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**Moth to a Flame: An Investigation of the Personality Traits and Early-Life
Trauma Histories of Women Who Have Survived Adult Relationships
with Men with Pathological Narcissism**

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DISSERTATION ABSTRACT

Although emotional and psychological abuse, in addition to physical assault, are now commonly accepted as aspects of Intimate Partner Violence (IPV), narcissistic abuse as a subset of IPV is not widely recognized or understood. Due to the extremely debilitating, chronic mental health effects of narcissistic abuse (Bremner, 2008; Campbell, 2002; Yoon et al., 2009), this study sought to explore the experiences, personalities, early-life (childhood) trauma histories and mental health outcomes of heterosexual women who self-identify as having been in an adult romantic relationship with a man with pathological narcissism. Specifically, this study aimed to identify the nature and frequency of abuses experienced by women during the relationship, their specific mental health symptoms during and after the relationship, and the kinds of mental health diagnoses they received. A cross-sectional online survey was utilized to test the research questions. The sample consisted of 1,995 participants who identified as female survivors of narcissistic abuse between the ages of 18 and 80 with a mean age of 46. The direct relationships of previous early-life (childhood) trauma, as well as elevations or deficits in certain personality traits, were tested for correlational patterns and predictions of Complex Post-Traumatic Stress Disorder (C-PTSD). Key findings include: 1) women scored four times higher than normative statistics for the presence of early-life trauma; 2) almost three-fourths (73.3%) of participants met the clinical criteria needed to diagnose C-PTSD, yet only 4.2% indicated they had been diagnosed with the

disorder; 3) the presence of early-life trauma predicted greater intensity and severity of C-PTSD-related symptoms; 4) slightly more than half of participants reported above average empathy, with 12.6% scoring as super empathizers (the highest category); 5) elevated empathy predicted greater intensity and severity of C-PTSD-related symptoms, though the practical ++significance was low; 6) the presence of narcissistic abuse predicted greater intensity and severity of C-PTSD-related symptoms when controlling for early-life trauma; and 7) the presence of altruistic and self-directed personality traits predicted greater intensity and severity of C-PTSD-related symptoms when controlling for early-life trauma. These findings may help researchers and clinicians to better understand the impact of narcissistic abuse on survivors and positively impact prevention and intervention efforts by helping to identify both risk and protective factors. Directions for future research regarding personality traits, early-life trauma and the limitations of present research are discussed.

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“Narcissistic abuse is a huge trauma made out of a million tiny shocks that shatter the memory, erode the self and break your life into fragments. It’s psychological terrorism at its worst, and confusing as hell at its best... Why would the same person who claimed to love and care for you hurt you – over and over without a hint of empathy or remorse?”

— Shahida Arabi

CHAPTER I

Moth to a Flame: The Personality Traits and Early-Life Trauma Histories of Women Who Have Survived Adult Relationships with Pathological Narcissists

Narcissistic abuse is a form of extreme psychological and emotional abuse marked by manipulative communication and intentional deception for the purposes of exploitation by someone who meets the clinical criteria for, or has traits of, pathological narcissism (Brown, 2009; Howard, 2019; Louis de Canonville, 2018; Milstead, 2018). Labels for pathological narcissists include sociopaths, psychopaths, narcissists, malignant narcissists, borderline personalities, or people who are prone to antisocial behavior. All of these personality types can generally be grouped under the term Cluster B as outlined by the *American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM), Fifth Edition* (American Psychiatric Association, 2013), and often relate to their partners in similar ways due to their deceitfulness, lack of emotional empathy and willingness to exploit even those closest to them (Becker, 2015; Brown, 2009; Hare, 1993; Peck, 1983). This study is focused on heterosexual women who self-identify as having been in adult romantic relationships with one or more men with pathological narcissism.

Even though researchers have produced a large body of knowledge about people with pathological narcissism, there is very little peer-reviewed research examining their intimate partners' personality traits, trauma experiences (before, during and after the relationship), mental health symptoms (during and after the relationship) and recovery process. Historically, researchers and clinicians have grouped these victims together with traditional intimate partner violence (IPV) or domestic violence survivors, codependents, and sex or relationship addicts, or labeled them with dependent personality problems, none of which have been particularly accurate or helpful in developing the best treatment approach for this uniquely damaging relationship experience (Brown, 2009).

Narcissistic abuse is a lesser-known formulation of IPV. While there is not a universally agreed upon definition, the experience of narcissistic abuse generally fits within the 'coercive control' model, a patterned structure of abuse that includes intimidation, isolation and control (Stark, 2007). Milstead (2018) further defines narcissistic abuse as "the intentional construction of a false perception of someone else's reality by an abuser for the purposes of controlling them" (p.14). In narcissistic abuse, the man with pathological narcissism uses deception and psychological manipulation over time to convince his partner of a "false reality" — that he cares about her well-being and their relationship. The goal, according to Milstead (2018), is purely transactional, to allow the man with pathological narcissism to help himself to whatever he finds useful from his partner, whether that be attention, adoration, prestige, sex, money and material possessions, a place to live or other resources. Writes Milstead (2018):

“The abuser takes advantage of societal norms that assume everyone participates in social relationships with a basic level of empathy, which makes it easy for the abuser to convince the survivor (and everyone else) that no abuse is taking place. Because the abuse is ‘hidden’ using deceptions, it is difficult for survivors to recognize, understand, and escape it” (pp. 19-20).

Therefore, “deception,” according to Milstead, is the key to defining and understanding narcissistic abuse, and that such betrayal is, in and of itself, abusive. This style of fraudulent relating by men with pathological narcissism often results in traumatic bonding, which Carnes (2019) defined as the duplicitous use of intensity, sexual feelings, and eventually, fear, to entangle another person in a relationship with qualities that are addictive, obsessive and compulsive. Because stronger bonds form in times of pain than in times of contentment (Freeman, 2017; Carnes, 2019), this phenomenon helps to explain why it is so difficult for many women to leave these relationships.

Narcissistic abuse tends to follow a pattern that includes specific behaviors at the beginning, middle and end of the relationship. At first, the victim is shown only the ideal self of the man with pathological narcissism. The relationship often develops quickly, and he will adopt a charming, loving persona, complete with the ability to express pseudo-empathy (Louis de Canonville, 2012). This behavior makes a deep impression on the victim, causing her to feel a profound bond and connection because she only sees his false self (Brown, 2009; Arabi, 2007; Howard, 2019). Once he has secured her trust and confidence, and she has committed to the relationship (i.e., getting engaged or married, moving in together, becoming pregnant, etc.), the man with pathological narcissism then will show his true self (Arabi, 2017; Brown, 2009; Milstead, 2018). He turns on her, often abruptly, treating her with cruelty and with

contempt, ignoring behavior (taking away love and affection that was once generously offered), intentionally making her feel jealous and insecure, and betraying her in myriad ways including adultery, sabotage, manipulation, verbal abuse, and, at times, physical violence (Arabi, 2017; Becker, 2015; Brown, 2009; Milstead, 2018; Moscovici, 2011).

The term “narcissistic” is used liberally and increasingly in popular culture and usually refers to someone who is conceited and self-centered, traits that most individuals possess from time to time. Narcissism, however, lies on a spectrum from healthy to pathological (Twenge & Campbell, 2014). The narcissist described in the DSM-5 lacks empathy, feels entitled, uses others for personal gain, envies others and believes others envy him, and reacts with rage or contempt to belittle others to make himself appear superior. A review of the research suggests that the construct of narcissism may be much more ubiquitous within the different categories of character pathology than is currently portrayed by the DSM-5 or its previous versions (Huchzemeier et al., 2007; Ronningstam, 2009).

Who is he?

Understanding the characteristics of pathological narcissism in its various forms makes it possible to identify the methods by which these abusers gain control of their victims. Huchzemeier et al. (2007) found that individuals diagnosed with Cluster B personality disorders — particularly Antisocial Personality Disorder (APD), Borderline Personality Disorder (BPD), and Narcissistic Personality Disorder (NPD) — are likely to display strong psychopathic traits. Similarly, Russ and Shedler (2013) found that the clinical criteria of these same Cluster B personality disorders corresponded highly with the subtypes of narcissistic expression captured in other validated psychometric tools.

For example, *grandiose/malignant narcissists*, as identified by the Shedler-Westen Assessment Procedure 200 (SWAP-200; Westen & Shedler, 1999b) share similarities with individuals with APD, NPD and psychopathy in that they are unable to empathize with others, refuse ownership for their problems and take deep offense at criticism. This subtype represents what Russ and Shedler (2013) called an “aggressive narcissistic style with a seething anger or rage, interpersonal manipulateness, an exaggerated sense of self-importance, and feelings of privilege (p. 36).” People with grandiose narcissism tend not to feel lesser than others. They also have little self-awareness, blame others for their problems and often respond to judgment with anger (Russ & Shedler, 2013).

Like grandiose narcissists, people with APD and psychopathy consistently show a lack of regard for right and wrong, ignore the rights and feelings of others, and are known to be predatory and deceitful in their relationships. They tend to treat others either cruelly or indifferently, rely on manipulation, show no regret for their actions, and may lie, act violently or without thinking, and abuse drugs or alcohol (APA, 2013). This assemblage of characteristics generally prohibits them from partaking normally in matters related to family, work or school. The alternative DSM-5 Model for Personality Disorders further identifies “an incapacity for mutually intimate relationships, as exploitation is a primary means of relating to others, including by deceit, coercion; use of dominance or intimidation to control others” as a key feature of APD (APA, 2013, p. 764).

Fragile narcissists, also called vulnerable or “covert” narcissists, share similarities with individuals with BPD in that they feel both grandiose and inadequate,

leading to fluctuating representations of self (Russ & Shedler, 2013). They also present with a defensive grandiosity when threatened. However, these highly wrought and improbable self-representations appear to help them quell feelings of inadequacy, smallness, anxiety, and loneliness. “They want to feel important and privileged, and when the defense is operating effectively, they do,” write Russ and Shedler (2013). “However, when the defense fails, they have a powerful current of negative affect that brings out feelings of inadequacy, often accompanied by rage (p. 37).”

Fragile narcissists tend to have the worst adaptive functioning of all the narcissism subtypes; like those with BPD, they also have the greatest number of problems at work and in their personal relationships (Russ & Shedler, 2013). This is consistent with the alternative DSM-5 Model for Personality Disorders (2013), which describes individuals with BPD as having “intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; close relationships viewed in extremes of idealization and devaluation and alternating between over involvement and withdrawal (p. 766).” Dutton (1995) estimated that 30% of men who batter their partners or children have BPD. Afraid of intimacy, men with this type of pathological narcissism vacillate between feeling abandoned and engulfed by their romantic relationships. This causes them to be overly dependent on their partners and are consequently “either at their wives’ knees or at their throats” (Dutton, 1995, p. 42).

Another psychological conception that brings together the personality traits contained within pathological narcissism is the Dark Triad. First coined by Paulhus and Williams (2002), the Dark Triad refers to a set of three different but related antisocial

personality traits: Machiavellianism, narcissism, and psychopathy. Giammarco and Vernon (2014) wrote that each of the Dark Triad traits is grounded in “feelings of superiority and privilege. These feelings, coupled with a lack of remorse and empathy, often lead individuals high in these socially malevolent traits to exploit others for their own personal gain (p. 23).” Psychology literature frames the Dark Triad as the root cause of a host of exploitative and harmful relationship behaviors, including aggressiveness, sexual opportunism, and impulsivity. A study of romantic partner communication by Horan, Guinn and Banghart (2015) found that individuals with higher levels of the Dark Triad personality structure also reported hostile and intense conflicts with their partners. The study’s finding that people with Dark Triad personalities, most of whom are men, generally reported higher levels of contempt, criticism, stonewalling and defensiveness provided a partial explanation for the nature of their partner conflicts (Horan, Guinn and Banghart, 2015).

Although they may never be officially diagnosed, men with all types of pathological narcissism tend to operate in intimate relationships in remarkably similar ways, from being overly critical and controlling toward their partners to putting them down through cruel verbal abuse and using manipulation to isolate and demean them. “For those who come into the orbit of someone with such depleted empathy, it means the risk of being on the receiving end of verbal insults, physical attacks, or experiencing a lack of care or consideration — in short, at risk of getting hurt” (Baron-Cohen, 2011, p. 46). The covert and often sadistic nature of such harmful traits produces relationship dynamics that go beyond what is seen in other dysfunctional or abusive relationships, yet often without bruises or other overt signs of abuse. Brown (2009) identified the

following three “inabilities” in individuals with pathological narcissism: The inability to a) “sustain consistent and mounting positive, non-manipulative change,” b) “grow to any significant and authentic emotional, spiritual and relational depth,” and c) “to have true empathic insight about how their behavior affects others” (p. 155). Without these rudimentary relational skills, “nothing else can happen in them or their relationships”; as a result, partners in relationships with pathological narcissists face “inevitable harm” (Brown 2009, p. 46).

Men with pathological narcissism often present a compelling false mask of innocence, one that fools even the most experienced psychotherapists (Arabi, 2017; Becker, 2015; Hare, 1993). They can exhibit convincing displays of empathy and remorse to sway others into believing either that they are innocent or have been wrongly accused, even though the exact opposite is true (Arabi, 2017; Baron-Cohen, 2012; Hare, 1993). Research indicates that individuals with psychopathy and other forms of pathological narcissism possess *cognitive empathy*, which allows them to assess their victim’s emotional vulnerabilities, but are unhindered by *affective empathy*, which would lead to regret for their actions (Arabi, 2017; Baron-Cohen, 2012). This combination makes them quite convincing and able to persuade others more effectively than their empathetic victims (Arabi, 2017). In fact, men with pathological narcissism can often convince others that *they* are the victim in the relationship (Arabi, 2017; Brown, 2009). Because individuals who fall into this personality spectrum also recruit supporters who enable them — even to the extent of carrying out their abuses for them — they often are able to find outside support even after being exposed for their actions (Arabi, 2017; Becker, 2015; Hare, 2003).

Only a few studies have specifically examined the relationship patterns of men with pathological narcissism. Kirkman (2005) identified characteristics of non-incarcerated psychopaths, the most virulent form of pathological narcissism, in heterosexual relationships. He found that women were talked into being victims, lied to, economically abused, emotionally abused, isolated, and the men had multiple infidelities. Similarly, Leedom et al. (2012), in a qualitative analysis of books written by the female partners of high-profile psychopaths, found that women in such relationships had been conned, manipulated, or coerced during all or most phases of the relationship, and that they also suffered from trauma bonding, intimate partner violence and Complex Post-Traumatic Stress Disorder (C-PTSD) — the severe psychological injury that occurs with prolonged, repeated trauma of an invasive and interpersonal nature (Herman, 1992).

Narcissistic Abuse in Relationships

Relationships with men with pathological narcissism follow a predictable pattern that consists of three stages: idealize, devalue, and discard (Brown, 2009; Leedom et al., 2012). Early in these relationships, victims are **idealized** and typically made to feel as if they have found their soulmate. Then comes a disagreement, or she does something he doesn't like, or he just finds himself bored. Seemingly insignificant fissures are swiftly followed by a complete and devastating **devaluation**. After this cruel and sudden shift, men with pathological narcissism then often **discard** their partners, disconnecting from the relationship altogether in order to preserve their energy so they can seek attention elsewhere (Brown, 2009; Hare, 1993; Moscovici, 2011).

During the **Idealization Stage**, men with pathological narcissism, adept at

mirroring, often imitate or copy their partner's characteristics, behaviors, traits, interests, and beliefs, making her believe she has found the ideal person with whom to spend her life. The pathological narcissist portrays himself as someone he fundamentally is not, creating an illusion to make his partner more vulnerable to manipulation and abuse (Becker, 2015; Brown, 2009). Walker (1979) identified a predictable cycle in abusive relationships that includes "honeymoon periods," times during the relationship, particularly in the beginning, when no abuse occurs. The cycle of narcissistic abuse is different, however. Pathological narcissists use the idealization stage at the start of a relationship to intentionally manufacture a "soulmate" persona that is not "who they genuinely are in order to encourage targeted partners to become vulnerable to them quickly and fall in love" (Milstead, 2018, p.11). This false representation may originate from the purposeful drive to control how their partner views him, but it may also grow from an unconscious process that is the product of his personality disorder (Arabi, 2007; Howard, 2019).

The **Devaluation Stage** begins when men with pathological narcissism become disinterested or otherwise tired of pretending to be who they are not (Arabi, 2017). This stage typically occurs shortly after they have secured their partners' trust and investment in the relationship, to the point that it will be difficult for her to leave for either emotional or financial reasons. At this point, a victim of narcissistic abuse may observe discrepancies in what her partner has told her about himself or notice that his actions fail to reflect beliefs he previously claimed to hold. She may sense he is pulling away and become aware or suspicious of a darker side that might include prostitutes, porn, crime, embezzlement, the use and misuse of other relationships, abuse,

drug/alcohol problems, sexual addiction, a parasitic lifestyle, or other relationships through secretive texts, calls or emails (Brown, 2009).

During this stage, men with pathological narcissism use emotional manipulation and other abusive strategies to keep their partners under control (Leedom et al., 2012), and destroy his target's sense of self. Besides ignoring behaviors, he will likely criticize her cruelly and make public comments to humiliate her further. These comments may seem innocuous to others because they often contain coded or suggestive language that appear outwardly normal but are intended to communicate specific things to the victim (Howard, 2019). The target of "dog-whistling" (so named because a dog whistle is a frequency that dogs can hear but humans can't) feels triggered or offended, yet everyone else only hears regular words (Howard, 2019). Among the most effective abuse employed by men with pathological narcissism during the devaluation stage is the use of a "chronic pattern of sabotaging and re-establishing closeness in the relationship without appropriate cause or reason" (Out of the FOG, glossary, 2018). This can include intermittent reinforcement (Skinner, 1966), a technique in which the victim is given small doses of affection throughout the abuse cycle in order to keep her engaged in the relationship. Swings from cold, callous behavior to loving, affectionate behavior become so common that the victim is not only conditioned to expect less loving attention each time the couple interacts, but also programs her to associate love with unpredictability, distress and unease (Freeman, 2017). The use of intermittent reinforcement of positive behaviors dispersed throughout the abuse cycle ensures that the victim releases oxytocin, a powerful hormone that builds trust, combats depressive feelings and contributes significantly to pair bonding, even after she experiences abuse

(Freeman, 2017). This oxytocin release can produce the sensation that she is “addicted” to her partner, regardless of whether the relationship is over or whether she is the one who preemptively decided to leave it (Freeman, 2017).

Another common tactic employed by men with pathological narcissism is gaslighting, the coercion of their targets into believing the abuse isn’t real through denial, minimization or rationalization (Stern, 2018). Based on the 1944 movie “Gaslight,” this is an ongoing and multi-pronged strategy of psychological torture in which false information is given intentionally to make a victim question her own memory and perceptual interpretations (Louis de Cannonville, 2018; Stern, 2018). The abuser may simply deny that he abused her, even when he had, or that he hadn’t said something that he had. He might also set up bizarre events with the intention of disorienting his partner. Or he may ghost her (cease all contact without warning or explanation) immediately after a time of closeness during which he pledged his love and affection. These covert mind games systematically target a victim’s mental equilibrium, eliciting an atmosphere of fear, hurt, intimidation, domination, instability, unpredictability, and irritation, making it easier for her to be controlled (Louis de Cannonville, 2018).

Men with pathological narcissism also tend to gain an advantage over their targets by manipulating them into disagreements with others. For example, a pathological narcissist may involve another person in an issue with his partner, describing the situation so as to portray her as the aggressor while he receives undeserved emotional support from the third party (Arabi, 2017).

This kind of “triangulation” can occur with other love interests, including ex-partners,

through the practice of pathological lying and deceit and the simultaneous pursuit of numerous affairs outside of the relationship, as well as comparisons of the current victim to others in terms of their appearance, personality, success and other attributes so as to instill in her a sense of worthlessness (Arabi, 2017). In many cases, infidelity is driven not by legitimate dissatisfaction with a primary partner, but rather by the need for additional narcissistic attention, also called “narcissistic supply.” This supply comes in the form of attention from multiple people, as well as the victim’s emotional anguish in response to the triangulation. Motives for triangulating are varied, but often the technique is used to make a partner feel jealous, insecure and emotionally dysregulated (Arabi, 2017; Brown, 2009). Men with pathological narcissism also tend to slander the character and reputations of their partners to outsiders during this stage. He may do this through false allegations or unwarranted complaints for extended periods of time, turning his target’s most sacred support networks against her before she even knows it’s happening (Arabi, 2017). It is theorized that men with pathological narcissism are fully aware of how much they are hurting their target, but that he doesn’t care because he either resents her for not meeting all his needs, or feels threatened by or inferior to her (Arabi, 2017).

During the **discard phase**, pathological narcissists typically abandon their partners abruptly and callously, although the manner of this abandonment may differ. One man may humiliate his victim by leaving her for another lover or by leaving her without telling her why (or sometimes even that he is leaving). Another might ignore his partner, refuse to speak to her, or use any number of other abusive behaviors to let her know that she is no longer important. (Arabi, 2017; Brown, 2009). Often a victim

who tries to exercise her rights by leaving or limiting contact in the dysfunctional relationship will get “Hoovered,” a metaphor taken from the popular brand of vacuum cleaners that describes how she “gets ‘sucked back in’ when her former partner manipulates her by temporarily exhibiting kind or remorseful behavior” (Out of the FOG, Glossary, 2018). For example, a man with pathological narcissism who previously ignored her suddenly becomes attentive, only to abuse and/or discard her again as soon as she takes him back. Unlike “normal” partners, pathological narcissists ensure that their partners never have closure (Arabi, 2017; Brown, 2009). And if his target is the first to leave, a man with pathological narcissism may stalk her or immediately flaunt a new relationship publicly to show that he still has control or that he’s “won” the breakup (Louis de Canonville, 2012).

Damage is Difficult to See and Understand

Narcissistic abuse is often quite difficult for outsiders to detect because the abuse is highly individualized to the personal dynamics of the man with pathological narcissism and his victim (Stark, 2013). Bruises and other evidence of physical injury represent a clear boundary that has been crossed (Stark, 2012), however non-physical abuse often is classified as low-level even though it often ends in domestic homicide (Weiner, 2017). Because narcissistic abuse leaves no physical signs, this invisible form of maltreatment is paid the least amount of attention in discussions of IPV (Arabi, 2017). Yet the impact on both a woman’s body and brain is significant. In a large population-based study, (Coker et al., 2002) found that high levels of psychological abuse inflicted by a partner is strongly associated with risk of current poor health, depressive symptoms, substance use, chronic mental illness, physical injury and

developing a chronic disease. Even more harmful than verbal abuse, the study found, was the abuse of power and control, a cornerstone of narcissistic abuse.

Many victims are left with post-traumatic stress disorder (PTSD) (Schneider, 2018), and damaged neurological processes which can impact fear, clear thinking, decision-making, and memory (Bremner, 2008; Sherin & Nemeroff, 2011). In the worst cases, victims can develop Complex Post-Traumatic Stress Disorder (C-PTSD) — the severe psychological harm that occurs with prolonged, repeated trauma (Schneider, 2018) — or even what psychotherapist Louis de Cannonville (2019) calls “Narcissistic Victim Syndrome.” This syndrome, which correlates highly with the symptoms of C-PTSD, is marked by “avoidance behavior, loss of interest, detachment, the sense of a limited future, difficulty sleeping or eating, irritability, hypervigilance, being easily startled, flashbacks, hopelessness, psychosomatic illnesses, dissociation, emotional paralysis, obsessions about the relationship, intense cravings for the disordered partner and the relationship after leaving, distorted thinking, an inability to remember the disordered partner’s negative flaws, and the loss of one’s identity and worldview” (Hammond, 2015, p. 24).

Those with PTSD and C-PTSD often experience a range of mental and somatic health problems, including but not limited to severe depression (Campbell, 2002), anxiety, substance abuse, isolation (Herman, 2015) despair and self-hatred (Courtois, 2008; Northrup, 2018; Pico-Alfonso, 2005), and can lead to suicide (LeBouthillier, McMillan, Thibodeau, & Asmundson, 2015), especially if the abuse is the result of multiple traumatic events (e.g. child abuse, prolonged domestic violence, concentration camp experiences) occurring over a period of time (World Health Organization, 2018).

They are also more likely to engage in self-destructive and risk-taking behaviors and are at a greater risk for re-victimization (Courtois, 2008; Pico-Alfonso, 2005). C-PTSD is not a diagnosis in the DSM-5, but it is included in the ICD-11 diagnostic manual.

Those who have not experienced narcissistic abuse may misunderstand it as “normal” relationship problems or a compatibility issue and fail to recognize the significant psychological and emotional damage involved (Brown, 2009; Louis de Canonville, 2018). At a larger level, society as a whole is prone to blaming survivors for their suffering because narcissistic abuse does not always leave observable injuries (Arabi, 2017; Becker, 2015). Yet women who reported being in narcissistic relationships described the experience as “incredibly different and more damaging” than any other relationship due to the unique traits expressed by men on the pathological narcissism spectrum, even when no physical violence occurred (Brown, 2009, p. 27).

Having a better understanding of the personality traits and trauma experiences of the women who’ve been harmed by men with pathological narcissism becomes more urgent when one considers the increasing statistical likelihood of such relationships. A recent study showed that clinically diagnosed narcissism is rising among younger Americans: Whereas narcissists make up 1 in 30 of those in the U.S. population over 64 years of age, 1 in 10 individuals in their 20s experience the clinical symptoms of Narcissistic Personality Disorder (NPD) (Brummelman, 2015). Additionally, American college students today are 40% less empathetic than students of 30 years ago, with the numbers dropping primarily after 2000 (Konrath, 2011). More specifically, today’s students scored 48% lower in empathetic concern and 34% lower in perspective taking, both of which are regarded as important indices of empathy. Other studies have

documented increasing narcissism among college students since the late 1980s (e.g., Twenge & Campbell, 2001). In addition, a recent meta-analysis of American college students found that dismissive attachment styles — which are related negatively to sociability, empathy, socialization, communality, and tolerance (Diehl et al., 1998), and correlated positively to narcissism (Rosenstein & Horowitz, 1996; Schore, 2002a; Tatkin, 2005; Tweed & Dutton, 1998) — grew by 6.69% (11.93% to 18.62%) between 1988 and 2011, even after controlling for age, gender and race (Konrath, 2014).

According to estimates, narcissistic abuse affects somewhere between 60 and 158 million people in the U.S. alone, and most of the victims are women (Bonchay, 2017; Brown, 2010). Globally, there has been a growing movement dedicated to raising the profile of narcissistic abuse, providing education, resources for survivors, and effecting policy change. To that end, June 1, 2016, the inaugural Narcissistic Abuse Awareness Day.

Yet only within the past 25 years or so have mental health professionals been able to diagnose pathological narcissism and its related disorders and name how they operate, let alone assess how they affect the people around them (Northrup, 2018). As a result, clinicians have been slow to understand and embrace narcissistic abuse survivors. With little research to guide clinical practice, many survivors report feeling judged and alienated upon seeking professional help (Birch, 2014; Brown & Young, 2018; Howard, 2019). One barrier is therapists' adherence to traditional couple and family systems theory and the related belief that there are “two sides to every story,” including that survivors somehow contributed to the abuse or that the abusive behavior was part of a dysfunctional relationship pattern where both parties contributed equally

to the problems in the relationship (Arabi, 2017). Narcissistic abuse, however, stems from an imbalance of power, one where the abuser can make the victim feel worthless — even alter her sense of reality — by subjecting her to psychological abuse tactics including name-calling, stonewalling, gaslighting, contempt, the silent treatment, sabotage and other forms of control for an extended period of time (Arabi, 2017; Becker, 2015; Birch, 2014; Brown & Young, 2018). The ways in which a victim responds, though sometimes maladaptive, are nevertheless often mistaken by clinicians as mutual abuse (Arabi, 2017) or as proof that she is the one who is troubled (Bancroft et al., 2012).

Psychologists, counselors, psychiatrists and others in the psychotherapy profession often fail to identify covert abusers because they themselves may have fallen for the falsehoods created through the narcissistic abuser's actions (Newton-Howes et al., 2015). A man with pathological narcissism generally seems calm, charming and likeable, whereas his target may come across as emotional, erratic or unhinged due to trauma (Arabi, 2017; Becker, 2015; Bancroft, Silverman, & Ritchie, 2012; Louis de Canonville, 2012). Clinicians must clear several obstacles before they can formulate a complete picture of a woman's experiences. For example, research has shown that trauma can affect the part of the brain concerned with speech and memory (Bremner, 2008), causing a victim of narcissistic abuse to appear confused and disoriented as she struggles to describe what has happened to her. She also may have unconsciously separated herself from her experiences (dissociation), making it difficult for even to her make sense of what has happened, let alone articulate it to someone else. Add to this the often-outrageous behaviors of men with pathological narcissism, which can make her

stories of the abuse sound far-fetched even to herself (Howard, 2019).

In a survey of 300 women who identify as narcissistic abuse survivors by The Institute for Relational Harm Reduction & Public Pathology Education (Brown & Young, 2018), 49% of those surveyed reported that their therapists were not effective at spotting the pathological narcissism in their partners, 51% reported that their therapists were not effective at identifying her symptoms as trauma, 59.3% reported that their therapist was not effective at recognizing the harmful relationship dynamics at play, 50% reported that they tried to educate their therapist on narcissistic abuse, with 32.3% of them reporting that their efforts did not help.

Because relationships between pathological narcissists and their targets are built on the abuser's "false self," the victim is left grieving someone who does not exist (Brown, 2009). Therefore, the complicated trifecta of disenfranchised grief, cognitive dissonance, and trauma can make it exceedingly difficult for victims to find therapists who are able to recognize and treat them (Brown, 2009; Milstead, 2018).

As a result, many narcissistic abuse survivors have turned to the internet to seek information and validation through online support forums, social media groups or paid online "healing" programs of varied quality that are often created by other survivors who have little or no professional training. A Google search for "narcissistic abuse support groups" that returned 3.95 million results suggests a worldwide cultural phenomenon. Indeed, a search on Instagram yields thousands of accounts dedicated to the topic of narcissistic abuse, most run by non-credentialed survivors who also offer "consulting" sessions for a fee, often ranging from between \$100 and \$200 per hour, to other survivors who are desperate to find validation for their experience. This landscape

creates additional vulnerability for victims who may already be dealing with significant psychological trauma, humiliation, isolation, financial devastation, health problems due to chronic stress, and stalking. According to the Finding Competent Care survey, 51.2% of women reported that “coaches” were not effective or worsened their trauma symptoms (Brown & Young, 2018).

Survivors are referred to as “women” and “she/her” throughout this paper, and abusers are referred to as “men” and “he/him.” This is meant to reflect that the majority of perpetrators of this form of psychological abuse are men and their victims are women (Stinson et al., 2008). It is not meant to disregard or minimize the experience of women abused by female partners, nor men abused by male or female partners. Most studies that have investigated the victimization of men in relationships by comparing these men to abused women, specifically by attempting to determine whether abused women experience more physical injuries than abused men. For example, the National Family Violence Survey (NFVS) found that only 1% of men who claimed to have been “severely” assaulted by their wives required medical attention. Additionally, about 90 percent of men who claimed to have been hit by their female partners said they were not frightened by their partner's violence. However, research suggests that men’s overall risk may be increasing (Karakurt & Silver, 2013). Archer (2000) now notes similar IPV rates for men and women, and although little existing research considers the emotional abuse of men, there is some evidence that more men are experiencing emotional abuse (Harned, 2001). An area for future research is men who identify as narcissistic abuse survivors.

Who is she?

Narcissistic abuse survivors have been conceptualized and labeled in various ways, including as codependents (Rosenberg, 2013), sadists (who enjoy watching their partner's cruelty), masochists (who subconsciously enjoy their partner's cruelty; Meloy, 2005), love addicts, co-narcissists (Louis de Cannonville, 2018), and empaths (Brown & Young, 2018; Orloff, 2017). However, there is no peer-reviewed research published to date on the personality traits and trauma experiences of these women to help inform and guide this discussion.

Personality Trait Theory

Brown (2009) developed one of the first and only theories about why this form of interpersonal violence is so psychologically damaging, and its female victims so misunderstood. Brown's "super traits" theory holds that relationships with men with pathological narcissism cause so much psychological trauma, at least in part, because of an unusual bundling of elevated personality characteristics possessed by the women themselves – which not only makes them sought-after targets, but also impairs their ability to read red flags and disengage from the relationship sooner. Snubbed empathy for narcissistic abuse victims is often based on questions of "Why didn't she leave?" and assumes various reasons when she doesn't. This is largely based on traditional intimate partner violence theory, which holds to the belief that staying is related to economic, religious, and familial restraints that prevent earlier exiting (Brown, 2009).

Brown (2009) argued that the true risk factors for survivors of narcissistic abuse lie in the woman's personality make-up, as well as from cognitive and self-perceptual injuries (caused both before and during the relationship) that undermine her ability to pick up on warning signs and to exit the relationship quickly and before significant

psychological damage is incurred. Most of the women in Brown's survey were highly educated or successful in their chosen line of work. Most had a minimum of a bachelor's degree or higher, and many were professionally trained as attorneys, doctors, therapists or social workers, female clergy, nurses or other medical professionals, teachers or professors, editors, CEOs of companies and non-profit agency directors (Brown, 2009). Using Cloninger's Temperament and Character Inventory (Cloninger, 1994), Brown surveyed roughly 75 of her own clients who self-identified as being in relationships with pathological narcissists and found that they scored higher than the general population mean in certain temperament and character indices: Novelty-Seeking (NS), which refers to the desire to seek exciting people, places and things to avoid boredom, specifically the subscales of exploratory excitability, extravagance, and disorderliness subscales; Reward Dependence (RD), which measures how easily one does or does not respond to the pleasurable rewards in relationships, specifically the sentimentality, attachment and dependence subscales; Cooperativeness (C), which measures a person's general agreeableness in their relations with others, including the social acceptance, empathy, helpfulness and compassion subscales; and Self-Directedness (SD), which measures self-determination, and all four of its subscales, responsibility, purposefulness, resourcefulness and self-acceptance. (Cloninger, 1994).

Results were mixed in the Harm Avoidance (HA) dimension, which refers to the tendency to shyness, worry, fear, pessimism, doubt and becoming easily fatigued and includes the subscales of anticipatory worry, fear of uncertainty, shyness and fatigability (Cloninger, 1994). About half of the women in Brown's study tested high in harm avoidance, and the other half tested average to low (Brown, 2009). Scores were

average in the Self-Transcendence (ST) dimension, which includes the self-forgetful, transpersonal identification and spiritual acceptance subscales.

The data from this 2007 survey formed the basis of Brown's "super traits" theory (2009), a widely referenced model that asserts that women, based on a specific bundling of their own personality traits, are more likely to both attract and tolerate pathologically narcissistic partners whose own personality traits stand in stark contrast to theirs. Specifically, Brown theorized that a high exploratory excitability score might make a woman an "excitement seeker" who doesn't like to lead a boring life and who may seek out partners who are similarly strong and outgoing (Brown, 2009). Such a woman, Brown argued, may pose a threat to men who are not themselves equally outgoing, competent and competitive. Due to this attraction, women with this trait might feel "pulled" to men with traits that are dominant, thrill-seeking and extraverted, traits which can often describe men with pathological narcissism (Brown, 2009).

About half the women in Brown's research tested high in overall harm avoidance, the tendency to maintain behavior to be socially rewarded and to avoid punishment (Cloninger, 1994), and the other half tested average-to-low. Scores were moderately high on the anticipatory worry subscale, which measures pessimism and worry, and low in the shyness and fatigability subscales. Brown (2009) theorized that both extremes of harm avoidance could be problematic: Those with high harm avoidance can become immobilized with anxiety and fail to leave a problematic relationship, and those with low harm avoidance can fail to pick up on the red flags shown early in relationships with men with pathological narcissism.

The women who tested low in harm avoidance tend to be carefree by nature and optimistic in situations that worry others, more relaxed, bold, daring, and dauntless, Brown theorized. They don't battle the issue of anxiety the way the women who are high in harm avoidance do. Add low harm avoidance with excitement-seeking traits, and "we have bold women excitedly seeking new adventures who aren't likely to be on the lookout for ways others can harm them," wrote Brown (2009, p. 124). Additionally, the women in Brown's survey scored in the 97th percentile for cooperativeness, which includes having empathy for others, the tolerance to manage differences, being friendly and approachable and supportive to others. This very high score, Brown (2009) hypothesized, could be a risk in that it would help her to empathize with her partner's struggles in life and "never stop listening, helping and hoping" (p. 131) even when a man with pathological narcissism began to show her his true character. She writes:

"What other woman could maintain her optimism in the face of the psychopath's narcissism if she wasn't cooperative? These cooperation traits are her drawing card to a psychopath. Her overflowing empathy, tolerance, friendliness, compassion, supportiveness and her moral principles are what balance the lopsided scales of the relationship, since he lacks these qualities to a gapping deficient degree. This delicate balance helps camouflage the glaring gaps of the character traits between them. Her cooperativeness helps to smooth out the character he doesn't have and makes the relationship seem more normal—at least in the beginning" (p. 131).

Similarly, high scores in self-directedness, or resourcefulness, led Brown to argue that this trait, too, was a risk factor for the women in her study because they might feel compelled to "build a structure to his life from which he could appear to function" (p. 144) since many men with pathological narcissism have difficulty holding down jobs due to problems with authority and following rules.

In 2014, building on this work, Brown administered the Five Factor Model Rating Form (Widiger, 2004), to a reported 600 women who identified as having been

survivors of narcissistic abuse. This form provides a brief measure of the Five Factor Model dimensions of: 1) conscientiousness versus undependability, 2) agreeableness versus antagonism, 3) openness versus closedness to one's own experience, 4) extraversion versus introversion, and 5) neuroticism versus emotional stability. Brown and Young (2018) reported that survivors of these relationships scored in the "high-normal" category of agreeableness, which includes the characteristics of trust, straightforwardness, a giving nature, cooperation, humbleness and empathy and is most strongly associated with the cooperativeness domain of the TCI (De Fruyt et al., 2000). Additionally, survey participants scored in the "high-normal" range in the category of conscientiousness, which includes being efficient, organized, dependable, achievement-striving, self-disciplined and deliberate. Brown and Young (2018) reported that this trait contributed to survey participants being academically and professionally successful, but also produced a persistence that led them to try to save their relationships at all costs. When an individual has a strong predisposition for pro-social behaviors, Brown and Young argued, her automatic response is in service of other, even when it places her at risk. Understanding how ingrained these responses can be is essential for clinicians working with this group. They write:

"While work is often done with survivors concerning boundaries, what therapists fail to realize is that her actions are not boundary violations generated from a conscious need to make others happy, as in codependency, but rather they are unconscious and personality-driven and so are less likely to be conscious" (Brown & Young, 2018, p. 310).

Regarding her sample's high scores in reward dependence, with elevations in the attachment, sentimentality, and dependence subscales, Brown (2009) theorized that this indicated "relationship investment," but not codependency. "Wanting love does not

make a person ... codependent,” she wrote (p. 116), “however, there can be excesses in traits related to relational harm.” For example, the more invested a woman is in her relationship, the harder she may fight to try to save it – even if she is being treated badly (Brown, 2009).

Though important, there are significant limitations to Brown’s work. First, her studies are not peer-reviewed, but instead are self-published in books in the popular press. Second, the first study is based on a small examination of 75 women and is supplemented with the qualitative observation of Brown’s own clinical work as a therapist (Brown, 2009), which extends beyond the group sampled. In the 2014 study, Brown does not report the statistical significance of the trait elevations found in her sample or how they support or contradict her 2007 findings. Perhaps most importantly, Brown’s theory does not statistically incorporate early-life trauma, which may play a significant role in whether a woman becomes involved with a man with pathological narcissism (Louis de Cannonville, 2013), particularly if she grew up with parents or caretakers who themselves expressed narcissistic traits.

Empathy Theory

Another theory that attempts to explain why women become involved with men with pathological narcissism is that her high or “hyper” empathy creates an almost ‘pathological altruism’ in which she is harmed by her own elevation of empathy (Oakley, 2010). While similar to personality trait theory, this theory focuses solely on the trait of empathy, arguing that victims of narcissistic abuse become ensnared in relationships because they are “empaths” (Orloff, 2017). Oakley’s theory reflects in part the ideas of McGregor and McGregor (2013), who have coined the term “empathy trap”

to describe how highly empathic people are especially vulnerable to narcissistic abuse simply by the fact that they are empathic and get hooked by their own nature. Precisely because they *do* have feeling and high empathy, it makes it difficult for them to believe that it is possible other people may not. Scholars, therapists, medical doctors and survivors who have observed, studied and written about narcissistic abuse also have noted stark characterological and behavioral differences between abusers and their victims (Arabi, 2017; Brown & Young, 2018; Howard, 2019; Louis de Cannonville, 2013). Indeed, the thousands of online narcissistic support forums are full of female commenters who identify themselves as “empaths.” Brown and Young (2018) noted the tendency among survivors to identify as empaths, stating that “this would be expected since this characteristic is tied to the issue of empathy which is elevated in their trait of agreeableness” (p. 372). However, much of the writing in this area is not in the academic realm and empirical study of women in these harmful relationships is needed.

Early-Life Trauma Theory

The vast majority of clinicians and researchers who work with narcissistic abuse survivors have theorized that early-life trauma plays a central role, both contributing to a woman’s risk and influencing her response. Being betrayed by one’s caregivers during childhood can lead to dysfunctional relating in adulthood, such as taking responsibility for the emotional well-being of others, becoming hypervigilant to gauging other’s moods, fear of failure or success, fear of rejection and abandonment, self-reliance, and self-sufficiency (Louis de Cannonville, 2018).

Landmark research clearly links early-life trauma with the experience of IPV in adulthood (Mair, Cunradi & Todd, 2013). The Adverse Childhood Experiences (ACEs)

scale measures 10 forms of early-life trauma, including physical, sexual, or emotional abuse, physical and emotional neglect, seeing one's mother treated violently, substance misuse within the household, household mental illness, parental separation or divorce, or having an incarcerated household member. ACEs were also predictive of physical dating violence, accounting for more than one half of dating violence victimization (53%) and perpetration (56%) (Miller et al., 2011).

Brown and Young (2018) reportedly administered the Adverse Childhood Experiences Scale (ACEs) during their 2014 research of narcissistic abuse victims. Without providing statistics from their raw data (Brown & Young, 2014), they published (Brown & Young, 2018) that a majority of the 600 respondents in their survey did *not* report early-life trauma. Despite being true for most categories of IPV survivors, they wrote that the "assumption" by most researchers and clinicians that early-life trauma contributes to women's victimization by a pathological narcissist, is "largely erroneous" (Brown and Young, 2018, p. 348).

Brenner (2018), on the other hand, argues that women who report early-life trauma are often attracted to destructive relationships, whether it be a romantic liaison, at work or a friendship, in a subconscious compulsion to repeat early-life trauma. Through transference, he argues that a woman may search for partners who fit her traumatic identity, resulting in the formation of a circle in which re-traumatization reoccurs despite her desire to make different and better choices. For example, a woman who was raised by a narcissistic mother might consciously want to find a healthy, available partner, but unconscious influences may cause her to select narcissistic or emotionally unavailable people (Brenner, 2018).

Trauma re-enactment theory (van der Kolk, 1989) maintains that this subconscious attraction to familiar trauma, whether experienced as a child, an adult, or both, can be repeated on behavioral, emotional, physiologic, and neuro-endocrine levels. According to van der Kolk (1989), normal social and biological development requires a “safe base” that includes appropriate internal and external resources for coping with external threats, such as abuse and neglect. Without these resources, “attachment” trauma can occur (van der Kolk, 1989), and contribute to the development of PTSD or C-PTSD. Because individuals often seek increased attachment in the face of external danger, a woman being abused by a man with pathological narcissism may develop strong emotional ties to the perpetrator of her abuse — the very person who intermittently harasses, beats and threatens her — thus creating a persistent attachment bond that ultimately leads to the confusion of pain and love (van der Kolk, 1989). This phenomenon is not unlike the “trauma bond” described by Carnes (2018). This vulnerability is amplified by the fact that individuals who experience early abuse and deprivation are especially vulnerable to entering into violent and/or abusive relationships as adults (Brenner, 2018; van der Kolk, 1989).

Individuals with early-life trauma, as well as those who have been in abusive adult relationships, tend to live in an ongoing state of physiologic hyperarousal, especially when any stimuli, even a slightly evocative reminder, of the original trauma exists (van der Kolk, 2015). This kind of persistent hyperarousal can interfere with the ability to make good decisions, as well as block the resolution and integration of the trauma (van der Kolk, 2015). For example, a woman may try to block out reactivation of her earlier trauma by focusing only on the pleasant aspects of her situation. This

behavior pattern helps explain why narcissistic abuse survivors often focus (even subconsciously) on her partner's "good" traits rather than face what is actually happening. Similarly, previously traumatized people will often revert to the patterns they know, even if those patterns cause them torment (Freeman, 2017; van der Kolk, 1989; van der Kolk, 2015). By engaging in familiar behavior, regardless of the dangers, she can avoid the anxiety and stress of new situations. Freyd's (1996) Betrayal Trauma Theory further highlights this concept. Trauma from deception, betrayal and the abuse of power and control in a relationship often can thwart a survivor's efforts to leave even when she knows she should. Betrayal trauma, which is inflicted by someone a victim loves, relies on, or trusts, is processed differently by the brain than other kinds of trauma (Freyd et al., 2001; Freyd, 2013). When a woman regards her perpetrator as integral to her very survival (someone she loves, relies on, trusts, or believes is her "soul mate"), she will often subconsciously downplay or "forget" the abuse in order to maintain the relationship (Freyd, 1996). Despite significant early-life trauma research in the field of IPV as a whole, there are no peer-reviewed studies that specifically examine its impact on survivors of narcissistic abuse.

Victim as "Target"

Altruistic personality traits, as well as a history of abuse, may both be important factors to consider given that many men with pathological narcissism possess the ability to pick up on nonverbal cues that suggest a target's vulnerability to victimization. Indeed, researchers have found that psychopathic traits may assist narcissistic abusers in identifying women who are easier to exploit due to their altruistic personalities. Camilleri et al. (2010), for example, found that psychopathic traits lead to an enhanced

memory for “helpers” (i.e., objects that aided other objects in achieving a goal) versus “hinders” (i.e., objects that kept other objects from reaching a goal), supporting previous descriptions of psychopaths as effective social predators who may focus more on “altruistic” individuals because they are easier to exploit. (Hare, 1993; Mealey, 1995).

Even a woman’s own body language might influence a potential abuser’s perception of her as a victim. A meta-analysis by Hall, Coats, and Smith-Le Beau (2005), for example, confirmed that nonverbal behaviors, including eye contact, posture, pace and manner of moving, are related to actual and perceived ratings of vulnerability. Similarly, Grayson and Stein (1981) found that previous abuse victims move their bodies differently than non-victims, sending inadvertent signals that suggest vulnerability (Montepare & Zebrowitz-McArthur, 1998). Additionally, individuals scoring higher in certain aspects of psychopathy were better at gauging a potential victim’s vulnerability by observing nothing but her gait (Wheeler, Book, & Costello, 2009). Book et al. (2013) found that, when compared to controls, individuals with more psychopathic traits, such as manipulateness, superficial charm, and lack of empathy, were more likely to correctly identify a woman with a history of victimization just by watching videos of her walking.

Codependency and Love Addiction

Most researchers and clinicians dismiss codependency and love addict labels for narcissistic abuse survivors. However, there is wide disagreement over what exactly plays the most prominent role in a woman’s likelihood to become involved with a man with pathological narcissism: Is it her personality traits or early-life trauma?

Brown and Young (2018) argue that personality — not previous trauma — plays the most significant role. They write:

“There have been many misguided assumptions as to why highly successful women invest in relationships that turn out to cause inevitable harm. These assumptions are precisely why survivors have been wrongfully labeled as dependent and codependent. Without the understanding that the survivor’s personality influences the course of her interactions, factors such as abuse, trauma, learned helplessness, PTSD, relationship addiction, and various forms of dependency, are assumed to be the culprits. (We) believe (personality) is a better explanation” (p. 297-298).

Citing Brown’s (2009) theory, Northrup (2018) argued that women with super traits are “decidedly not codependent, nor are they relationship addicts. Their light and goodness and super traits are just misunderstood. And so, these women ... are constantly mislabeled and misdiagnosed (p. 112).”

Other researchers, however, maintain that early-life trauma is the most significant factor, forging a lifelong pattern by abuse survivors to find ways to “stay safe” while in dangerous relationships because as children they unconsciously learned that such adaptations may discourage the hostile reactions of abusive caregivers. Louis de Cannonville (2018):

“The co-dependent individual acts out of their submissive behaviors to keep those they love happy, because they are afraid of being alone in the world. Whereas the co-narcissist (survivor) acts out their submissive behaviors to accommodate and endure the pathological narcissist’s interpersonally rigid and abusive behaviors to survive” (p.6).

Add to that the biochemically addictive underpinnings of “trauma bonding,” created by a narcissistic abuser’s use of intermittent reinforcement. Researchers and clinicians often compare narcissistic abuse survivors’ recovery to withdrawal from drug addiction (Freeman, 2017; Taylor et al., 2000). The “deeply upsetting behavior” of a man with pathological narcissism can cause his partner’s neurochemicals (dopamine,

endogenous opioids, corticotropin releasing factor, and oxytocin) to become

“significantly dysregulated” (Freeman, 2017, p. 27). She writes:

“In the presence of such an addiction, there will be intense craving, a heightened value attributed to the abuser, and a hyper-focus on the relationship and conflict resolution. The victim’s thoughts will often follow to make sense of these feelings. Her brain usually turns to self- deception and rationalizations to resolve the cognitive dissonance (p.28).”

Knowing the related causes of violence and why some women are more likely to experience narcissistic abuse is crucial in addressing and preventing violence in all its forms. As such, this dissertation study seeks to examine the personality traits of women who have survived relationships with men with pathological narcissism, as well as how early-life trauma might contribute to their vulnerability to narcissistic abuse.

This exploratory, descriptive dissertation study sought to more closely examine the traits, trauma and relationship experiences of women who self-identify as having survived narcissistic abuse by male partners. This information allowed for the assessment of whether early-life trauma, as well as elevations or deficits in certain personality traits, yielded correlational patterns to a woman’s romantic involvement with narcissistic partners. This study also gathered information about the abuse experienced by women while in relationship with men with pathological narcissism, and how those experiences correlated with psychological and physical aftermath symptoms. This information may contribute to the knowledge about narcissistic abuse survivors and may help the counselors who are dedicated to helping them heal.

This study contributes to the literature by: (a) assessing the personality traits of women who self-identify as having survived narcissistic abuse; b) assessing the reported presence of early-life trauma in relation to narcissistic abuse later in life; c)

providing the first measure of women's appraisals of a broad array of narcissistic abuse experiences; and (d) providing the first empirical basis for the psychological symptoms that constitute Narcissistic Abuse Syndrome.

Research Questions:

1. What are the personality characteristics of women who have survived abuse by a male partner with pathological narcissism as compared to normative data?
2. What is the average empathy score of women who have survived abuse by a male partner with pathological narcissism and how does it compare to normative data?
3. What is the average early-life trauma score of women who have survived abuse by a male partner with pathological narcissism as compared to normative data?
4. Do women who identify as survivors of narcissistic abuse report clinically significant symptoms of complex trauma as compared to normative data?
5. How does early early-life trauma relate to the length of time in relationship with a man with pathological narcissism?

Hypotheses:

1. Women who identify as survivors of narcissistic abuse will show significant elevations when compared to normative data of the personality characteristics of Honesty-Humility (H), Agreeableness (A), and Conscientiousness (C).
2. Women who identify as survivors of narcissistic abuse will show higher empathy as compared to normative data.
3. Higher empathy scores will predict greater severity of abuse and more symptoms of complex trauma in women who identify as survivors of narcissistic abuse.
4. Personality, empathy and the presence of narcissistic abuse will all predict complex

trauma.

CHAPTER II

METHODS

Participants

The participants ($N=1,995$) for this study were adult women, 18 years of age and older, in the United States, who self-identified as heterosexual narcissistic abuse victims whose abuser was male. The present dissertation study included 1,995 female participants total from the survey. Inclusion criteria for this dissertation study were participants who: (a) identify as female (b) were between 18 and 99 years old at the time of data collection; and (c) were involved in at least one romantic (dating or marriage) relationship with a man they believed to have pathological narcissism.

Participants identified as being in one of 5 monoracial groups, as biracial or multiracial. Of the total sample, participants identified racially as: White ($n=1683$) 84.4%, Black or African American ($n=93$) 4.7%, Biracial or Multiracial ($n=87$) 4.4%, Asian ($n=86$) 4.3%, Alaska Native or American Indian ($n=15$) .8%, Native Hawaiian or Pacific Islander ($n=8$) .4%. Of the total participants, 7.3% ($n=146$) identified as Hispanic/Latino. The ages of those who participated ranged from 18 to 80, with a mean age of 46.

Most participants endorsed an advanced range of education levels: 21.9 % obtained a master's degree or higher ($n=437$), 5.3% attended some graduate school ($n=105$), 26.7% obtained a bachelor's degree ($n=533$), 11.2 % completed an associate's degree ($n=224$), and 22.8 % attended at least some college ($n=455$). Only 9.4% said they received a high school diploma or GED ($n=186$), and only 1.9% had attended only some high school or less ($n=38$). Almost half of all participants (47.2%) reported that

they had been diagnosed with a mental disorder ($n=942$), with the most common diagnosis (13.8%) being Post-Traumatic Stress Disorder (PTSD) ($n=226$), followed by Generalized Anxiety Disorder at 10.4% ($n=208$), Major Depressive Disorder at 6.9% ($n=163$) and Complex Trauma at 4.1% ($n=82$).

When it came to how they assessed their partner's pathology, 55.2% ($n=1102$) said they recognized the traits because of the books and social media articles that they have read, 10.2% ($n=203$) said they recognized the traits because they have mental health training, 8.9% ($n=178$) said their partners had been diagnosed by a mental health professional, and 7.4 % ($n=148$) said someone they trust told them they thought their partner had pathological traits. Another 17.9 % ($n=357$) said they assessed their partner's pathology in other ways (see Table 1).

Participants were far more likely to endorse psychological abuse and other forms of coercive control by their narcissistic partners than physical abuse. For example, 81.8% ($n=1632$) reported that their partner had frequently or very frequently ended a discussion with them and made the decision himself, 80.4% ($n=1603$) said their partner had frequently or very frequently called them a name or criticized them, 75.3% ($n=1502$) said their partner frequently or very frequently gave them angry stares or looks, 66.6% ($n=1329$) said their partner frequently or very frequently put down their family and friends, 61.9% ($n=1234$) said their partner frequently or very frequently tried to keep them from doing something they wanted to do (e.g., going out with friends, going to meetings), 63.2 % ($n=1262$) said their partner accused them frequently or very frequently of paying more attention to someone/something else, 45.6% ($n=908$) said their partner frequently or very frequently checked up on them (e.g., listened to their

phone calls, checked the mileage on their car, called them repeatedly at work), 40.1 % ($n=799$) said their partner frequently or very frequently said things to scare them (e.g., told them something “bad” would happen, threatened to commit suicide), and 39.6% ($n=790$) said their partner frequently or very frequently made them do something humiliating or degrading (e.g., beg for forgiveness, ask for permission to use the car or to do something) (See Table 2).

Measures

Demographic survey. A demographic questionnaire was designed to determine participants’ age, race/ethnicity, educational status, employment status, socioeconomic status, disability status, relationship status, narcissistic abuse disclosure, mental health treatment received, number of relationships in which they experienced narcissistic abuse, time since last narcissistic abuse experience, and several questions from the Aftermath Trauma Checklist (2013) to help women determine if they have experienced narcissistic abuse. This screener was written by therapists and based on first-hand clinical experience with several hundred women who have experienced narcissistic abuse.

Empathy Levels. The Empathy Quotient (EQ; Baron-Cohen & Wheelwright, 2004) consists of 60 items (40 items relating to empathy and 20 control/filler items) assessing both affective and cognitive empathy, or a combination of the ability to feel an appropriate emotion in response to another's emotion, as well as the ability to understand the others' emotion. Each item is a first-person statement which the participant rates on a six-point Likert-type scale ranging from 0 (*strongly agree*) to 5 (*strongly disagree*). Sample questions are: “I can easily tell if someone wants to enter a

conversation,” “I really enjoy caring for other people,” “I find it hard to know what to do in a social situation,” and “Friendships and relationships are just too difficult, so I tend not to bother with them.” Scores on each item are summed with a possible range of 0 to 120, with higher scores representing higher empathy. Evidence for the face validity of the EQ can be found in the method by which the measure was created. During early testing, six experimental psychologists were asked to rate how items in the measure of the EQ matched the following definition of empathy: “Empathy is the drive or ability to attribute mental states to another person/animal, and entails an appropriate affective response in the observer to the other person’s mental state” (Cohen & Wheelwright, 2004). Principal Components Analysis suggests a three-factor solution for the EQ: cognitive empathy, emotional reactivity (used as a measure of emotional empathy) and social skills (Berthoz et al., 2008; Lawrence et al., 2004). Cronbach’s alphas have been observed for the EQ varying from .85 in a sample of 346 university students (Muncer & Ling, 2006) to .88 in a sample of 1,761 university students (Wakabayashi et al., 2006). The EQ has also been demonstrated to have good test–retest reliability (Lawrence et al., 2004) in a sample of 110 healthy individuals and 62 people reporting depersonalization. Furthermore, the EQ has established convergent validity with the Interpersonal Reactivity Index (IRI), another self-report measure that includes scales on perspective taking and empathetic concern (Lawrence et al., 2004). The Cronbach’s alpha for this sample was .83.

Personality Traits. The HEXACO-60 (Ashton & Lee, 2009), a shorter version of the HEXACO Personality Inventory-Revised, consists of 60 items and assesses the six personality dimensions found in lexical studies in several European and Asian

languages. They include: Honesty-Humility (H), Emotionality (E), Extraversion (X), Agreeableness (A), Conscientiousness (C), and Openness to Experience (O). Each factor is composed of traits with characteristics indicating high and low levels of the factor. The HEXACO model shares several common elements with The Big-Five Inventory (BFI) that measures an individual on the Big Five Factors (dimensions) of personality (Goldberg, 1993; Costa and McCrae, 1992). However, the HEXACO model is unique mainly due to the addition of the Honesty-Humility dimension (Ashton & Lee, 2001, 2007). Each item is a first-person statement which the participant rates on a six-point Likert-type scale ranging from 0 (*strongly agree*) to 5 (*strongly disagree*). H subscale facets include sincerity, fairness, greed avoidance and modesty (Sample item: “I wouldn’t use flattery to get a raise or promotion at work, even if I thought it would succeed”). E subscale facets include fearfulness, anxiety, dependence, and sentimentality (Sample item: “I sometimes can’t help worrying about little things”). X subscale facets include social self-esteem, social boldness, sociability and liveliness (Sample item: “In social situations, I’m usually the one who makes the first move”). A subscale facets include forgiveness, gentleness, flexibility and patience (Sample item: “Most people tend to get angry more quickly than I do”). C subscale facets include organization, diligence, perfectionism and prudence (Sample item: “People often call me a perfectionist”). O subscale facets include aesthetic appreciation, inquisitiveness, creativity and unconventionality (Sample item: “People have often told me that I have a good imagination.”). Item scores are averaged to form subscale scores and higher scores reflect predictors of the corresponding personality trait.

Ashton and Lee (2009) administered the shortened version to samples of college students and community adults. When administered in self-report form, the scales showed internal consistency reliabilities in the .70s despite their brevity and breadth of content. Scale intercorrelations were all below .30 and thus compare favorably with measures of the Big Five factors. Factor analytic results showed that when six factors were extracted and rotated, all items (or all facets) of a given scale showed their primary loadings on the same factor. In addition, the levels of self-observer agreement in data collected from samples of college students and community adults were found to be reasonably high for all six HEXACO-60 scales, with all values exceeding .45. Finally, the properties of the HEXACO-60 were similar to those of the longer versions of the HEXACO-PI-R, showing only a modest loss in internal consistency reliabilities and in correlations with related measures and maintaining approximately equal levels of self-observer agreement (Ashton & Lee, 2009). The Cronbach's alphas for this study ranged from .69 to .81.

Experiences of Early-Life Trauma. The Adverse Childhood Experiences Questionnaire (ACEs; Murphy et. al, 2007) is a 10-item self-report measure developed for the ACE study to identify early-life experiences of abuse and neglect. It suggests that early-life trauma and stress early in life can cause trauma and chronic stress responses in adulthood. Many high-risk behaviors, chronic diseases and poor health outcomes people experience as adults have roots in multiple, chronic or persistent stress stemming from childhood. Questions on the ACES Questionnaire are answered on a yes-no basis, and each affirmative answer is assigned one point. At the end of the questionnaire, the points are totaled for a score out of ten, which is known as the ACE

score. Sample questions include, “Did a parent or other adult in the household often push, grab, slap, or throw something at you?” “Was a household member depressed or mentally ill or did a household member attempt suicide?” and “Did you often feel that you didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you?” The ACEs Questionnaire was found to be a reliable, valid screen for the retrospective assessment of adverse childhood experiences (Wingenfeld et al., 2011). In a 2013 study using the ACE to assess the psychosocial well-being of women who were in foster care as children, the number of ACEs was associated with the level of psychological distress. At 0.81, Cronbach’s alpha indicated adequate internal consistency of the ACE questionnaire used in this study (Bruskas and Tessin, 2013). The Cronbach’s alpha for this study was .72.

Complex Trauma. The Complex Trauma Inventory (CTI; Litvin, Kaminski, & Riggs, 2017) is a 20-item self-report measure that asks about the intensity and frequency of symptoms associated with complex trauma. For each symptom, respondents are asked to indicate the intensity on a five-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely*), and frequency from 0 (*none*) to 4 (*daily or almost daily*). The scale then provides for the assessment of severity by averaging the intensity and frequency scores for each symptom and identifying subscales that measure the presence of specific symptoms of the disorder. Sample items include: “Having bad dreams or nightmares about traumatic event(s),” “Being “super-alert” or on the guard/watchful”, “Feeling distant from other people,” and “Trying not to think about the traumatic experiences (s).” The validity of the CTI supports the distinction between CPTSD, a form of ongoing or cumulative trauma that typically occurs between people at

vulnerable times in an individual's development and involves direct harm, exploitation and ill-treatment, and PTSD, a mental disorder that can arise following exposure to a traumatic, life-threatening event, such as sexual assault, warfare, or traffic collisions. Internal consistencies for the CTI were good to excellent (Cronbach's alphas ranged from .89 to .92) in two separate samples of diverse college students who reported exposure to at least one traumatic event and having at least occasional functional impairment. Supplementary analyses supported the gender invariance, as well as convergent and discriminant validity of the CTI. In a study of two separate samples of diverse college students, confirmatory factor analysis of the CTI supported two highly correlated second-order factors (PTSD and Disturbances in Self-Organization (DSO)). Internal consistencies for the subscales of PTSD and DSO also were good to excellent ($\alpha = .89-.92$). Cronbach's alphas ranged from acceptable to excellent: PTSD (.89), DSO (.92), Reexperiencing (.78), Avoidance (.84), Sense of Threat (.82), Affect Dysregulation (.76), Negative Self-Concept (.84) and Disturbances in Relationships (.89) (Litvin, Kaminski, & Riggs, 2017). For this study, the Cronbach's alphas performed similarly well. For the total severity score (intensity plus frequency equals severity), the alpha was .93. For the subscales, Cronbach's alphas ranged from acceptable to excellent: PTSD (.92), DSO (.93), Reexperiencing (.80), Avoidance (.83), Sense of Threat (.78), Affect Dysregulation (.80), Negative Self-Concept (.81) and Disturbances in Relationships (.79). The subscales were used to identify the presence of C-PTSD in this study, while the total severity score was used in the hierarchical multiple regressions conducted.

Intimate Partner Violence Experiences. The Abusive Behaviors Inventory (ABI; Shepard & Campbell, 1992) is a 30-item, self-report inventory designed to measure the frequency of physical, sexual, psychological, and economic abuse a respondent has experienced from a former or current intimate partner. The ABI is used to measure IPV experiences that participants had experienced since age 18 years. Sample items include, “Prevented you from having money for your own use,” “Pressured you to have sex in a way you didn’t like or want,” and “Slapped, hit, or punched you.” Using a Likert-type scale ranging from 0 (*never*) to 4 (*very frequently*), participants rate how often each abusive behavior occurred. An overall ABI score is calculated by summing all items. Scores may range from 0-120, with higher scores indicating a higher frequency of abuse experienced. Reliability estimates of .70 to .92 have been calculated for the ABI with adult populations who have experienced IPV (Shepard & Campbell, 1992). The ABI has good criterion-related validity, as it is able to distinguish between groups. The ABI demonstrated good criterion-related validity in adults, as it was able to distinguish between groups of abusers and non-abusers across both men and women (Shepard & Campbell, 1992). For this study, which used the total score, the Cronbach’s alpha was .92.

Procedure

After obtaining IRB approval, a digital announcement of the study, including a hypertext link to access the website where the survey was located, was sent to a variety of Instagram sites, and other Internet resources, including the author’s Instagram and Facebook account for narcissistic abuse survivors. The study link and advertisement also were shared via an e-mail blast to several thousand subscribers of a database that

prompts people to sign up if they are interested in recovering from narcissistic abuse. Surveys generally took approximately 45-50 minutes to complete online, though some participants finished more quickly/slowly than others. Several participants made contact with the principal investigator by phone, through email or social media direct message to ask questions about the survey prior to completing it. Participants who completed the survey online received a printable page of community resources, as well as research team contact information and an invitation to contact a research team member to debrief after completing or exiting the survey. The study link was open between July 1, 2020, and August 5, 2020.

When potential participants used the hypertext link to access the survey web site, they were presented with an informed consent page. After reading this page, participants who clicked “yes” and then clicked the Continue button provided their consent to participate. Data integrity was ensured by: (a) instructing participants to only complete the survey once; (b) using “cookies” to identify multiple submissions of data from the same computer; and (c) using of a secure and firewall-protected server to protect the confidentiality and integrity of the data (Schmidt, 1997).

Women with a variety of demographic backgrounds were encouraged to take the survey. In order to assist study participants in the self-identification process, a screening tool from the Institute for Relational Harm Reduction, the Aftermath Trauma Checklist, was utilized. Each of the six items was a question that the participant answered with a five-point Likert-type scale ranging from 0 (*Definitely no*) to 5 (*Definitely yes*). The questions were: “Do you have symptoms of depression, anxiety or even what you suspect is Obsessive Compulsive disorder that is a result of this relationship?”, “Did

you experience gaslighting (him lying or otherwise denying your experiences with him) to extreme that it made you question what you thought you knew about yourself, others, and the world and/or made you wonder if you were delusional?”, “Did you experience deep and unusual bonding with unmanageable craving even when you knew he was probably disordered?”, “Did the relationship and its dynamics feel different than any other of the more ‘normal’ relationships you have been in?”, “Did the relationship produce severe, unrelenting and debilitating cognitive dissonance often referred to as ping-pong brain — jumping back and forth between ‘he’s good/he’s bad, I love him/I loathe him’?”, “Did this emotional injury feel like it impacted as deeply as the spiritual level, what some call ‘soul damage’?” Each of these questions, according to the Institute for Relational Harm Reduction, is indicative of having experienced narcissistic abuse. Women had to positively endorse a minimum of three of the six questions to be included in the final dataset (see Table 2).

A total of 3,070 surveys were completed. SPSS 22.0 was used to analyze the data. Data were screened for missing data and outliers. Of the total sample, 1,063 surveys were removed because they were incomplete, five additional surveys were removed because the respondents did not identify as female, and an additional seven surveys were removed because the respondents did not endorse three of the six narcissistic abuse self-identification questions, leaving a sample size of 1,995.

CHAPTER III

RESULTS

Data Screening

The data were examined to assure that statistical test assumptions of normality, multicollinearity, and homoscedasticity were met. The normal distribution of criterion variables was determined by: (a) the roughly normal distribution of errors observed in the P-Plots, (b) the normal curves for each variable. Examination of scatterplots showed no significant violation of linearity. The homoscedasticity assumption was not violated, as determined by observing: (a) an equal spread of errors above and below the regression line, (b) the model residual scatterplots, (c) the values for the Durbin Watson test, which fell between 1.5 and 2.5, and (d) the values for Cook's Distance of each variable, which were less than 1, signifying no severe or influential outliers. Skewness and kurtosis values were assessed each of the main continuous variables (the EQ, CTI, ABI and the ACE), and all values were less than 2.0 (See Table 3). In sum, all statistical assumptions were satisfied. Then the data were examined to see if the demographic characteristics of race, age, and educational attainment correlated with outcome variables in order to identify and incorporate covariates prior to statistical analyses. No covariates were identified. Linearity was examined specific to each statistical analysis conducted. Key findings include: 1) women scored four times higher than normative statistics for the presence of early-life trauma; 2) almost three-fourths (73.3%) of participants met the clinical criteria needed to diagnose C-PTSD, yet only 4.2% had been diagnosed with the disorder; 3) the presence of early-life trauma predicted greater intensity and severity of C-PTSD-related symptoms; 4) slightly more than half of

participants reported above average empathy, with 12.6% scoring as super empathizers (the highest category); 5) elevated empathy predicted greater intensity and severity of C-PTSD-related symptoms, though the significance was low; 6) the presence of narcissistic abuse predicted greater intensity and severity of C-PTSD-related symptoms when controlling for early-life trauma; and 7) the presence of altruistic and self-directed personality traits predicted greater intensity and severity of C-PTSD-related symptoms when controlling for early-life trauma.

Hypothesis 1

The first hypothesis was that women who identified as survivors of narcissistic abuse would show significant elevations when compared to normative data on the personality characteristics of Honesty-Humility (H), Agreeableness (A), and Conscientiousness (C). The norm group was 1,126 college students ($n=691$, 61% female) (Ashton & Lee, 2009).

T-tests were run to ascertain differences between the survey respondents and the norm group. Assumptions for the tests were examined; there was a violation of normality for each subscale as confirmed by significant Shapiro-Wilk tests. As the *t*-test is widely documented to be robust against violations of normality, the determination was made to continue. As summary tests were conducted, equal variances were not assumed. All of the sample participant means were significantly different from the normative group means (see Table 4). Women who identified as survivors of narcissistic abuse showed significant elevations when compared to normative data on the personality characteristics of Honesty-Humility, Agreeableness and Conscientiousness. Therefore, the hypothesis was supported.

Although it was not part of the hypothesis, a supplemental analysis showed that women who identified as survivors of narcissistic abuse also showed significant elevations when compared to normative data on two of the three remaining HEXACO subscales, Emotionality and Openness to Experience. The supplemental analysis of subscale findings was also significant in that women who identified as survivors of narcissistic abuse were significantly less likely to show traits of Extraversion (see Table 5).

Hypothesis 2

Hypothesis 2 was that women who identified as survivors of narcissistic abuse would show higher empathy as compared to normative data. The norm group was comprised of 126 females from the general population with a mean age of 39.5 ($SD = 12.8$) (Baron-Cohen & Wheelwright, 2004).

A t -test was conducted to compare the study participant means against normative group means. Assumptions for the t -test were verified; the scores for the survey participants violated the assumption of normality as confirmed by a significant Shapiro-Wilk test. However, as indicated for hypothesis 1, the t -test is known to be robust against errors of normality, so the decision was made to continue. As summary data were used, equal variances could not be assumed. The mean empathy score of women who reported surviving abuse by a male partner with pathological narcissism was 52.2 with a standard deviation of 9.96, above the normative data (all female) mean of 47.2. The difference in means was significant, $t(140.5) = 5.34, p < .0005, 95\% \text{ CI } 3.2 - 6.8$. The hypothesis was supported.

In a supplemental analysis, participants ($n=1995$) were also classified as Very High empathizers (EQ scores 64 and up) 12.6% ($n=252$), Above Average empathizers (EQ scores 52-63) 42.6% ($n=849$), Average empathizers (EQ scores 33-52) 41.8% ($n=833$), and Low empathizers (EQ scores 1- 32) 3.1% ($n=61$).

Research Question 3

Research Question Three sought the average early-life trauma score of women who have survived abuse by a male partner with pathological narcissism as compared to normative data, which consisted of 239 undergraduates ($n=182$, 77% female) with a mean age of 20 years (Karatekin, 2016).

A t -test was conducted to compare the study participant means against normative group means. Assumptions for the t -test were verified; the scores for the survey participants violated the assumption of normality as confirmed by a significant Shapiro-Wilk test. However, as indicated for hypothesis 1 and 2, the t -test is known to be robust against errors of normality, so the decision was made to continue. As summary data were used, equal variances could not be assumed. Women who identified as survivors of narcissistic abuse had an Adverse Childhood Experiences (ACEs) score ($M=3.9$) that was significantly higher than the norm group ($M=1.1$) $t(df=408.98) = 25.22$ $p < .001$, 95% CI 2.5, 3.1).

Hypothesis 3

The hypothesis was that higher empathy scores would predict greater severity of abuse and more symptoms of complex trauma in women who identify as survivors of narcissistic abuse, while controlling for early-life trauma. Prior to the analysis, assessment of assumptions was conducted. There was linearity as assessed by partial

regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 1.87 (values should typically be between 1.5-2.5). There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. There was no evidence of multicollinearity as assessed by tolerance values. There were no leverage values greater than 0.2. The assumption of normality was met, as assessed by a Q-Q Plot.

A hierarchical multiple regression was run to determine if the addition of empathy (EQ) and complex trauma (CTI) improved the prediction of abuse (ABI) over and above the early-life trauma (ACE) score. The first step (ACE score) was significant, $R^2 = .03$, $F(1, 1740) = 50.76$, $p < .0005$. The addition of empathy and the CTI score to the prediction of abuse in the second step led to a statistically significant increase in R^2 (R^2 change = .103, $F(2, 1738) = 87.49$, $p < .0005$).

A simple linear regression was conducted to examine how well empathy predicted the CTI severity. The assumptions as detailed above were examined and were met (with a Durbin-Watson of 2.0. The model (empathy as a predictor and CTI severity as the dependent variable) was significant; however, the R^2 was very small, $F(1, 1841) = 8.17$, $p = .004$, $R^2 = .004$.

Hypothesis 3 was partially supported. Early-life trauma did predict abuse and more symptoms of complex trauma in this sample. Empathy also predicted abuse and more symptoms of complex trauma in this sample, but the practical significance was very small.

Research Question 4

This research question asked if women who identified as survivors of narcissistic abuse would report clinically significant symptoms of complex trauma. The CTI is a new measure that is in the final stages of development by researchers Kaminski, Litvin and Pereira in the Department of Psychology at the University of North Texas. Soon-to-be published cutoff scores were obtained directly from the researchers for the purposes of interpreting the CTI results for this study (P. Kaminski, personal communication, Oct. 10, 2020).

Cutoff scores depend on the priority of the test, sensitivity or specificity. Sensitivity describes the ability to detect “true” diagnostic cases, for example, when screening individuals for a trauma disorder during a clinical intake. Specificity refers to the ability to distinguish between a true criterion diagnosis and other conditions, such as between PTSD and depression. A test user may want to prioritize the specificity of the CTI when screening potential participants for a study that will require extensive resources. A priority of sensitivity was selected for this study because it is important to learn how many women who identify as survivors of narcissistic abuse may have clinically significant and/or diagnosable symptoms of CPTSD, which closely align with the symptoms of Narcissistic Abuse Syndrome, an unofficial diagnosis but one that is being discussed widely in clinical circles.

In order to reach the threshold as having CPTSD as scored by the CTI, study participants must meet or exceed the cutoff scores for both PTSD (1.72) and Disturbances in Self-Organization (DSO) (2.31). Of the total sample, 88.2% ($n=1,760$) endorsed symptoms at or above the cutoff score for PTSD, and 75.5% ($n=1,506$) reported symptoms at or above the cutoff score for DSO. A crosstab analysis was run to

determine who met or exceeded the cutoff scores for both PTSD and DSO, and therefore would likely qualify for a diagnosis of CPTSD. Of the total sample, 73.3% ($n=1,462$) met the criteria for CPTSD.

Hypothesis 4

Hypothesis 4 was that personality, empathy and the presence of narcissistic abuse would all predict complex trauma in a sample of women who identified as survivors of narcissistic abuse, when controlling for early-life trauma.

A hierarchical multiple regression was run to predict CTI severity from the subscales of the HEXACO (Honesty-Humility, Emotionality, Extraversion, Agreeableness, Conscientiousness and Openness), the EQ score, and the ABI score, while controlling for the ACE score. The ACE score was the sole predictor used in Step 1, with the remaining predictors added in Step 2. Prior to the analysis, an examination of assumptions was conducted. There was linearity as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 2.0. There was no evidence of multicollinearity, as assessed by tolerance values greater than 0.1. There were no leverage values greater than 0.2. The assumption of normality was met, as assessed by a Q-Q Plot.

The first step (ACE score) was significant, $R^2 = .038$, $F(1, 1740) = 68.54$, $p < .0005$. The addition of the remaining predictors in the second step led to a statistically significant increase in R^2 (R^2 change = .22, $F(9, 1732) = 66.65$, $p < .0005$).

Seven of the 9 predictors (emotionality, extraversion, agreeableness, openness to experience, EQ, ABI, and ACE score) were statistically significant ($p < .0005$), as

shown in Table 5. Emotionality, openness, the EQ, the ACE and the ABI were positively related to the CTI scores. Higher scores on emotionality, openness, empathy, early-life trauma, and abuse history all predicted greater complex trauma scores. Extraversion and agreeableness were negatively related with the CTI score, such that lower scores on extraversion and agreeableness predicted higher CTI scores. Honesty-Humility and Conscientiousness were not related to CTI scores. Thus, the hypothesis was mostly supported (Table 6).

Research Question 5

The fifth research question was how does early-life trauma relate to personality characteristics and length of time in relationship with a man with pathological narcissism?

The majority of those who indicated the length of their relationship ($n=1752$) had spent between 3 to 10 years with the narcissist (40%).

All respondents had an ACE score; 72.4% had a score between 0 to 5, 27.6% had a score of 6 to 10. Given that length of time in the relationship was an ordinal variable, Somers' d (a nonparametric procedure) was conducted to ascertain any association between the length of time in the relationship and the ACE score. There was no relationship between the ACE score and time in the relationship ($d=.03$, $p=.24$). (Table 7.)

CHAPTER IV

DISCUSSION

This study assessed whether early-life trauma, as well as elevations or deficits in certain personality traits, was related to a woman's romantic involvement with a man with pathological narcissism and whether or not she experienced symptoms of complex trauma after the relationship. This was important to understand because of the significant clinical implications surrounding this group of largely misunderstood but highly vulnerable victims. In a broader sense, this study revealed more about the kind and frequency of abuses experienced by women, their specific mental health symptoms during and after the relationship, and the kinds of diagnoses they received. This information may contribute to what is empirically known about narcissistic abuse survivors and help clinicians design more targeted interventions. This chapter includes a thorough discussion of study results and is organized by (1) an assessment of results for each research question and hypothesis; (2) implications of study findings; and (3) study strengths and limitations.

The Role of Personality

The first research question focused on the assessment of the personality characteristics of women who have survived abuse by a male partner with pathological narcissism as compared to normative data. Previous researchers and clinicians (Brown and Young, 2018; Northrup, 2018; Orloff, 2017) have argued that survivors of narcissistic abuse are at risk due to of a unique cluster of elevated personality characteristics that not only makes them sought-after targets by men with pathological narcissism, but also impairs their ability to detect warning signs and easily disengage

from this kind of abusive relationship. It was hypothesized that the women in our sample would show significant elevations compared to normative data on the personality characteristics of Honesty-Humility (H), Agreeableness (A), and Conscientiousness (C). These three personality factors were chosen for analysis because they align with the characteristics identified in Brown's (2009) super traits theory and correspond with clinical observations about this population. The HEXACO model, versus the more traditional Five-Factor Model of Personality, also known as the "Big Five" factors of personality (Costa & McCrae, 1992), was selected for its addition of the honesty-humility factor, a component of moral character that reflects how much or how little someone places their own interests above others (Ashton & Lee, 2001, 2007). Results showed that women who identified as survivors of narcissistic abuse display significant elevations when compared to normative data of the three hypothesized personality characteristics. A supplemental analysis showed that survey participants also scored high in Emotionality (E) and Openness to Experience (O), but slightly below average in eXtraversion (X).

Elevations in honesty-humility and agreeableness create an "altruistic tendency," while low scores result in an "antagonistic tendency" (Ashton & Lee, 2012, p. 26). The honesty-humility factor (the tendency toward active cooperation) consists of Sincerity, Fairness, Greed Avoidance and Modesty sub-dimensions. It includes traits such as sincere, honest, loyal, modest/unassuming, fair-minded and as opposed to versus sly, deceitful, greedy, pretentious, hypocritical, boastful, pompous, conceited and self-centered. The agreeableness factor (the tendency toward reactive cooperation, i.e., non-retaliation) consists of Forgiveness, Gentleness, Flexibility and Patience sub-

dimensions. This factor includes characteristics such as patient, tolerant, peaceful, mild, agreeable, lenient, gentle and forgiving versus ill-tempered, quarrelsome, stubborn, temperamental, headstrong and blunt.

Current study findings may broaden the understanding of personality trait theory for survivors of narcissistic abuse. This study examined honesty-humility in conjunction with agreeableness and conscientiousness, offering more nuanced results. For example, an elevated honesty-humility score is likely to compel someone to cooperate even when they could get away with being exploitative. Furthermore, high agreeableness could make an individual more likely to cooperate even when someone is not cooperating with her. Thus, a pathologically narcissistic partner, who is likely to be low in both traits, may be easily able to undermine her cooperation by taking unfair advantage. In its most adaptive form, high agreeableness can be truly valuable — such as when a work supervisor initially appears to be unfair but is not actually trying to inflict harm. An individual high in this trait “will have a tendency to continue (or resume) cooperating ... and therefore won’t miss out on the gains of ongoing future cooperation” (Lee and Ashton, 2012, p. 28). However, the disadvantage of high agreeableness, particularly for a woman with a pathologically narcissistic partner, is that this trait allows her to *continue* cooperating with a person who truly is trying to exploit her.

The conscientiousness factor, meanwhile, consists of Organization, Diligence, Perfectionism and Prudence sub-dimensions. The characteristics of this factor are organized, self-disciplined, hard-working, efficient, careful, thorough, precise and perfectionistic versus sloppy, negligent, reckless, lazy, irresponsible, absent-minded and

messy (Ashton and Lee, 2005; 2007; 2008a; 2008b, 2012). Individuals with elevations in conscientiousness tend to perform better in school and on the job and are less likely to have substance abuse problems (Lee and Ashton, 2012). In its most basic form, individuals high in conscientiousness feel and demonstrate an awareness of how their own behavior impacts others. They may feel a sense of duty toward others and try hard not to offend or hurt anyone. This trait is also associated with goal-oriented behavior, which can often result in significant life accomplishments, such as success in work, school and other endeavors. For women who identify as narcissistic abuse survivors, this trait may cause her to be more willing to persevere through difficult circumstances, such as a relationship that started out loving but turned cruel and confusing. Because people high in conscientiousness are willing to work hard for what they desire, she may devote considerable energy towards saving her relationship, thus exposing herself to greater trauma, and the risk of developing C-PTSD.

The emotionality factor consists of Fearfulness, Dependence and Sentimentality. This factor includes characteristics such as emotional, oversensitive, sentimental, fearful, anxious, nervous, vulnerable and clingy versus tough, fearless, unemotional, independent, self-assured, unfeeling and insensitive. The emotionality factor is similar to the neuroticism factor in the Five Factor Model and plays a significant role in how individuals experience negative emotions in response to stress. Because they tend to have more negative emotions, people high in this trait often possess a depth that can help them find empathy and understanding for other people's struggles. This may cause a woman in a relationship with a man with pathological narcissism to overlook red flags early in the relationship and excuse abusive behavior later on. Elevations in

emotionality may also heighten a woman's own self-criticism, which might cause her to internalize her partner's abuse at the same time she is more forgiving of his shortcomings.

The openness to experience factor consists of Aesthetic Appreciation, Inquisitiveness, Creativity and Unconventionality sub-dimensions. This factor includes characteristics such as intellectual, creative, unconventional, imaginative, innovative, complex, deep, inquisitive and philosophical versus shallow, simple, unimaginative, conventional and closed-minded. Individuals high in openness are generally have a curious, non-suspicious, and unguarded approach to people, situations and ideas that are new or different. Additionally, they tend to be flexible and thrive with change. Therefore, the women in this study may be more likely to ignore red flags, instead seeing some of their partners' more outrageous and unconventional behaviors as interesting and exciting.

The Extraversion factor consists of Social Self-Esteem, Social Boldness, Sociability and Liveliness sub-dimensions. This factor includes characteristics such as lively, extraverted, sociable, talkative, cheerful, and active versus shy, passive, withdrawn, introverted, quiet, and reserved (Ashton and Lee, 2007; 2009a; Lee and Ashton, 2004; 2018). In her 2007 work, Brown relied on elevated novelty-seeking and reward dependence scores (measured by the TCI) to make the assertion that survivors of narcissistic abuse are highly extraverted, as both traits are positively associated with the extraversion categories of the Five Factor Form and the HEXACO. In the present study, however, women scored moderately low in extraversion, meaning they were more likely to show a preference for subdued and solitary experiences. Because they are

unlikely to enjoy small talk and superficiality, the intensity of the early stages of a relationship with a man with pathological narcissism may feel deeper and more meaningful to a woman who is more introverted. Her high attunement to others around her, however, may cause her to try harder to understand the confusing and painful behavior of her narcissistic partner.

The Role of Empathy

The second research question aimed to determine whether the study group had significantly higher empathy as compared to normative data. It was hypothesized and shown that women who identify as survivors of narcissistic abuse would, in fact, showed higher empathy as compared to normative data. The mean Empathy Quotient (EQ) score of women who reported surviving abuse by a male partner with pathological narcissism was 52.2, above the normative data (all female) mean of 47.2. The average score for women is about 47, and average score for men is about 42 (Baron-Cohen and Wheelwright, 2004). Additionally, the third hypothesis predicted that higher empathy scores would predict greater severity of abuse and more symptoms of complex trauma in women who identify as survivors of narcissistic abuse, while controlling for early early-life trauma.

As expected, early-life trauma predicted both the level of abuse in the relationship, as well as more symptoms of complex trauma. Empathy also predicted more symptoms of complex trauma; however, the association was very low. One possible interpretation is that the more empathetic a person is, the more significantly she experiences trauma. In other words, the more she is impacted by it. Another possibility is that more empathy could, indeed, “trap” her in the relationship and, therefore, lead

her to experience more trauma (McGregor & McGregor, 2013). However, the slight practical significance found in this large data set may not translate to clinical realities.

Even though it captures components of the trait, the HEXACO is not a pure measure of empathy. Therefore, the EQ was administered in order to zero in on the construct of empathy. Current study findings support the validity of singling out empathy when examining the narcissistic abuse experience. Empathy is perhaps the most self-identified trait among survivors (Brown and Young, 2018; Northrup, 2018), which has given rise to a surge of social media groups, online discussion groups and self-publishing titles focusing on narcissistic abuse survivors who identify as “empaths.” As reported, study participants scored well above the mean group in empathy. However, only 12.6% ($n = 252$) of the study group scored as a Very High or “super” empathizer and 42.6 % ($n = 849$) were Above Average empathizers. While slightly more than half of participants had elevated empathy scores, nearly half did not. Indeed, 41.8% ($n = 833$) had average empathy scores, and 3.1% ($n = 61$) had low empathy. So, while many women who identified as survivors of narcissistic abuse showed elevated empathy that predicted complex trauma, only slightly more than one in 10 could arguably be considered a super empathizer, or an “empath.” Therefore, more study is needed to determine whether empathy is a significant factor in a woman’s vulnerability to narcissistic abuse, and to what degree she is psychologically harmed by the experience. Not only was the association between C-PTSD and empathy low in this study, there is no measurable definition of what constitutes an “empath” to make completely valid assertions. Indeed, only 12.6% of women in this study scored in the highest category of empathy, despite the fact that a prominent narrative among this

survivor population is their status as “empaths” (Brown and Young, 2018).

The Role of Early-Life Trauma

The third research question aimed to determine whether the study group had significantly higher early-life trauma when compared to normative data. Women in this study had an ACEs score ($M = 3.9$), almost four times that of the norm group ($M = 1.1$), strongly suggesting the relationship of early-life trauma to their adult involvement with a man with pathological narcissism. These findings are consistent with numerous studies that link a woman’s adverse childhood experiences to the increased likelihood of intimate partner violence in adulthood (Mair, Cunradi & Todd, 2013).

Study findings showed that early-life trauma was the most consistent and strongest predictor of complex trauma of all of the variables investigated, contradicting Brown and Young’s (2018) widely published assertion that an “overwhelming majority” of the 600 narcissistic abuse survivors they surveyed in 2014 did not experience early-life trauma as measured by the ACEs. Even though Brown did not publish statistics to support this claim, it is discussed here due to the overall significance of her work in the field, which includes the nation’s first and only clinician training program for therapists on how to effectively treat narcissistic abuse.

Individuals with attachment trauma are often unaware that their early-life trauma, and not present stress, is why they often live in a persistent state of hyperarousal (van der Kolk, 2015). This kind of ongoing trauma response can interfere with the ability to make good decisions, such as when to leave an abusive situation (van der Kolk, 2015). It may also contribute to her “betrayal blindness,” a tendency among early trauma survivors to primarily focus (even subconsciously) on his “good” traits

rather than face what is actually happening (Freeman, 2017; van der Kolk, 1989; van der Kolk, 2015).

To that end, research question five sought to determine whether a high ACE score would correlate to the length of time a woman would spend in a relationship with a narcissistic partner. In other words, would being betrayed by one's caregivers during childhood lead to dysfunctional relating in adulthood, such as taking responsibility for the emotional well-being of others, fear of rejection and abandonment (Louis de Cannonville, 2018), trap a woman in her abusive relationship longer? Analysis showed there was no significant correlation between participants' experiences of early-life trauma and the length of time spent in relationship with narcissistic partners. This research question may have produced a significant result had nominal, rather than ordinal, data been collected.

High Rates of C-PTSD

The fourth research question sought to investigate whether women who identify as survivors of narcissistic abuse experienced clinically significant complex trauma symptoms. Present study results found that of the total sample, 73.3% ($n=1,462$) met the CTI threshold for C-PTSD and could be expected to fit diagnostic criteria. Additionally, 88.2% ($n=1,760$) endorsed symptoms at or above the cutoff score for PTSD, and 75.5% ($n=1,506$) reported symptoms at or above the cutoff score for Disturbances in Self-Organization (DSO).

Even though three-fourths of study participants met the criterion for PTSD and C-PTSD, very few reported that they had been officially diagnosed with either. PTSD was the most common diagnosis among study participants, yet only 13.8% ($n=226$)

indicated that they had been professionally diagnosed with the disorder. And though three-fourths of all study participants met CTI threshold for C-PTSD, only 4.1 % ($n=82$) indicated they have been diagnosed with the disorder.

This finding is significant because it suggests the serious psychological impact of narcissistic abuse, even when controlling for early-life trauma (which will be explained next). It also suggests that many mental health practitioners may not understand the patterns and individual features of narcissistic abuse, which would allow them to more accurately investigate and identify a woman's presenting symptoms.

Personality, Empathy and Abuse in the Prediction of C-PTSD

The fourth hypothesis was that personality, empathy, and the level of abuse experienced in the relationship would all predict the presence of complex trauma symptoms when controlling for early-life trauma. As noted above, early-life trauma predicted complex trauma in the study sample. When controlling for early-life trauma, six of the 9 remaining predictors were statistically significant. The personality traits of emotionality, eXtraversion, agreeableness and openness to experience, empathy, and the presence of abuse, all predicted greater complex trauma scores. Extraversion and agreeableness were negatively related with CTI scores, such that lower scores on these two facets predicted higher CTI scores. Honesty-humility and conscientiousness, despite being significantly elevated in the sample when compared to normative samples, did not predict complex trauma. These findings suggest that early-life trauma, certain personality traits and the level of narcissistic abuse a woman experiences in her relationship may each contribute to the intensity and severity of participants' complex trauma symptoms.

This study builds on a large existing body of research and clinical observation that children who grow up in homes where there is no consistent safety, comfort or protection have difficulty developing healthy, supportive relationships as adults, including abusive relationships (Beeghly & Cicchetti, 1996; Bowlby, 1988; Cook et. al, 2003). Given the high mean ACE score reported in this study group, it is likely that significant emotional and physical abuse occurred in their childhoods. Therefore, the link between early-life trauma and C-PTSD in this sample is not surprising, nor is the link between early-life trauma and the presence of narcissistic abuse.

How elevations in certain personality constructs may be associated with C-PTSD is less clear and warrants further study. Even so, this finding adds a deeper level of understanding to the assumptions discussed in the first research question and suggests that personality traits should be discussed not only in the context of what makes a woman vulnerable to relationships with men with pathological narcissism, but also how those traits can aid in her recovery. Personality factors are an important predictor the ability to develop positive changes and outlook following trauma, according to Tedeschi & Calhoun's (2004) model of Post-Traumatic Growth (PTG). Specifically, researchers have found personality elevations in extraversion, openness to experience, agreeableness and conscientiousness have been found to support PTG.

In the present study, women scored moderately low in extraversion. The negative association of extraversion to C-PTSD supports existing research that introversion creates an increased risk of PTSD (Jakšić, 2012; Tehrani, 2016) and a barrier to PTC, perhaps because her introversion will make her less likely to seek out a social support system. Similarly, agreeableness was negatively related to C-PTSD.

Since most women in this study scored high in agreeableness, this may further support an idea posed earlier in this paper that high agreeableness could make a woman more vulnerable to a pathologically narcissistic partner who is willing to undermine her cooperation by taking unfair advantage. However, elevations in agreeableness may also offer a significant pathway toward PTG (Young et al., 2018).

The personality trait of high emotionality (expressed as being emotional, oversensitive, sentimental, fearful, anxious and nervous) also predicted C-PTSD in this study. Jakšić (2012) found that emotionality, similar to the trait of neuroticism, is positively related to PTSD. This study group showed only a slight elevation in this category, so its overall significance is not clear. Openness to experience also predicted C-PTSD in this study. This seems to support previous research that found openness was positively associated with reports of greater stress exposure in early childhood. However, openness was also linked to resilience, a factor in PTG (Oshio et. al, 2018).

To this author's knowledge, there is no existing research that explores the connection between empathy and C-PTSD, and there have only been a few studies to examine empathetic responding with adults with PTSD. Previous research does not support a strong association between trauma and empathy, let alone elevated empathy. Nietlisbach et al. (2010), for example, found that, compared to healthy controls, participants with a history of PTSD reported significantly lower levels of empathetic response as measured by the Interpersonal Reactivity Index (IRI) (Davis 1980, 1983) in a highly mixed sample including those who had experienced traumas ranging from sexual assault to natural disaster. A subsequent study, Parlar et al. (2014) found that a small group of women (n=29) with early-life trauma and PTSD reported impaired

empathetic functioning, including less feelings of care and concern in response to other's emotional experiences, as assessed by the empathic concern subscale on the IRI. More research is needed to understand why the current study population, which scored high in empathy as assessed by the EQ when compared to a normative sample, may veer from previous research findings.

These findings help provide a beginning overview of the role of personality traits in the vulnerability, resilience and PTG associated with C-PTSD. More research, particularly in the area of sub-domains, may help in further uncovering ways to build new strategies for prevention, identification and reduction of risks among this unique trauma population.

Strengths and Limitations

A major strength of this dissertation study is the participant sample of nearly 2,000 adult women who self-identified as having experiences of narcissistic abuse. Larger samples more closely approximate the population (therefore increasing external validity), produce more accurate mean values, identify outliers that could skew the data in a smaller sample, provide a smaller margin of error, and form a better picture for analysis. The current study sample is unique within narcissistic abuse literature due to its size and diversity in certain categories, and therefore may allow for increased generalizability of results because a broader range of narcissistic abuse experiences are represented. However, the study sample was predominantly White, which was a clear limitation; results should not be generalized to women of color.

The present study tried to capture diverse narcissistic abuse experiences that may be more generalizable to the study population. Strengths in measurement include

the way in which personality traits, empathy, presence of abuse in the relationship, early-life trauma and the presence of complex trauma were measured. The HEXACO provided a validated, consistent measure of personality traits, offering a broadened conceptualization of the elevated personality traits found in women who identify as narcissistic abuse survivors. Previous research on the personality traits in this population has relied on the “blending” of various trait measures (primarily the TCI and the Five Factor Form) to form broad conclusions that have been published in the popular press without statistical evidence or peer oversight. The EQ measures both affective and cognitive empathy, or a combination of the ability to feel an appropriate emotion in response to another's emotion, as well as the ability to understand the others' emotion, offering a more targeted measure of empathy in a population that largely identifies as “empaths.” The ABI measures women’s experiences of physical, sexual, and psychological abuse. Sexual and psychological abuse in the context of narcissistic abuse have been underrepresented in the small amount of literature that includes narcissistic survivors at all (DePrince et al., 2011; Martin et al., 2013). The CTI provided a validated measure of complex trauma that uniquely measures a number of subdomains, as opposed to solely measuring PTSD as a mental health outcome for narcissistic abuse survivors. The ACEs provides a reliable, valid screening of early-life experiences of abuse and neglect, which can cause trauma and chronic stress responses in adulthood. All of these measures (HEXACO, EQ, ACEs, ABI and CTI) demonstrated movement toward a more comprehensive and inclusive view of narcissistic abuse and related mental health outcomes. Similarly, to address the possibility that some women might self-identify as a narcissistic abuse survivor without actually having the

experience, the inclusion of several screening questions in the demographic section helped to ensure confidence in sampling and is a study strength.

A limitation of the present study is the failure to track the geographic location of participants. Even though the study was advertised on social media accounts and marketed to United States-based narcissistic survivor groups, the demographic survey itself did not ask participants to indicate where they live. As a result, it is not known what percentage of study participants live outside the United States.

A limitation of the present study is that it was descriptive and cross-sectional, and all data were collected at one time point. Though predictive relationships were examined and found for each of the five research questions, causal relationships between variables could not be established. In addition, all of the data were self-report. When measuring sensitive topics such as personality traits, feelings of low self-worth, and acts of violence, use of self-report increases the likelihood of social desirability bias (Krumpal, 2013). Future research may want to account and control for social desirability.

Another important limitation in measurement was that many contextual factors related to participants' abuse experiences were not measured (i.e., time passed since last experience of narcissistic abuse, access to resources and/or social support, community response to disclosure, issues related to parenting, etc.). These contextual factors related to women's abuse experiences may influence the kinds and strength of observations that women make. For example, if a woman receives strong community support during or after her experience of narcissistic abuse, she may be less likely to make strong assessments of sense of threat (SOT) and disturbances in relationship (DR), potentially

decreasing her level of C-PTSD symptoms. Future research should consider the influence these contextual factors may have on specific outcome variables such as length of time in relationship, treatment-seeking behaviors, and the presence of complex trauma.

Implications and Future Research

Theory

This study was the first step in establishing an empirical link between personality, empathy, and early-life trauma as factors in a woman's likeliness to identify as someone who has experienced narcissistic abuse. This study also established that certain facets of personality and the presence of narcissistic abuse predicted C-PTSD when controlling for early-life adverse experiences. Future research might include a more thorough examination of the HEXACO model sub-domains, which could offer significantly more clarity on clinical implications.

While early-life trauma appears to be an important factor in whether or not a woman experiences narcissistic abuse, personality trait research seems less clear. Although elevations in certain personality traits seem to exist in this population, it may be more beneficial to consider how these elevations may contribute to her resiliency rather than her vulnerability. A 2018 meta-analysis of personality traits and resilience, for example, found that high openness and agreeableness are associated with strengthened ego-resiliency (Oshio et. al, 2018). To that end, there is a developing area of research about how internal changes and transformation after a traumatic event can eventually lead to positive outcomes, including a changed perception of self, sense of new possibilities in life, a newfound appreciation of life, enhanced spirituality, changed

and improved relationships with others, and increased mindfulness toward the meaning of life and one's place in the world (Janoff-Bulman, 2004; Park & Helgeson, 2006; Tedeschi & Calhoun, 2004). Future research on narcissistic abuse survivors might focus on how their personality traits could best be marialed for this kind of post-traumatic growth.

Practice

The most significant implication for this study finding involves the high presence of C-PTSD in this sample. Even though a large majority of respondents met the criterion for PTSD and C-PTSD, as measured by the CTI, few women in the current study reported that they had been diagnosed with either. This disconnect may validate what many narcissistic abuse survivors have long claimed about their experiences seeking help. A lack of understanding around the language and formulation of narcissistic abuse can lead mental health professionals to pathologize women's experiences of trauma, in turn leading them to associate the problem with the survivor (i.e., that she is codependent) and misdiagnosing her level of trauma (Freyd, 2013). As such, there is strong potential for clinicians to miss the deeper work related to the conflation of early-life trauma and trauma stemming from the adult relationship (Louis de Cannonville, 2012). In such a case, a clinician could further harm a victim by blaming her, failing to provide psychoeducation about narcissistic abuse, and failing to recommend evidence-based trauma treatments to relieve her limbic response symptoms, such as EMDR (Eye Movement Desensitization and Reprocessing). Not doing so could leave the client open to being re-victimized by other narcissists in the future (Louis de Cannonville, 2018). Currently, the number of women needing this level of trauma care

is greater than the number of therapists who can provide it. Therefore, professional clinicians should be encouraged to gain additional training in this area of advanced trauma interventions. Additionally, more training on trauma, personality pathology and treatments such as EMDR, somatic experiencing, and attachment-focused therapies should be taught and emphasized in masters and doctoral-level coursework.

The development of research-based clinical trainings, as well as an introduction to this material in educational programs, would greatly help mental health professionals to recognize the signs of narcissistic abuse and arrive at more accurate assessments and diagnoses. In turn, this would help survivors receive the proper identification, validation and treatment that they need. Additionally, understanding more about this population's unique personality profile, and how it differs from traditional IPV survivors, also may help clinicians to tailor more effective interventions and treatment. Understanding that a survivor of narcissistic abuse is likely to show elevations in certain altruistic personality traits, for example, a therapist could design a treatment plan that acknowledges not only PTG, but also a woman's engrained helping patterns that could leave her vulnerable to future abuse.

Traditional therapeutic skills, such as effective listening, acknowledgement and validation of the individual's experiences, are an important first step to helping a survivor of narcissistic abuse to change negative perceptions of herself and her situation. However, given the likely high level of C-PTSD in this population, even a therapist who can identify and understand narcissistic abuse may not have the skill set required to treat this level of trauma. Future research might examine correlations between specific types of ACEs, the types of abuses experienced while in relationship

with men with pathological narcissism and the severity of C-PTSD in order to more closely target intervention and treatment strategies.

Policy

There is a lack of public health recognition on how others are affected by the pathology of individuals demonstrating a severe personality disorder which hold the features of a lack of conscience and inability to show empathy (Brown, 2009).

Institutions and organizations that aim to provide services to survivors — from mental and physical health organizations to law enforcement and the courts — would likely benefit from policies that increase awareness about narcissistic abuse, as well as how to identify individuals with pathological narcissism and their victims. To that end, ensuring that students in counseling, psychology, social work and nursing programs have significant exposure in their coursework to the characteristics of pathological narcissism is an important first step in training the clinical community to identify and understand narcissistic abuse. Additionally, offering specialized training to professional therapists could help them to recognize the features of narcissistic abuse so that they can provide what might be the most important factor for a woman in beginning her journey of recovery: Validation of her experience. This early acknowledgement, combined with trauma-focused therapeutic skills, could be the difference in surviving narcissistic abuse and not surviving it (Howard, 2019).

Conclusion

The present study provides evidence that narcissistic abuse is a promising avenue

for investigating and addressing an often-misunderstood category of interpersonal violence against women. This research provides a unique contribution to the narcissistic abuse literature by: (a) establishing the strong presence of early-life trauma and C-PTSD among survivors; (b) examining the relationship among specific personality traits, empathy, early-life trauma, present abuse and complex trauma; and (c) doing so with a large, diverse sample of adult narcissistic abuse survivors. The present study demonstrates that narcissistic abuse is, in fact, a theoretically relevant construct, a meaningful area for assessment and research, and an important target for clinical interventions aimed at improving mental health outcomes and promoting resilience among this unique and often misunderstood survivor group.

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Table 1*Participant Demographics*

Characteristic	<i>n</i>	%	M	SD	Min	Max
Hispanic/Latino	146	7.5				
Race						
Alaskan Native/American Indian	15	.8				
Asian	86	4.4				
Biracial or Multiracial	87	4.4				
Black or African American	93	4.7				
Native Hawaiian or Pacific Islander	8	.4				
White or Caucasian	1,683	84.4				
Age	1,983		46.2	10.9	18	80
Educational Attainment						
Less than High School	6	0.3				
Some High School	32	1.6				
High School Diploma	157	7.9				
GED	29	1.5				
Some college (no degree)	455	23.0				
Associate degree	224	11.3				
Bachelor's degree	533	26.7				
Some graduate school	105	5.3				
Master's degree or higher	437	21.9				
Length of most recent relationship with narcissist						
Less than six months	51	2.6				
Six months to 1 year	73	3.7				
1 to 3 years	343	17.2				
3 to 5 years	295	14.8				
5 to 10 years	405	20.3				
15 to 20 years	175	8.8				
More than 20 years	410	20.6				
Profession						
Aviation and Transportation	261	13.1				
Animal-Related Careers	12	.6				
Engineering/Environmental Science	21	1.1				
Trades and Labor	19	1				
Homemaker	38	1.9				
Retired	14	.7				

Student	19	1
Arts	76	3.8
Business/Legal/Accounting	515	49.5
Education	253	12.7
Law Enforcement/Military	27	1.4
Media	53	2.7
Caring Professions	320	16
Service Industry	321	16.1
Technology	31	1.6
Where she met him		
Support group	13	.7
Random in Public Space	72	3.6
Pursued or Stalked	10	.5
Reconnected from High School	121	6.1
At School	127	6.4
He was a Service Provider (Handyman, Electrician, Car Salesman, Etc.)	35	1.8
He was her Boss or in a Power Role	12	.6
At Work	342	17.1
In a Bar	142	7.1
Through a Religious Community	68	3.4
Online Dating Sites	345	17.3
Through Family and Friends	478	23.9
At the Gym	26	1.3
Mutual Hobby and Recreation	37	1.9
Social Gatherings	50	2.5
Proximity (Neighbors, etc.)	54	2.7

Table 2*Aftermath Symptom Checklist Screening Items Endorsed*

Items	<i>n</i>	<i>%</i>
<i>Do you have symptoms of depression, anxiety or even what you suspect is Obsessive Compulsive disorder that is a result of this relationship?</i>		
Definitely/Probably Yes	1704	85.4
Definitely/Probably No	141	7.1
Unsure	147	7.4
<i>Did you experience gaslighting (him lying or otherwise denying your experiences with him) to extreme that it made you question what you thought you knew about yourself, others, and the world and/or made you wonder if you were delusional?</i>		
Definitely/Probably Yes	1944	97.5
Definitely/Probably No	29	1.5
Unsure	22	1.1
<i>Did you experience deep and unusual bonding with unmanageable craving even when you knew he was probably disordered?</i>		
Definitely/Probably Yes	1735	87
Definitely/Probably No	118	6
Unsure	142	7.1
<i>Did the relationship and its dynamics feel different than any other of the more 'normal' relationships you have been in?</i>		
Definitely/Probably Yes	1808	90.6
Definitely/Probably No	36	1.9
Unsure	146	7.3
<i>Did the relationship produce severe, unrelenting and debilitating cognitive dissonance often referred to as ping-pong brain — jumping back and forth between 'he's good/he's bad, I love him/I loathe him'?</i>		
Definitely/Probably Yes	1941	97.3
Definitely/Probably No	31	1.6
Unsure	23	1.2
<i>Did this emotional injury feel like it impacted as deeply as the spiritual level, what some call 'soul damage'?</i>		
Definitely/Probably Yes	1898	95.1
Definitely/Probably No	26	1.4
Unsure	71	3.6

Table 3*Descriptive Statistics for Instruments*

Subscale	Mean	SD	Cronbach's α
HEXACO			
Honesty-Humility	3.94	.576	.74
Emotionality	3.63	.552	.68
Extraversion	3.07	.699	.81
Agreeableness	3.36	.619	.76
Conscientiousness	3.74	.561	.74
Openness to Experience	3.76	.639	.78
Empathy (EQ)	52.2	9.96	.83
ABI	77.19	21.47	.93
ACE	3.89	2.44	.72
CTI Severity (scaled)	12.75	4.08	.93

Table 4*Abusive Behavior Inventory (ABI) Items Endorsed*

Items	<i>n</i>	<i>%</i>
<i>Called you a name and/or criticized you.</i>		
Very Frequently/Frequently	1603	80.4
Occasionally	275	13.8
Rarely/Never	109	5.5
<i>Tried to keep you from doing something you wanted to do (e.g., going out with friends, going to meetings).</i>		
Very Frequently/Frequently	1234	61.9
Occasionally	401	20.1
Rarely/Never	351	17.6
<i>Gave you angry stares or looks.</i>		
Very Frequently/Frequently	1502	75.3
Occasionally	308	15.4
Rarely/Never	174	8.7
<i>Prevented you from having money for your own use.</i>		
Very Frequently/Frequently	767	38.5
Occasionally	255	12.8
Rarely/Never	964	48.3
<i>Ended a discussion with you and made the decision himself/herself.</i>		
Very Frequently/Frequently	1632	81.8
Occasionally	239	12
Rarely/Never	115	5.8
<i>Threatened to hit or throw something at you.</i>		
Very Frequently/Frequently	475	23.8
Occasionally	331	16.6
Rarely/Never	1181	59.2
<i>Pushed, grabbed, or shoved you.</i>		
Very Frequently/Frequently	358	18
Occasionally	437	21.9
Rarely/Never	1190	59.6
<i>Put down your family and friends.</i>		
Very Frequently/Frequently	1329	66.6
Occasionally	390	19.5

Rarely/Never	266	13.4
<i>Accused you of paying more attention to someone/something else.</i>		
Very Frequently/Frequently	1262	63.2
Occasionally	362	18.1
Rarely/Never	363	18.2
<i>Put you on an allowance.</i>		
Very Frequently/Frequently	449	22.5
Occasionally	179	9
Rarely/Never	1357	68
<i>Used your children to threaten you (e.g., told you that you would lose custody, said he/she would leave town with the children).</i>		
Very Frequently/Frequently	584	29.3
Occasionally	231	11.6
Rarely/Never	1144	57.3
<i>Became very upset with you because dinner / housework, was not done when s/he wanted it or the way s/he thought it should be.</i>		
Very Frequently/Frequently	775	38.8
Occasionally	403	20.2
Rarely/Never	801	40.1
<i>Said things to scare you (e.g., told you something "bad" would happen, threatened to commit suicide).</i>		
Very Frequently/Frequently	799	40.1
Occasionally	444	22.3
Rarely/Never	743	37.2
<i>Slapped, hit, or punched you.</i>		
Very Frequently/Frequently	183	9.2
Occasionally	254	12.7
Rarely/Never	1549	77.6
<i>Made you do something humiliating or degrading (e.g., beg for forgiveness, ask for permission to use the car or to do something).</i>		
Very Frequently/Frequently	790	39.6
Occasionally	453	22.7
Rarely/Never	742	37.2
<i>Checked up on you (e.g., listened to your phone calls, checked the mileage on your car, called you repeatedly at work).</i>		
Very Frequently/Frequently	908	45.6
Occasionally	393	19.7
Rarely/Never	681	34.1

<i>Drove recklessly when you were in the car.</i>		
Very Frequently/Frequently	679	34
Occasionally	493	24.7
Rarely/Never	807	40.4
<i>Pressured you to have sex in a way you didn't want.</i>		
Very Frequently/Frequently	697	34.9
Occasionally	436	21.9
Rarely/Never	849	42.5
<i>Refused to do housework or child care.</i>		
Very Frequently/Frequently	968	48.5
Occasionally	335	16.8
Rarely/Never	671	33.6
<i>Threatened you with a knife, gun, or other weapon.</i>		
Very Frequently/Frequently	92	4.6
Occasionally	139	7
Rarely/Never	1753	87.9
<i>Spanked you.</i>		
Very Frequently/Frequently	124	6.3
Occasionally	137	6.9
Rarely/Never	1718	86.1
<i>Told you that you were a bad parent.</i>		
Very Frequently/Frequently	551	27.6
Occasionally	370	18.5
Rarely/Never	1047	52.5
<i>Stopped /tried to stop you from going to work/school.</i>		
Very Frequently/Frequently	400	20.1
Occasionally	348	17.4
Rarely/Never	1236	62
<i>Threw, hit, kicked, or smashed something.</i>		
Very Frequently/Frequently	547	27.4
Occasionally	428	21.5
Rarely/Never	1011	50.6
<i>Kicked you.</i>		
Very Frequently/Frequently	81	4.1
Occasionally	107	5.4
Rarely/Never	1792	89.9
<i>Physically forced you to have sex.</i>		

Very Frequently/Frequently	201	10.1
Occasionally	211	10.6
Rarely/Never	1572	78.8
<i>Threw you around.</i>		
Very Frequently/Frequently	172	8.7
Occasionally	249	12.5
Rarely/Never	1557	78
<i>Physically attacked the sexual parts of your body.</i>		
Very Frequently/Frequently	73	3.7
Occasionally	122	6.1
Rarely/Never	1786	89.6
<i>Choked or strangled you.</i>		
Very Frequently/Frequently	108	5.4
Occasionally	179	9
Rarely/Never	1695	85
<i>Used a knife, gun, or other weapon against you.</i>		
Very Frequently/Frequently	36	1
Occasionally	61	3.1
Rarely/Never	1881	94.3

Table 5

Results for HEXACO Subscales,

*T-test of study group against norm group (1,126 college students (n=691, 61% female))
(Ashton & Lee, 2009).*

Subscale	Mean	SD	<i>t</i> (df)	<i>p</i>	CI (95%)	Cronbach's α
Honesty-Humility	3.94	.573	30.29 (2082)	<.005	.67-.76	.742
Emotionality	3.63	.553	11.27 (1919)	<.005	.23 - .32	.686
Extraversion	3.06	.703	-18.30 (2570)	<.001	.08 - .17	.812
Agreeableness	3.36	.614	11.17 (2300)	<.005	.22 - .31	.762
Conscientiousness	3.74	.563	12.30 (2177)	<.005	.23 - .32	.740
Openness to Experience	3.75	.637	10.92 (2243)	<.005	.22 - .32	.780

Table 6*Hierarchical Multiple Regression Coefficients*

Model		Coefficients ^a				
		Unstandardized Coefficients		Standardized Coefficients Beta	t	Sig.
		B	Std. Error			
1	(Constant)	11.484	.181		63.505	.000
	ACE Total Score	.325	.039	.195	8.279	.000
2	(Constant)	6.278	1.198		5.239	.000
	ACE Total Score	.140	.036	.084	3.869	.000
	EQ Total Score	.050	.010	.123	4.909	.000
	Honesty-Humility Score	-.060	.163	-.008	-.368	.713
	Emotionality Score	.940	.164	.127	5.716	.000
	Extraversion Score	-1.597	.135	-.275	-11.813	.000
	Agreeableness Score	-.439	.154	-.066	-2.855	.004
	Conscientiousness Score	-.181	.158	-.025	-1.145	.252
	Openness Score	.734	.140	.115	5.231	.000
	ABI TotalScore	.057	.004	.300	14.145	.000

a. Dependent Variable: CTI_Severity_Scaled

Table 7*Length of Time in Relationship and ACE Score*

Time in Relationship in Years	ACE Score	
	0 to 5 (Percent of Row)	6 to 10 (Percent of Row)
0 to 3	338 (72.4)	129 (27.6)
3 to 10	495 (70.7)	205 (29.3)
10 to 20	129 (73.7)	46 (26.3)
20 or more	300 (73.2)	110 (26.8)

Appendix

Demographic Questionnaire

1. How old are you (in years)?
2. What gender do you identify with?
 - Male
 - Female
 - Transgender Male
 - Transgender Female
 - Gender-queer
 - Other (please tell us here)
 - Prefer not to answer
3. Are you Hispanic, Latino or Spanish origin?
 - Yes
 - No
4. How would you describe yourself?
 - Black or African American
 - White or Caucasian
 - Asian
 - Biracial or Multiracial
 - Alaska Native or American Indian
 - Native Hawaiian or Pacific Islander
5. Have you ever been diagnosed with a mental health disorder?
 - Yes
 - No
6. If yes, what was the diagnosis?
 - Major Depressive Disorder
 - Bipolar Disorder
 - Attention Deficit Hyperactivity Disorder (ADHD)
 - Schizophrenia
 - Post-Traumatic Stress Disorder (PTSD)
 - Complex Trauma
 - Generalized Anxiety Disorder

- Borderline Personality Disorder
 - Substance Use Disorder
 - Other (please specify)
7. Are you currently working with a mental health professional (e.g. therapist, counselor, psychologist, psychiatrist)?
- Yes
 - No
8. Have you ever worked with a mental health professional (e.g. therapist, counselor, psychologist, psychiatrist)?
- Yes
 - No
9. Are you currently taking any medications to manage your mental health symptoms such as depression or anxiety prescribed to you by a doctor?
- Yes
 - No
10. If yes, please specify the type of medication and what it is for. Don't worry if you don't know the exact spelling or if you don't remember the name. Just write what it is for.
11. What is your current employment status? (Pick all that apply)
- Employed part-time (less than 30 hours a week)
 - Employed full-time (40 hours a week)
 - Student
 - Unable to work (receiving benefits)
 - Unemployed, looking for work
 - Unemployed, not looking for work
 - Other please specify
12. What is the highest level of education you have completed?
- Less than High School
 - Some High School
 - High School Diploma
 - GED
 - Some college classes, no degree
 - Associates degree
 - Bachelor's degree
 - Some graduate school
 - Completed Master's program
13. Describe your profession:
14. What is your relationship status?

- In a relationship
- Not in a relationship
- Married
- Divorced
- Separated
- Widowed

If the options above do not accurately describe your relationship status, please share with us your relationship status.

15. Do identify as someone who has been (or is currently in) a romantic/partner relationship with someone you believe has pathological narcissism (i.e. Borderline Personality Disorder, Narcissistic Personality Disorder, Antisocial Personality Disorder, Psychopathy?)
 - Yes
 - No
 - Maybe
16. How did you assess whether your current or former partner has pathological narcissism?
 - They have been diagnosed by a mental health professional
 - I recognize the traits because I have mental health training
 - I recognize the traits because of books and social media articles I have read
 - Someone I trust told me they thought my partner had these traits
 - Other (please describe)
17. How many years were you in (or have you been in) your most recent romantic/partner relationship with someone you believe has pathological narcissism?
 - Six months or less
 - Six months to one year
 - 1 to 3 years
 - 3 to 5 years
 - 5 to 10 years
 - 10 to 15 years
 - 15 to 20 years
 - More than 20 years
18. How many different romantic partners (as an adult) have you had whom you believe had pathological narcissism to the extent that it negatively impacted your relationship?
19. If you have left your relationship, how long have you been out of your most recent relationship with the person you believed to have had pathological narcissism?
20. Do you have symptoms of depression, anxiety or even what you suspect is Obsessive Compulsive disorder that is a result of this relationship?

21. Did you experience gaslighting to extremity that it makes you question what you thought you knew about yourself, others, and the world and/or made you wonder if you were delusional?
22. Did you experience deep and unusual bonding with unmanageable craving even when you knew he was probably disordered?
23. Did the relationship and its dynamics feel different than any other of the more 'normal' relationships you have been in?
24. Did the relationship produce severe, unrelenting and debilitating cognitive dissonance often referred to as ping pong brain or monkey mind jumping back and forth between 'he's good/he's bad, I love him/I loathe him'?
25. Did this emotional injury feel like it impacted as deeply as the spiritual level, what some call 'soul damage'?
26. How/where did you meet your most recent narcissistic partner?
27. How did you hear about this survey?
 - Email
 - Social media (Facebook, Yahoo groups, etc)
 - Friend
 - Other (please specify)