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Cluster B Personality Disorders: Borderline, Histrionic, and Narcissistic Presentations in Clinical Practice.

A Systematic Literature Review of Diagnostic Criteria, Evidence-Based Treatments, and Cultural Considerations

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Abstract

Cluster B personality disorders, comprising Borderline Personality Disorder (BPD), Histrionic Personality Disorder (HPD), and Narcissistic Personality Disorder (NPD), represent pervasive patterns of dramatic, emotional, and erratic functioning that profoundly disrupt interpersonal relationships, self-identity, and emotional regulation. These conditions affect approximately 1.5% to 5.9% of the general population globally. This systematic literature review synthesizes diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), clinical phenomenology, differential diagnostic frameworks, evidence-based psychotherapeutic interventions, and etiological models with particular emphasis on empirical meta-analyses and neuroimaging findings. Key findings reveal shared diathesis-stress pathways involving genetic vulnerabilities, early adversity, and fronto-limbic dysregulation across these disorders. Disorder-specific treatments demonstrate differential efficacy: Dialectical Behavior Therapy (DBT) for BPD yields effect sizes ranging from d = 0.5 to 1.0 for reductions in suicidality, while Schema Therapy and Mentalization-Based Treatment show promise for identity disturbance and affective instability. In African contexts, particularly Kenya, cultural stigma surrounding mental illness and communal relational norms may exacerbate symptom presentations, underscoring the imperative for culturally adapted interventions. Findings advocate for dimensional assessment frameworks consistent with the International Classification of Diseases, Eleventh Revision (ICD-11), integrated multimodal therapies, and culturally informed clinician training to mitigate the substantial suicide risk associated with BPD (approaching 10% lifetime prevalence) and reduce societal costs. Implications for marriage and family therapy practice in collectivist cultural contexts are discussed.

Keywords: *Borderline Personality Disorder, Histrionic Personality Disorder, Narcissistic Personality Disorder, Cluster B, psychotherapy, etiology, cultural factors, DSM-5-TR, affect dysregulation, marriage and family therapy*

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1. Introduction

Cluster B personality disorders, as classified in the DSM-5-TR, encompass Borderline Personality Disorder (BPD), Histrionic Personality Disorder (HPD), Narcissistic Personality Disorder (NPD), and antisocial personality disorder (ASPD). These conditions are characterized by pervasive patterns of emotional dramatization, impulsivity, and relational instability that typically emerge in early adulthood and engender significant functional impairment across occupational, interpersonal, and intrapsychic domains (American Psychiatric Association [APA], 2022). The present review focuses specifically on BPD, HPD, and NPD, given their particular relevance to marriage and family therapy clinical practice.

Epidemiological estimates suggest that between 9% and 15% of individuals in clinical settings meet criteria for Cluster B presentations. Community prevalence rates indicate that BPD affects approximately 1.6% of the population, HPD affects approximately 1.8%, and NPD prevalence ranges from 0.5% to 6.2% (APA, 2022). However, substantial underdiagnosis persists due to pervasive stigma and considerable symptom overlap across categorical boundaries. The clinical significance of these disorders cannot be overstated: BPD alone accounts for approximately 20% of psychiatric hospitalizations, and suicidal ideation affects 47% of outpatients presenting with Cluster B symptomatology.

Contemporary ecological developments, including the transition to dimensional models in the ICD-11, emphasize transdiagnostic trait dimensions such as negative affectivity and antagonism, encouraging more nuanced clinical assessment and conceptualization (Bach & First, 2022). This evolution reflects growing recognition that categorical approaches inadequately capture the heterogeneity and complexity inherent in personality pathology.

This systematic review examines diagnostic criteria, clinical phenomenology, differential diagnosis, evidence-based treatments (with particular attention to randomized controlled trials and meta-analytic findings), and etiological frameworks (incorporating biosocial and neurobiological models) for each disorder (Leichsenring et al., 2024; Stoffers-Winterling et al., 2021). Methodological critiques address limitations, including restricted sample sizes and Western cultural biases pervading the extant literature (Carreiras et al., 2021; Weinberg & Ronningstam, 2022). Additionally, cultural perspectives pertinent to African contexts, particularly Kenya's collectivist, communally oriented relational structures, examine how familial invalidation patterns and culturally embedded gender scripts may potentiate vulnerability to these conditions (APA, 2022; Chakhssi & de Ruiter, 2021).

2. Borderline Personality Disorder

Diagnostic Criteria and Clinical Presentation

Borderline Personality Disorder is diagnosed when an individual manifests at least five of the nine polythetic criteria delineated in the DSM-5-TR. These include: (1) frantic efforts to avoid real or imagined abandonment; (2) unstable and intense interpersonal relationships characterized by alternation between idealization and devaluation; (3) identity disturbance marked by persistently unstable self-image or sense of self; (4) impulsivity in at least two

potentially self-damaging areas such as spending, sexuality, or substance use; (5) recurrent suicidal behavior, gestures, threats, or self-mutilating behavior; (6) affective instability due to marked reactivity of mood with dysphoric episodes lasting hours to days; (7) chronic feelings of emptiness; (8) inappropriate, intense anger or difficulty controlling anger; and (9) transient stress-related paranoid ideation or severe dissociative symptoms (APA, 2022).

Clinical presentations typically feature identity confusion, interpersonal hypersensitivity, and chronic relational crises. Neuroimaging research has demonstrated amygdala hyperreactivity, coupled with reduced prefrontal cortical activation, providing neurobiological correlates of characteristic emotional dysregulation (Leichsenring et al., 2024). Notably, approximately 75% of individuals with BPD report histories of self-harm behavior. In urban Kenyan contexts, economic instability and associated psychosocial stressors may heighten relational triggers, although empirical research examining these dynamics remains limited.

Differential Diagnosis

Borderline Personality Disorder presents notable phenomenological overlap with Bipolar II Disorder regarding mood instability. However, critical distinctions exist: BPD mood shifts are characteristically brief and reactive, typically lasting minutes to hours and precipitated by interpersonal stressors, whereas bipolar episodes persist for extended periods and occur independent of environmental triggers. Furthermore, BPD does not involve manic or hypomanic phases (Lari et al., 2021).

When differentiating BPD from Complex Post-Traumatic Stress Disorder (C-PTSD), BPD prominently features identity disturbance rather than trauma re-experiencing phenomena. Additionally, considerable symptom overlap exists among Cluster B disorders, including the dramatic relational behaviors characteristic of HPD. These diagnostic complexities underscore the necessity of employing structured assessment instruments such as the Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD) to systematically evaluate self-harm patterns and abandonment fears (Leichsenring et al., 2024; Wright et al., 2022). High comorbidity rates, with approximately 50% of individuals with BPD concurrently meeting criteria for mood disorders, further emphasize the importance of comprehensive longitudinal evaluation.

Evidence-Based Treatments

Dialectical Behavior Therapy (DBT), developed by Linehan, constitutes the gold-standard intervention, with Level 1 evidence supporting its efficacy. DBT achieves approximately 50% reduction in self-harm behaviors through systematic skills training in four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. Clinical trials of 12-month duration demonstrate 50% decreases in suicidality, with gains sustained at 24-month follow-up (Stoffers-Winterling et al., 2021). Meta-analytic synthesis of 35 randomized controlled trials confirms moderate effects on overall functioning ($g = 0.44$).

Schema Therapy has demonstrated superiority over treatment as usual for individuals experiencing chronic, schema-driven symptomatology (Wibbelink et al., 2021). Mentalization-Based Treatment (MBT) enhances mentalizing capacities, yielding significant reductions in impulsivity with effect sizes of $d = 0.8$ (Carreiras et al., 2021). Transference-Focused Psychotherapy (TFP) effectively modifies pathological object relations, demonstrating particular efficacy in inpatient treatment contexts (Carreiras et al., 2021).

Pharmacotherapy, including selective serotonin reuptake inhibitors (SSRIs), primarily addresses symptomatic dimensions without inducing core characterological change. Methodological critiques of the treatment literature include elevated attrition rates approaching 25% and limited longitudinal outcome data beyond five years. Furthermore, cultural adaptations of these evidence-based approaches for African communal contexts remain underdeveloped.

Etiology

Heritability estimates for trait impulsivity and affective lability range from 40% to 60%, indicating substantial genetic contributions. Fronto-limbic imbalances, including reduced prefrontal-amygdala connectivity, interact with invalidating developmental environments in accordance with biosocial theoretical models (Leichsenring et al., 2024; StatPearls, 2024). Childhood adversity demonstrates a robust association with BPD development (odds ratio = 3.5), disrupting attachment organization and promoting maladaptive coping strategies (Faramarzi & Rezazadeh, 2024). In Kenyan contexts, caregiver neglect, particularly in conditions of socioeconomic deprivation, elevates risk for personality pathology development.

Case Illustration

Angela, a 26-year-old Kenyan woman, presented for treatment with pervasive interpersonal conflicts rooted in abandonment fears, recurrent self-cutting behavior, impulsive spending, and chronic feelings of emptiness. Her presentation illustrates how cultural and familial contextual factors, including experiences of parental emotional unavailability within a communal family system emphasizing relational harmony, may shape BPD symptomatology. Treatment incorporating culturally-adapted DBT principles, with attention to collectivist values and extended family dynamics, offers a promising therapeutic framework.

3. Histrionic Personality Disorder

Diagnostic Criteria and Clinical Presentation

Histrionic Personality Disorder requires at least five of the following criteria for diagnosis: (1) discomfort in situations where the individual is not the center of attention; (2) inappropriate sexually seductive or provocative behavior; (3) rapidly shifting and shallow emotional expression; (4) consistent use of physical appearance to draw attention; (5) speech that is excessively impressionistic and lacking in detail; (6) self-dramatization, theatricality, and exaggerated emotional expression; (7) suggestibility and susceptibility to influence; and (8) consideration of relationships as more intimate than they actually are (APA, 2022).

HPD demonstrates a female-to-male prevalence ratio of approximately 2:1 and is characterized by charming interpersonal manipulation that conceals underlying feelings of inadequacy. Community prevalence is approximately 2%, and neurobiological research suggests hypersensitivity of the reward system in affected individuals (Torrico, 2024). In Kenyan cultural contexts, societal gender performance expectations and norms regarding feminine expressivity may amplify histrionic presentations.

Differential Diagnosis

Differential diagnostic considerations include distinguishing HPD from BPD, where individuals with HPD typically maintain relatively stable self-esteem and do not engage in self-harm behavior. In contrast to NPD, HPD presentations feature interpersonal charm rather than

grandiose superiority. When differentiating from Bipolar Disorder, HPD lacks the characteristic cyclical mood episodes (Gunderson et al., 2022; Millon & Grossman, 2021). The Personality Inventory for DSM-5 (PID-5) trait measures can enhance diagnostic precision.

Evidence-Based Treatments

Cognitive Behavioral Therapy (CBT) for HPD focuses on restructuring attention-seeking cognitive patterns, yielding moderate improvements in interpersonal functioning (d = 0.6). Psychodynamic approaches aim to uncover relational defenses and address underlying insecurity (Clark et al., 2023; Yang, 2023). The evidence base for HPD treatment remains limited, with fewer than ten randomized controlled trials published; however, group therapy formats show promise. Cultural sensitivity in treatment is essential, as clinicians must differentiate pathological histrionic presentations from culturally normative expressive emotionality observed in many African cultural contexts (Chakhssi & de Ruiter, 2021).

Etiology

Etiological factors include temperamental extraversion with heritability estimates of approximately 30%, the influence of caregiver modeling, and early traumatic experiences. Neurobiological research suggests dopamine-driven validation-seeking behavior (Ibrahim & Al-Sawah, 2025; IJFMR, 2024). Sociocultural factors, including media portrayals and gender role reinforcement, contribute to symptom development. Research in Kenyan correctional settings has documented elevated histrionic traits associated with status-seeking relational scripts.

Case Illustration

Catherine, a 35-year-old Kenyan marketing professional, presented with excessive interpersonal flamboyance and pervasive approval-dependence that created occupational and marital difficulties. Treatment integrating cognitive-behavioral restructuring of attention-seeking cognitions with psychodynamic exploration of attachment-related insecurities fostered the development of autonomous self-worth and more authentic relational engagement (Livesley, 2022).

4. Narcissistic Personality Disorder

Diagnostic Criteria and Clinical Presentation

Narcissistic Personality Disorder is characterized by five or more of the following: (1) grandiose sense of self-importance; (2) preoccupation with fantasies of unlimited success, power, brilliance, beauty, or ideal love; (3) belief in being special or unique; (4) requirement for excessive admiration; (5) sense of entitlement; (6) interpersonal exploitation; (7) lack of empathy; (8) envy of others or belief that others are envious of them; and (9) arrogant, haughty behaviors or attitudes (APA, 2022).

Contemporary conceptualizations recognize vulnerable narcissism as a distinct subtype comprising approximately 50% of cases, characterized by underlying fragility concealed beneath grandiose presentations. Community prevalence ranges from 1% to 6%, with elevated rates observed in leadership and entrepreneurial populations. Interpersonal conflicts typically arise when self-esteem is threatened or challenged (Mitra et al., 2024). In Kenyan entrepreneurial contexts, overt narcissistic expressions may receive cultural reinforcement through success-oriented value systems.

Differential Diagnosis

Key differential diagnostic considerations include: NPD features stable grandiosity without the abandonment fears characteristic of BPD; NPD demonstrates exploitative superiority in contrast to HPD's approval-seeking charm; and NPD shows preference for admiration over the criminal exploitation seen in Antisocial Personality Disorder (Jørgensen et al., 2023). Research data from Kenya indicate that NPD is more prevalent than ASPD in correctional populations (odds ratio = 2.5).

Evidence-Based Treatments

Psychodynamic approaches, particularly variants of Transference-Focused Psychotherapy, focus on building self-cohesion by exploring narcissistic transference configurations (Weinberg & Ronningstam, 2021). Schema Therapy targets pathological shame schemas and is tailored to specific narcissistic subtypes, with emphasis on developing empathy for vulnerable presentations. Randomized controlled trials for NPD remain sparse, and observed treatment effects are modest ($g = 0.4$). Pharmacotherapy has no established primary role in the treatment of NPD.

Etiology

Heritability for narcissistic traits is estimated at 40% to 50%. Neuroimaging studies reveal altered functioning of self-referential neural networks. Developmental antecedents include both neglect and excessive parental overvaluation (Davis & Shulman, 2024; Day, 2024). Cultural contexts that emphasize status acquisition and competitive achievement may amplify the expression of narcissistic traits.

Case Illustration

Alice, a 36-year-old Kenyan business founder, presented with employee complaints of workplace bullying and her spouse's concerns regarding emotional unavailability. Treatment focused on addressing the denial of envy, exploring vulnerable narcissistic dynamics, and examining the relational costs of narcissistic interpersonal patterns within both professional and marital contexts.

5. Discussion and Clinical Implications

Convergent Findings

Synthesis of the reviewed literature reveals that Cluster B disorders converge on several key pathogenic factors: affect dysregulation, including amygdala hyperreactivity and prefrontal cortical hypofunction; adverse childhood experiences, with odds ratios ranging from 2 to 4; and genetic contributions accounting for 40% to 60% of the variance in trait dimensions. These shared vulnerabilities result in substantially elevated suicide risk, approaching tenfold increases compared to the general population (Bach & First, 2022).

Divergent Presentations

Despite shared vulnerabilities, the disorders demonstrate distinctive phenomenological presentations: individuals with BPD experience relational terror and abandonment sensitivity; those with HPD manifest panic regarding visibility and attention; and those with NPD struggle with shame avoidance and narcissistic injury. These divergent presentations necessitate tailored therapeutic approaches.

Treatment Implications

Psychotherapeutic interventions demonstrate superiority over pharmacological approaches, with numbers needed to treat ranging from 4 to 6. Dimensional assessment frameworks serve as better predictors of treatment outcomes than categorical diagnoses (Bach & First, 2022). Significant gaps persist in the literature, particularly regarding longitudinal outcome data from African populations and economic analyses of treatment cost-effectiveness. Estimated annual costs in the United States amount to approximately $20 billion.

Implications for Marriage and Family Therapy Practice

Clinical implications underscore the imperative to train marriage and family therapists in cultural humility, incorporating understanding of Kenyan communal relational structures and extended family systems into treatment formulations. Policy recommendations include implementing early screening protocols in primary care and mental health settings. Research priorities should emphasize hybrid treatment models that integrate evidence-based approaches with culturally responsive adaptations. Destigmatization efforts through psychoeducation could enhance treatment engagement and recovery rates, which currently range from 30% to 50%, achieving remission (Bach & First, 2022).

6. Conclusion

Cluster B personality disorders, BPD, HPD, and NPD, represent complex clinical presentations with shared etiological pathways yet distinctive phenomenological features requiring differentiated therapeutic approaches. The substantial evidence base supporting DBT for BPD contrasts with the comparatively limited empirical foundation for interventions for HPD and NPD, highlighting priorities for future research. Cultural considerations are paramount: marriage and family therapists practicing in African contexts must navigate the interface between Western-derived diagnostic constructs and indigenous relational frameworks.

The transition toward dimensional assessment models, as exemplified in the ICD-11 framework, offers promise for more nuanced clinical conceptualization and treatment planning. For marriage and family therapists, understanding how Cluster B pathology manifests within couples and family systems, and how cultural contexts shape both the expression and interpretation of symptoms, remains essential for effective clinical practice. Future research must address the significant gap in the empirical literature on these disorders in non-Western populations, with particular attention to developing and validating culturally adapted interventions suitable for African clinical contexts.

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