.

This patient demonstrates the behavioral characteristics of the hysterical personality disorder: (1) histrionic behavior, (2) emotional lability, (3) dependency, (4) excitability, and (5) seductiveness. Histrionic behavior is characterized by dramatic, theatrical gestures, with an air of artificial superiority aimed at gaining attention. Emotional lability is characterized by outbursts of laughter and crying; the individual may swing from one to the other with minimal stimulation. Excitability includes impulsive behavior. The external environment produces an exaggerated emotional response in these individuals. Seductiveness represents a defense mechanism or means of reacting with those around her.

Management of the Hysterical Personality Disorder in the Medical Setting

Roger Peele and Stella Rubin[7] offer four general goals in the management of hysterical personalities in a medical setting: (1) shift the patient's emphasis on control of others to control of self; (2) help her develop appropriate ways of communicating her needs; (3) avoid iatrogenic drug abuse; and (4) reduce dependency to an acceptable level. We offer some concrete suggestions for the family physician for achieving these goals.

1. Increase Self-Control

To help this patient learn self-control, the physician himself must be the model of self-control. As closeness develops in the doctor-patient relationship, the patient may feel uncomfort-

able and try to provoke the doctor into rejecting her. The provocations may well produce intense anger. The physician must understand the origins of his anger and remain steadfast in his willingness to maintain a neutral stance.

At a time of confrontation, the doctor might try to interpret this process to the patient. When the physician recognizes that the patient is trying to arouse emotion in him, he can invite the patient to examine the interaction. He can say, for example, "It might be well for us to look at what is happening here." Or, "Let's try to understand what's going on." Or, "Perhaps we can figure out what this might lead to." The main idea is to present an attitude of observation in which both patient and clinician cooperate. This sort of cooperative effort is known in psychiatry as the therapeutic alliance. When the patient's cooperation has been enlisted – if only momentarily – the physician can try to translate an inappropriate behavior into a verbal communication. The clinician might ask, "What did you imagine would be my reaction when you did what you just did?" "What did you wish I would feel (or do, or say)?" "What did you fear I might feel (or do, or say)?"

The basic strategy is to add some distance, objectivity, and perspective to the patient's intense emotional experience. As the observational process is emphasized, the patient comes to recognize that manipulation, threats, and other histrionic behaviors serve as a form of communication. The clinician can then encourage the patient to communicate by talking rather than by acting. This change will take time. A life-long pattern of adaptation is not relinquished easily. The clinician must help the patient to see that talking is preferable and not unduly painful. At the same time he must demonstrate that impulsive action is often damaging, self-defeating, irreversible, dishonorable, and contrary to the patient's ideals. The knowledgeable physician who is successful in this effort may demonstrate for the first time to the patient that she can participate in a nonthreatening heterosexual relationship.

2. Improve Communications

The practitioner can help the patient develop appropriate ways for communicating her needs by first offering an example himself of clear and accurate communication. He should be explicit in his relationship and clearly define the rules that he expects her to abide by in dealing with himself and his office staff.

As an expression of her wish for intimacy, this patient will usually try to obtain more information about the personal life of the physician than is appropriate. The physician must set limits for the amount of information about his personal life that he can share comfortably with the patient. At the same time he can invite the patient to try to understand the attempt to get the information.

The egocentric nature of the patient's personality produces a great thirst for attention. The physician is tempted to give this attention by listening to her many unbelievable stories. This type of attention is counterproductive and encourages the patient to continue inappropriate behavior. She may feel compelled between visits to get involved in some untoward event so that she has some material to give the physician. If this pattern develops, the physician might discourage her descriptions of bizarre behavior and encourage her to discuss the feelings that preceded this activity. The doctor can help the patient develop ways for communicating verbally rather than through inappropriate behavior or suicidal gestures.

The female with a hysterical personality disorder may interact with the office staff in a manipulative manner. By manipulative, we mean that the patient attempts to evoke emotions or to provoke responses in a purposeful way. Usually the patient is not conscious of that purpose, although it is often obvious to the victim of the manipulation or to other observers. If the physician and his staff understand that this manipulative behavior is part of the emotional disorder, a successful manipulation might not evoke the usual degree of anger. It will be productive for the physician to discuss the patient's behavior with the staff and to encourage the staff to maintain a mature, neutral stance in their encounters with the patient. The physician might, as described above, initiate an open discussion with the patient of what the patient was trying to accomplish with this inappropriate behavior. This must be done in a nonthreatening and nonconfronting way, always emphasizing and encouraging the therapeutic alliance. The goal is to have the patient learn how to translate her behavior into more appropriate verbal communication with those about her.

It is sometimes highly productive to ask the patient how she feels when she talks to the physician. How does she imagine his reaction? What does she wish or fear that his attitude might be?

If there is a significant male in the patient's life, the doctor might encourage her to try to communicate with him in a more meaningful fashion. This intervention should take into account the anxiety which greater meaningfulness might evoke. If she can share her inner feelings with that person, she may be more successful in controlling her behavior. If the family physician also provides care for this significant male (boyfriend, husband, etc), he might spend some time explaining to him why the patient has such an intense thirst for proof that she is loved, why she is uncomfortable with intimacy, and why she appears so dependent on him. This information may help that person, as the patient and he try to improve their relationship. The physician must be careful not to breach the patient's confidentiality by first obtaining her informed permission to talk with the significant other.

3. Avoid Iatrogenic Drug Abuse

A very simple but important principle is that the physician should consistently and affirmatively avoid iatrogenic drug abuse. The patient may offer varied and multiple somatic complaints. These symptoms often are presented in an exaggerated and dramatic manner. Dismissing the patient by writing a prescription can be another form of rejection. Multiple visits and multiple prescriptions expose the patient to the hazards of adverse drug reactions.

Patients with hysterical personality disorders have been shown to be drug and alcohol addiction prone. Rather than freely using sedatives and tranquilizers that have the potential for addiction, it is recommended that the physician reserve the phenothiazines for severe anxiety, and the tricyclics for marked depression. Use of any medication should be made with exceptional caution and parsimony.

4. Reduce Dependency

The physician may help the patient reduce her dependency on people in general by not allowing her to become too dependent on the physician. This can be accomplished most effectively through interpretation of the process. "How do you feel when you ask me to decide (do, prevent, advise) something for you?" "How do you feel when I do it?" "How do you feel when I don't?" The clinician can encourage the patient to take an active role in her own medical care. If the physician becomes involved in formal counseling, he must avoid the temptation to give advice. He must avoid offering reassurance about the future. The physician will be more effective if he can get the patient to examine her own behavior or to examine alternative possibilities and then reach her own conclusion. When dealing with issues of dependency, the patient can assume responsibility and receive some recognition even for minor changes in behavior that might help foster her sense of independence.

Conclusion

The case history, the "long interview," and the formulation are presented in some detail. It is suggested that they be studied thoroughly by the reader. When dealing with emotional problems, there is no substitute for obtaining sufficient historical data in making a reasonably accurate diagnosis. It has been clearly demonstrated that this investment of time ultimately reduces the total demand on the health-care system made by patients with emotional problems.[8]

The subsequent suggestions for managing the female with a hysterical personality disorder include no mention of time. These are concrete guidelines for physician and staff interaction with such a patient in a traditional medical setting. The development of a therapeutic alliance need not extend the usual encounter more than a few minutes. The avoidance of anger and the satisfaction of helping the patient grow in her ability to interact with others compensate for the additional effort. The latter therapeutic goal is a long-term one, which the physician can work towards over months or years as he provides continued comprehensive medical care for the family unit.

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