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LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with the
Faculty of Graduate Studies

Clinician's Recommendations in Treating
Victims and Survivors of Narcissistic Abuse

by

Sadaf Shalchian

A Project submitted in partial satisfaction of
the requirements for the degree
Doctor of Marital and Family Therapy

December 2022

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Each person whose signature appears below certifies that this doctoral project in his/her opinion is adequate, in scope and quality, as a doctoral project for the degree Doctor of Marital and Family Therapy.

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I would like to express my deepest gratitude to my parents who raised me with love and care and set a strong foundation for me to have big dreams with confidence and belief in myself. Words cannot describe my gratitude for my mother, her love, and her sacrifices. My mother has lovingly sacrificed her life and comfort so that I can reach my most potential; this degree is a gift to her for overcoming life's obstacles in the name of love for her children. My father's spirit has always been my north star, one that has directed me to be good and do good; I hope I have made him feel loved and proud. This degree is a symbol of my care, love, and empathy for my father. My parents gifted me with a wise and strong younger sister that I get to look up to; her drive, focus, persistence, and hard work has always inspired me. I could not imagine celebrating this accomplishment and it's impact on my future without my sister, I am excited do life alongside her. Thank you all for waiting these long years with such love, motivation, and patience.

My gratitude goes to my extended family; I have been blessed to have their support along the way. I especially want to thank my uncle who supported us wholeheartedly through the most difficult time of our life; without his generosity and open arms, I would not have had the same opportunities. I feel blessed to have family and friends whose love and support through this long endeavor have carried me through.

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difficult journey that seemed never-ending; thank you for your positive feedback when I needed it the most.

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And most importantly, I would like to thank God for directing and teaching me to see the beauty in the ashes. Through the journey, I learned to find internal love and fire to be able to create this purposeful doctoral project from the ashes of suffering.

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This work is dedicated to the body of literature in support of victims and survivors of hidden manipulative mistreatment such as narcissistic abuse. The experience of hidden abuse is valid and menace, regardless of the label of it. I hope for more consistency in awareness and advocacy of narcissistic abuse. This work was done to prove and validate the deceptive, confusing, destabilizing, and harmful experience of narcissistic dynamics in order to raise awareness and importance for further research and resources in support of victims and survivors of narcissistic abuse. Go regain your sense of worth, identity, and reality! You got this! This work was done so that you can build beauty from the already beautiful soul that you are.

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To Creating Beauty from Ashes

Sadaf

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ABBREVIATIONS

MFT	Marriage and Family Therapist
LMFT	Licensed Marriage and Family Therapist
COAMFTE	The Commission on Accreditation for Marriage and Family Therapy
DSM-5	The Diagnostic and Statistical Manual of Mental Disorders (5 th edition)
NPD	Narcissistic Personality Disorder
CE	Continuing Education
APA	American Psychiatric Association
AAMFT	American Association of Marriage and Family Therapy
PTSD	Post-Traumatic Stress Disorder
CPTSD	Complex Post-Traumatic Stress Disorder
CHEA	Council for Higher Education Accreditation
ASPA	Association of Specialized and Professional Accreditors
DARVO	Deny, Attack, and Reverse Victim and Offender
ASUS	Adult Substance Use Survey
BDI	Beck Depression Inventory
ACE	Understanding of Adverse Childhood Experiences
ADHD	Attention deficit hyperactivity disorder
CBT	Cognitive Behavioral Therapy
DBT	Dialectical behavior therapy
CBP	Component Based Psychotherapy
EMDR	Eye Movement Desensitization and Reprocessing

IFS

Internal Family System

TRM

The Trauma Resiliency Model

ABSTRACT OF THE DOCTORAL PROJECT

Clinician's Recommendations in Treating Victims and Survivors of Narcissistic Abuse

by

Sadaf Shalchian

Doctor of Marital and Family Therapy,
Department of Counseling and Family Sciences
Loma Linda University, December 2022
Dr. Lena Lopez Bradley, Chairperson

Although marriage and family therapists are one of the main providers in treating mental and relational health issues, there is not a significant emphasis on the identification, assessment, and treatment of victims and survivors of narcissistic abuse in COAMFTE-accredited Masters level Marriage and Family Therapy programs (COAMFTE, 2017). This needs assessment aimed to identify the knowledge and clinical skills recommended by clinicians who treat victims and survivors of narcissistic abuse to identify some needs, assessments, and treatment practices that can guide LMFTs in treating this population. This needs assessment explored current literature, research, and academic and clinical resources focused on narcissism and narcissistic abuse, followed by interviewing 14 mental health clinicians who self-identified as competent, proficient, or expert in narcissistic abuse recovery.

There is a dearth of empirical research, academic and clinical resources, training and treatment models, and evidence-based programs and modalities focused on victims and survivors of narcissistic abuse. The dearth in awareness and advocacy of this population has led to discrepancies and insufficiencies in developing standardized diagnoses, terminology, clinical training, and treatment.

The results of this needs assessment concluded fundamental therapeutic recommendations in clinician's required knowledge, clinical skills, resources, assessment, and treatment of victims and survivors of narcissistic abuse. The recommendations can be a stepping stone in the development of further empirical research, diagnosis, assessment tools, academic curriculum, evidence-based treatment models, training model and program development.

CHAPTER ONE

EXECUTIVE SUMMARY AND PROJECT PURPOSE

Executive Summary

Interpersonal violence or abuse such as Family and Domestic Violence (DV), elder abuse, rape or sexual assault (SA), adverse childhood experiences (ACEs) is a significant and pervasive public health, human rights, social, and developmental concern (Lewis et al., 2019; Rosenberg et al., 2006; Sumner et al., 2015). The World Health Organization (WHO) defines violence as the intentional use of threat or act of power or physical force against oneself, another person, or against a group or community that can result in physical harm, psychological harm, mal-development, deprivation, or death (Krug et al., 2002).

Exposure to interpersonal violence or abuse can cause immediate physical wounds that can be recognizable but can also result in less apparent long-lasting physical and mental health problems, infectious diseases, reproductive health problems, and chronic and noncommunicable diseases (NCDs) (Krug et al., 2002; Oram et al., 2017). Some common mental health and behavioral disorders caused by interpersonal violence include depression, posttraumatic stress disorder, personality and conduct disorders, anxiety, sleep and eating disorders, substance abuse, and suicide and suicide attempts (Oram et al., 2017).

The National Intimate Partner and Sexual Violence Survey (NISVS) indicated that 41% of women and 26% of men experienced contact sexual violence, physical violence, and/or stalking by an intimate partner (Lemis et al., 2022). Domestic and family

violence includes patterns of abusive behaviors including a wide range of physical, sexual, psychological, emotional (CDC, 2020), economical (Adams et al., 2008), and coercive control and abuse to gain power, control, and authority (WHO, 1970). It was reported for the impact of domestic violence to include injury, physical and mental health issues, trauma symptoms, safety concern, decreased quality of life, decreased productivity, negative emotions, law enforcement involvement, employment issues, and even mortality (Lemis et al., 2022).

Child maltreatment and Adverse Childhood Experiences (ACEs), including family dysfunctions, abuse, and neglect is a considerable social and public health problem in the United States (Merrick et al., 2019). A survey across 25 states showed that 61% of adults have experienced at least one ACE and 16% have experienced 4 or more types of ACEs (Merrick et al., 2019). ACE can cause long-term health impacts, brain development issues, mental illness, substance use, and education and job problems in adolescence and adulthood (CDC, 2020; Brown, et al., 2009).

Finding from the National Intimate Partner & Sexual Violence Survey (NISVS) shows that approximately half of Americans reported experiencing lifetime emotional or psychological abuse (the most common form of domestic violence) by an intimate partner (Black et al. 2011) and 4 in 10 women and 4 in 10 men have experienced at least one form of coercive control by an intimate partner in their lifetime (Breiding, 2014). Psychological abuse can occur in different forms of relationships and settings such as coercive cults, family, workplace, and school settings (Rodríguez-Carballeira et al., 2013). Psychological abuse, or Emotional abuse, is any nonphysical behavior or attitude, often a precursor to physical abuse, that is designed to control, subdue, punish, or isolate

another person through the use of humiliation, fear, verbal assault, dominance, control, isolation, ridicule, or the use of intimate knowledge for degradation (Engel, 2002; Follingstad et al., 2005).

On the other hand, workplace harassment and abuse are globally and nationally frequent (Krieger et al., 2006). One of the common forms of abuse that occurs in the workplace is sexual harassment; about 50% of U.S. women experience sexual harassment at work (Das, 2009), but only a minority report it (Feldblum and Lipnic, 2016). Moreover, Sexual violence, including both penetrative and non-penetrative acts as well as non-contact forms, is a frequent social and public health problem in the US. According to the National Intimate Partner and Sexual Violence Survey (NISVS), 1 in 5 women and nearly 1 in 59 men have experienced an attempted or completed rape by use of force or through alcohol/drug facilitation in their lifetime and an estimated 12.5% of women and 5.8% of men reported sexual coercion in their lifetime (i.e., unwanted sexual penetration after being pressured in a nonphysical way) (Basile et al., 2014).

Abusive behavior or trauma does not always involve tangible violence and does not only happen within family dynamics; interpersonal abuse can occur within different forms of dynamics including but not limited to intimate, parent or caregiver-child, friendship, and professional relationships. The impact of violence is a systemic issue because many forms of violence are interconnected at the individual level, across relationships and communities, and even intergenerationally (Sumner et al., 2015).

Though different categories of violence can have overlapping risk factors or protective factors, distinctions must be made between different forms of abuse such as physical violence/abuse—traditionally, the most researched and detectable form—and

emotional or psychological (Karakurt and Silver, 2003), sexual, spiritual, and financial abuse. For instance, perpetrators of different forms of violence can have certain characteristics, personality disorders, or neuropsychological deficits such as hostile attributional biases, poor impulse control, or lack of empathy that can lead to certain abusive behavior (Sumner et al., 2015). Moreover, typically efforts to comprehend, prevent, and respond to interpersonal violence have been constrained by the way violence has been categorized—usually in terms of the relationship between the abuser and the victim or survivor (eg, peer to peer, parent or caregiver-child, intimate relationships) (Sumner et al., 2015). However, not all forms of abuse in interpersonal relationships have been equally investigated or officially defined, categorized, conceptualized, or empirically researched.

One form of interpersonal abuse that has not been clinically classified or defined is narcissistic abuse. The abundance of professional and popular publications suggests narcissistic abuse to be of communal interest, importance, and worthy of further acknowledgment and research. The professional and popular publications have come to vaguely describe “narcissistic abuse” as any type of abuse that is perpetrated by an individual with a narcissistic personality type within any form of relationship including but not limited to intimate, parent or caregiver-child, peer to peer, or professional relationships (Day et al., 2022; Lance, 2016; Howard, 2019). Narcissistic abuse can be subtle and often worsens over time; the abuse may be coercive control, psychological (or emotional), physical, sexual, spiritual, or financial (Lance, 2016; Howard, 2019). Due to perpetrator’s certain narcissistic personality traits, narcissistic abuse typically involves an abusive cycle of idealizing, devaluing, and discarding the victim in the form of temporary

charm followed by criticism, degradation, emotional withdrawal, accusations, punishment, contempt, coercive force, and/or threats (Gaum and Herring, 2020).

Marriage and Family Therapists (MFTs) are one of the main lines of contact for consumers of mental and relational health services (AAMFT, 2022). Due to their focus on understanding symptoms and diagnoses within interactions, relationships, and environmental and familial systems (AAMFT, 2022), MFTs should have sufficient competence in treating individuals, couples, and families with relational issues such as interpersonal violence. Although in most Marriage and Family Therapy programs some course content is dedicated to addressing family and domestic violence, less attention is given to narcissistic abuse which can be correlated with other types of physical and psychological abuse. There is not a significant emphasis in the identification, assessment, and treatment of victims and survivors of narcissistic abuse in COAMFTE accredited Masters level Marriage and Family Therapy programs (COAMFTE, 2017). Therefore, it is important to better understand the knowledge and clinical skills that licensed marriage and family therapists (LMFTs) may need in order to treat victims and survivors of narcissistic abuse. Identifying common knowledge and clinical skills of competent, proficient, and expert level clinicians can help in developing appropriate services, resources, and academic curriculum and training for clinicians who treat this population. This needs assessment aimed to identify the knowledge and clinical skills recommended by clinicians who treat victims and survivors of narcissistic abuse to identify some needs, assessments, and treatment practices that can guide Licensed Marriage and Family Therapists in treating this population. This needs assessment explored current literature, research, and academic and clinical resources focused on narcissism and narcissistic

abuse followed by interviewing 14 self-identified competent, proficient, or expert level clinicians who treat victims and survivors of narcissistic abuse. The virtual and recorded 60-90-minute interviews were transcribed verbatim. Qualitative thematic analysis was used to identify common themes regarding clinicians' recommendations in the needs, assessment, and treatment of victims and survivors of narcissistic abuse. The needs assessment highlighted the gaps in the needs, assessment, and treatment of victims and survivors of narcissistic abuse in order to develop recommendations addressing the needs.

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; APA, 2013) is the most widely accepted nomenclature used by clinicians and researchers to classify mental disorders. According to the DSM-5, a person who is diagnosed with narcissistic personality disorder (NPD) has a personality style that includes grandiosity, self-importance, sense of entitlement, need for admiration, lack of empathy, interpersonally exploitative, erraticism, arrogance, haughtiness, disdainfulness, patronizing, and has a lack of relational reciprocal interest (APA, 2013). The diagnostic criteria for NPD in DSM-5 include narcissistic characteristics that are grandiose, leaving out vulnerable manifestations of the disorder (Caligor et al., 2015). Research suggests that personality variations of narcissistic individuals to be beyond what is included in the DSM-5 criterion, which expand to “grandiose or self-loathing, extraverted or socially isolated, captains of industry or unable to maintain steady employment, model citizens or prone to antisocial activities.” (Caligor et al., 2015, p.416). Thus, the incomplete definition and manifestation of narcissistic personality disorder (NPD) may have led to discrepancies in the diagnosis, assessment, and treatment of narcissistic individuals as well as victims and survivors of narcissistic abuse. Although the current definition

provided in the DSM-5 begins to capture NPD, an expanded definition incorporating the complete manifestation of narcissism would reflect some of the most recent research on this condition.

Although the body of research has grown in understanding narcissism and Narcissistic Personality Disorder (Larson et al., 2015; Miller et al., 2010; Ronningstam, 2005), currently there is a dearth of empirical research, evidence-based programs and modalities, academic and clinical resources, diagnosis, assessment, and treatment models focused on individuals who are in any form of relationship with a person who has a narcissistic personality type.

The abundance of professional and popular publications have suggested unofficial definitions and descriptions of the construct of narcissistic abuse. The various unofficial descriptions or definition of narcissistic abuse among different publications have played a positive role in increasing awareness, validation, and advocacy for victims and survivors. However, the inconsistency in descriptions on different sources has led to challenges in explaining the abuse, providing accurate and consistent information, support and treatment, and most importantly adding to the confusion in the victim's experience. Thus, there is a need to develop a better understanding of narcissistic abuse and its impact as well as a better defining official clinical and academic classifications of the narcissistic abuse dynamic. Moreover, there is a gap in the awareness, advocacy, and services focused on victims and survivors of narcissistic abuse in empirical research, academia, DSM-5 diagnosis, clinical community, law enforcement policy, and the court system. Additionally, there is a lack of sufficient availability, accessibility, and acceptability of

clinical and therapeutic support and services, treatment programs, and educational resources focused on victims and survivors of narcissistic abuse.

The literature review showed much overlap that concluded for narcissistic abuse within family and intimate relationships to be domestic violence, however “narcissistic abuse” is not formally recognized in most court systems. Therefore, there is a gap in the awareness and advocacy of narcissistic abuse being acknowledged as domestic violence in the larger system such as policy makers, stakeholders, clinical practice, court system, law enforcement, and the public at large. This lack of acknowledgement and advocacy in the domestic violence field has caused tremendous life-changing problems for victims and survivors of narcissistic abuse.

As mentioned, academic and clinical programs, including MFT programs, have not covered the identification, needs, assessments, or treatment of victims and survivors of narcissistic abuse. This gap has led to limited and insufficient teaching and training in the subject, which has led to limited knowledge and clinical skills in the mental health field. Although COAMFTE-accredited Master’s level Marriage and Family Therapy programs do place an emphasis on treating victims and survivors of interpersonal and intimate partner violence, providing expanding education specifically on narcissistic abuse would further equip developing therapist to effectively address the relational dynamic that will likely present itself in treatment (COAMFTE, 2017). Licensed marriage and family therapists (LMFTs) are one of the main lines of contact for of mental and relational health services, therefore it would be highly beneficial to require them to have sufficient knowledge and clinical skills to treat victims and survivors of narcissistic abuse.

In addition to getting exposure and training in their academic degree, it might prove beneficial for mental health professionals to also complete related continuing education courses as part of their license renewal. There are some available and accessible continuing education courses and trainings offered through US accredited agencies focused on narcissistic abuse recovery. Recently, there has been a slight increase in some Continuing Education (CE) sources and trainings accredited by well-known programs, such as Pesi.com, that offer workshops, conferences, and training courses focused on the narcissistic dynamic and narcissistic abuse. Such CE courses have been a valuable addition to educating clinicians; however, there is still a need for additional accessible and comprehensive educational resources.

In addition to the development of agreed upon formal definitions of narcissistic abuse, there is a need to understand how narcissistic abuse is described and characterized in popular culture. There are common narcissistic-related terms being used among blogs, books, google, movies, social media, YouTube, and Tiktok, etc. However, most terms, such as gaslighting or flying monkeys, have not yet been classified or connected to clinical terms associated with narcissistic abuse. There are advantages and disadvantages to some of these terms. The various narcissistic related terminology and descriptions have played a positive role in increasing awareness, validation, and advocacy for victims; there is a benefit to having a common language in describing constructs that have not yet to be officially acknowledged. Professional and popular publications and internet-based resources have increased awareness of narcissistic related jargon such as narcissistic abuse, the narcissistic abuse cycle, narcissistic dynamic, gaslighting, flying money, grey rocking, love bombing, hoovering, narcissistic supply, and narcissistic family system to

voice a common language in describing such antagonistic relational dynamics (Durvasula, 2014). On the other hand, the use of informal terminology has caused inconsistency and inaccuracy in descriptions and information, possibly adding to the confusion in the victim's experience.

An important part of refining language and definition for narcissistic abuse and its subsequent assessment and treatment is outlining a conceptual lens that might facilitate this process. Individuals go through learning and growth as they interact and make meaning of their lives and experiences; learners can be motivated by community reward, inner drive, and psychological self (Vygotsky, 1978). Social constructivism showed that language is the basis of learning due to its support in activities such as reading, writing, communicating, and reasoning and reflecting (Vygotsky, 1978). Moreover, social constructivism suggests that individuals are active participants in creating their knowledge and most learning occurs in social and cultural settings (Schreiber & Valle, 2013). Thus, gathering communities that are knowledgeable in the terminology and treatment of narcissism and narcissistic abuse, despite limited academic materials, can spark a culture of learning through discussions and interactions within groups and communities. In other words, cognitive functions and understandings can be changed based on professional social interactions and collaboration. Therefore, the understanding of narcissism and narcissistic abuse can change based on safely facilitated collaboration and interactions between experts in the field of narcissism, clinical providers, and higher education authorities and policy makers. The social negotiation can create change in the competency of clinicians, clients, and the education system.

In conclusion, this needs assessment seeks to identify the needs, assessments, and treatment recommendation for victims and survivors of narcissistic abuse through interviewing active practitioners and self-identified experts working with clients who have experienced narcissistic abuse. Further, this needs assessment recommendations for addressing the needs, assessment, and treatment of victims and survivors of narcissistic abuse can be a stepping stone in the development of further evidence-based research, diagnosis, assessment, treatment, training and program development, and policy change focused on narcissistic abuse. This needs assessment plays a role in increasing awareness and advocacy as well as reducing stigma and systemic traumatization regarding narcissism, narcissistic abuse, and it's devastating impact on individuals and the public at large. It is the hope that this needs assessment can spark further progress and systemic change in areas of academia, policy making, clinical practice, legal field and court system, law enforcement, and the public at large.

Project Purpose

Although the body of research has grown in understanding narcissism and Narcissistic Personality Disorder (Larson et al., 2015; Miller et al., 2010; Ronningstam, 2005), currently there is a dearth of empirical research, evidence-based programs and modalities, academic and clinical resources, diagnosis, assessment, and treatment models focused on victims and survivors of narcissistic abuse.

Rationale

The professional and popular publications have come to vaguely describe “narcissistic abuse” as any type of abuse that is perpetrated by an individual with a

narcissistic personality type within any form of relationship including but not limited to intimate, parent or caregiver-child, peer to peer, or professional relationships (Day et al., 2022; Lance, 2016; Howard, 2019). Narcissistic abuse can be subtle and often worsens over time; the abuse may be coercive control, psychological (or emotional), physical, sexual, spiritual, or financial (Lance, 2016; Howard, 2019).

Through history, narcissism and narcissistic personality disorder has gone through an evolving definition and description. Various researchers and professionals from different schools of thought have played a role in understanding and defining narcissism from various therapeutic frameworks such as clinical theory, social-personality psychology, and psychiatric diagnosis (Campbell and Miller, 2011; Pincus et al., 2009). However, there are still discrepancies, disagreements, and irregularities in the construct of narcissism, including a common definition, diagnosis, prevalence, and treatment of narcissism and narcissistic personality disorder (NPD) (Pincus et al., 2009; Caligor et al., 2015).

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) is the most current and widely accepted nomenclature used by clinicians (including MFTs) and researchers to classify mental disorders. According to the DSM-5, Narcissistic Personality Disorder (NPD) is “a personality style characterized by grandiosity, self-importance, a sense of entitlement, a need for admiration, a lack of empathy, interpersonal exploitation, irrationality, arrogance, haughtiness, disdain, patronizing, and a lack of relational reciprocal interest” (American Psychiatric Association, 2013). Although DSM-5’s focus on the grandiosity features are indeed a core component of narcissistic personality, a rich literature focused

on the phenotypic descriptions of pathological narcissism across clinical theory, social-personality psychology, and psychiatric diagnosis reveals expanded criteria and understanding of narcissism that includes different subtypes of narcissistic personality disorder (Cain et al., 2008; Caligor et al., 2015). The diagnostic criteria for NPD in DSM-5 includes overt grandiose features, leaving out vulnerable manifestations of the disorder that include instances of depressed mood, insecurity, hypersensitivity, shame and identification with victimhood (Caligor et al., 2015). This inconsistency has played a negative role in the understanding and identification of individuals with a narcissistic personality type as well as the victims in relationship with them. Therefore, an expanded definition of NPD might aid in the complete definition and manifestation of narcissism and narcissistic personality disorder that leads to addressing the discrepancy in the diagnosis, assessment, and treatment of narcissistic individuals as well as the victims and survivors of narcissistic abuse.

Due to perpetrator's certain narcissistic personality traits, narcissistic abuse typically involves an abusive cycle of idealizing, devaluing, and discarding the victim in the form of temporary charm followed by criticism, degradation, emotional withdrawal, accusations, punishment, contempt, coercive force, and/or threats (Gaum and Herring, 2020). Despite the scarce academic and empirical attention on victims and survivors of narcissistic abuse, many experienced professionals in the field of NPD and narcissistic abuse have described narcissistic abuse to be drastically impactful and traumatic on one's emotional, psychological, physical, financial, and spiritual well-being (Brown and Young, 2018; Day et al., 2020; Durvasula, 2022; Howard, 2019; Leedom, 2019). The impact of narcissistic abuse on victims can cause a variety of issues including but not

limited to depression, anxiety, cognitive dissonance, shame, confusion, PTSD, Complex PTSD, helplessness, emotional dysregulation, executive dysfunction, confusion, somatization, despair, and loss of sense of self and reality (Brown and Young, 2018; Day et al., 2020; Durvasula, 2022; Howard, 2019; Leedom, 2019; MedCircle, 2020).

Despite the life-altering impact of potential narcissistic abuse, research into its nature and consequences has been hampered by the absence of a rigorous and official way to define and measure it. Moreover, there is little to no focus on victims and survivors in empirical research, academic and educational sources, and evidence-based clinical training and treatment models and programs. However, victims and survivors of narcissistic abuse have been recognized in professional and popular publications such as books, blogs, articles, podcasts, and videos written by experienced mental health professionals and individuals who have experienced or witnessed narcissistic abuse. Nevertheless, the paucity of academic and empirically peer-reviewed resources on this population has become problematic in ways that has affected the development of a standardized and consistent diagnosis, terminology, treatment, and clinical and societal acknowledgement of narcissistic abuse.

Moreover, academic and clinical programs, including MFT programs, have not covered the identification, needs, assessments, or treatment of victims and survivors of narcissistic abuse. The lack of coverage in many MFT programs has led to limited and insufficient teaching and training in the subject, which has led to limited knowledge and clinical skills in the mental health field. According to the American Association of Marriage and Family Therapy (AAMFT), marriage and family therapists (MFTs) are recognized as the five core mental health professions, along with psychiatrists, clinical

psychologists, clinical social workers and psychiatric nurse specialists (2022). MFTs are one of the main lines of contact for consumers of mental and relational health services (AAMFT, 2022). Due to their focus on understanding symptoms and diagnoses within interactions, relationships, and environmental and familial systems (AAMFT, 2022), MFTs should have sufficient competence in treating individuals, couples, and families with relational issues such as relational trauma.

Although MFTs are expected to have competency in treating mental and relational health issues, there is no significant emphasis on the identification, assessment, and treatment of victims and survivors of narcissistic abuse in COAMFTE-accredited Masters level Marriage and Family Therapy programs (COAMFTE, 2017). The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) is the main accrediting agency for the American Association for Marriage and Family Therapy (AAMFT) (COAMFTE, 2017). The American Association for Marriage and Family Therapy (AAMFT) is a professional organization representing more than 50,000 marriage and family therapists in the United States, Canada, and worldwide. Thus, being the main policy makers in the field of marriage and family therapy, AAMFT and COAMFTE organizations have not placed an emphasis on the importance of improving clinician's knowledge and clinical skills in narcissistic abuse recovery.

Aim

Identifying common knowledge and clinical skills in the needs, assessment, and treatment of narcissistic abuse among competent, proficient, and expert level clinicians can help in developing appropriate services, resources, and academic curriculum and

training for clinicians who treat this population. This needs assessment aimed to identify the knowledge and clinical skills recommended by clinicians who treat victims and survivors of narcissistic abuse to identify some needs, assessments, and treatment practices that can guide Licensed Marriage and Family Therapists in treating this population. This needs assessment explored current literature, research, and academic and clinical resources focused on narcissism and narcissistic abuse followed by interviewing 14 self-identified competent, proficient, or expert level clinicians who treat victims and survivors of narcissistic abuse.

Potential Benefits

Identifying common knowledge and clinical skills in the needs, assessment, and treatment of narcissistic abuse victims and survivors can help provide appropriate services, resources, and academic curriculum and training for clinicians who treat this population. Due to the gaps in the availability, accessibility, and acceptability of services for victims and clinicians, some victims are currently suffering without adequate mental health assistance, making this needs assessment all the more important. While waiting on policy makers and stakeholders to develop systemic change, licensed marriage and family therapists are still responsible for effective and appropriate mental health services. In that case, it is pressing to take action towards increasing the current knowledge and clinical skills of therapists who treat that population in order to ensure the client's safety, therapy quality, and therapist competency. Victims often learn about their abuse when they stumble onto professional and popular publications, social media, internet forums, or seek out therapists who may or may not be qualified to help them, and this thus necessitates

more extensive empirical research undertakings in this area. Professionals and victims gaining a diluted understanding of such understudied interpersonal abuse may cause further harm. In other words, while victims and survivors might be suffering, they might seek therapists who have limited knowledge and expertise in narcissistic abuse recovery, leading to potential ineffective or harmful therapeutic assessment and treatment practices.

Notwithstanding the dearth of availability, accessibility, and acceptability of resources available to victims and clinicians, this needs assessment can be a crucial guide in improving clinician's knowledge and clinical skills and a stepping-stone in the development of further research, diagnosis, assessment, training, and treatment programs and models.

CHAPTER TWO

LITERATURE REVIEW

In order to understand narcissistic abuse and its gaps in knowledge and proper treatment, it is important to understand narcissism and narcissistic personality disorder and their impact on self and others. There are many common traits and behaviors displayed by narcissistic individuals that are self-benefiting to the narcissist yet detrimental and harmful to people in a relationship with them. Self-benefiting and self-centered behaviors make it difficult for narcissistic individuals to seek help for traits that help them feel powerful, even though it is harmful to others.

Additionally, it is important to explore the current MFT educational system and core competency to understand the possible gaps in the knowledge and clinical skills of licensed marriage and family therapists in narcissism and narcissistic abuse. Furthermore, interviewing clinicians with dedicated post-graduate work to increase their competency in treating victims and survivors of narcissistic abuse may be a stepping stone to understanding the needs, assessments, and treatment of narcissistic abuse.

Definition of Narcissism and Narcissistic Personality Disorder

According to the DSM-5, Narcissistic Personality Disorder (NPD) is “a personality style characterized by grandiosity, self-importance, a sense of entitlement, a need for admiration, a lack of empathy, interpersonal exploitation, irrationality, arrogance, haughtiness, disdain, patronizing, and a lack of relational reciprocal interest” (American Psychiatric Association, 2013). Although DSM-5’s focus on the grandiosity features are indeed a core component of narcissistic personality, a rich literature focused

on the phenotypic descriptions of pathological narcissism across clinical theory, social-personality psychology, and psychiatric diagnosis reveals expanded criteria and understanding of narcissism that includes different subtypes of narcissistic personality disorder (Cain et al., 2008; Caligor et al., 2015). The diagnostic criteria for NPD in DSM-5 includes overt grandiose features, leaving out vulnerable manifestations of the disorder that include instances of depressed mood, insecurity, hypersensitivity, shame and identification with victimhood (Caligor et al., 2015).

Research shows the phenotypic personality variations of narcissistic individuals to be “grandiose or self-loathing, extraverted or socially isolated, captains of industry or unable to maintain steady employment, model citizens or prone to antisocial activities” (Caligor et al., 2015, p.416). Such variable presentation and characterization of narcissistic pathology can appear and be described in a wide variety of ways, which has led to diagnostic uncertainty in light of the DSM-5’s gaps (Caligor et al., 2015).

A review of the literature by Caligor et al. (2015) classifies individuals with narcissistic personality disorder into three distinct subtypes: the overt or grandiose subtype, the covert or vulnerable subtype, and the high-functioning or healthy subtype. On the other hand, Russ et al. (2008) classifies individuals with narcissistic personality disorder into grandiose/malignant narcissism, fragile narcissism, and high-functioning narcissism. In order to understand narcissistic personality types, Russ et al. (2008) utilized various instruments including the clinical data form, the Shedler-Westen Assessment Procedure-II, the Axis II Criterion Checklist, assessments of personality disorder constructs, and Q-factor analysis.

Russ et al., (2008). describes the hallmarks of grandiose/malignant narcissism to include anger, manipulation, a desire for power and control over others, a lack of empathy, a bloated sense of self-importance, and a sense of entitlement, wrath, oblivious to their faults, and quick to blame others (Russ et al., 2008). Similarly, Caligor et al. (2015) classifies a similar subtype, “the grandiose, thick-skinned, overt subtype is characterized by overt grandiosity, attention seeking, entitlement, arrogance, and little observable anxiety” (p. 416). Individuals with the grandiose, thick-skinned, overt subtype are interpersonally exploitive and are also able to act charming on the outside, while lacking care for the needs of others (Caligor et al., 2015).

On the other hand, Russ et al., (2008) suggests that fragile narcissism is characterized by grandiosity that serves a defensive function, warding off painful feelings of inadequacy, smallness, anxiety, and loneliness. An individual with fragile narcissism desires the feeling of being important and privileged; however, when their egos are threatened, they experience a powerful undercurrent feeling of inadequacy that are often expressed through rage. Similarly, Caligor et al., (2015) describes that “the vulnerable, fragile or thin-skinned, covert subtype is inhibited, manifestly distressed, hypersensitive to the evaluations of others while chronically envious and evaluating themselves in relation to others” (P. 416). Through they are very self-absorbed, individuals with the vulnerable fragile or thin-skinned, covert subtype present as more interpersonally shy, outwardly self-effacing, and hypersensitive to slights, while harboring secret grandiosity. Interpersonally these individuals are often shy, outwardly self-effacing, and hypersensitive to slights, while harboring secret grandiosity (Caligor et al., 2015).

Lastly, Russ et al., (2008) adds that individuals with high-functioning narcissism have an exaggerated sense of self-importance but are also articulate, energetic, and outgoing. Individuals with high-functioning narcissism are interpersonally functional while showing good adaptive functioning; they use their narcissism as a motivation to succeed. Similarly, Caligor et al. (2015) explains that individuals with high-functioning exhibitionistic, or autonomous narcissism present healthier compared to the other narcissistic subtypes due to demonstrating adaptive functioning and using their narcissistic traits to succeed. However, these individuals are grandiose, competitive, attention seeking, and sexually provocative (Caligor et al. 2015). Due to their high level of functioning, individuals in this subtype are difficult to identify as narcissistic; making it more possible to overlook the narcissistic personality disorder diagnosis during assessment (Caligor et al. 2015).

Some research suggest that it is common for personality pathology to be mostly expressed through disturbed interpersonal relations (e.g., Benjamin, 1996; Pincus, 2005). When their idealized and inflated sense of self is challenged, narcissists often react with a form of violence, hostility, animosity, rage, and wrath (Bushman & Baumeister, 1998; Twenge & Campbell, 2003; Reidy, Foster & Zeichener, 2010; Bushman & Thomaes, 2011; Krizan & Johar, 2015;). In general, narcissists have an inflated impression of themselves based on flattering delusions, while their confidence is often relatively low (Gabriel, Critelli, & Ee, 1994, Rhodewalt, Madrian, & Cheney, 1998; Campbell, Rudich & Sedikides, 2002). Twenge and Campbell (2003) state that individual with a narcissistic personality type desire power and dominance over others in order to maintain their inflated self-belief; their emotional needs include a low desire for affiliation and a high

need for power (Twenge & Campbell, 2003). In addition, individuals with a narcissistic personality type are typically disinterested in mutually healthy and reciprocal relationships; they create a manipulative relationship dynamic (Twenge & Campbell, 2003). In addition, individuals with a narcissistic personality types display violent envy due to their weakness and lack of a true sense of self (Krizan & Johar, 2012). They are not very altruistic, and they often violate ethical norms by, for instance, taking credit for their accomplishments while shifting blame (Twenge & Campbell, 2003).

Furthermore, individuals with a narcissistic personality types are more likely to engage in sexual coercion and violence against others (Baumeister et al., 2002). Narcissism is characterized by self-serving cognitive errors and an overall exploitative attitude toward sexual interactions without consent (Baumeister, Catanese & Wallace, 2002).

Holtzman et al. (2011) employed the Electronically Activated Recorder (EAR) to capture naturalistic data from the everyday lives of individuals with a narcissistic personality types in order to validate actions consistent with theories on narcissistic traits. According to Holtzman et al. (2011), narcissism is associated with characteristics such as extroversion, unlikable behavior, sexual language, a sense of entitlement or privilege, and difficulties in self-esteem regulation. In addition, those with a narcissistic partner are more likely to exhibit infidelity (McNulty & Widman, 2014), a lack of commitment (Campbell et al., 2002), manipulative game-playing, selfishness, a lack of empathy, and the use of an exaggerated sense of self to explain relationship dissatisfaction (Campbell et al., 2002). Moreover, individuals with a narcissistic personality types seek partners or are motivated by partners in order to enhance their social status, admiration, and self-image

(Campbell, 1999; Tanchotsrinon et al., 2007). The destructive activities of individuals with a narcissistic personality type are frequently hidden by more attractive attributes, such as charisma, social success, self-confidence, and entertainment value, which assists in attracting and manipulating their victim (Campbell et al., 2002; Back et al., 2010; Watson & Biderman, 1994).

Narcissistic Personality Disorder and Discrepancies in the DSM

Narcissistic personality disorder is one of the least studied personality disorders, though it is prevalent, highly comorbid with other disorders and causes functional and psychosocial impairment (Miller et al., 2007; Grant et al., 2008). Therefore, there is confusion regarding the reliability, validity, specificity, and sensitivity of diagnostic criteria, as well as the prevalence of the disorder, or the efficacy of any treatment for the disorder (Caligor et al., 2015). The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) is the most current and widely accepted nomenclature used by clinicians (including MFTs) and researchers to classify mental disorders. The diagnostic criteria for NPD in DSM-5 includes overt grandiose features, leaving out vulnerable manifestations of the disorder that include instances of depressed mood, insecurity, hypersensitivity, shame and identification with victimhood (Caligor et al., 2015). This inconsistency has played a negative role in the understanding and identification of individuals with a narcissistic personality type as well as the victims in relationship with them. Therefore, an expanded definition of NPD might aid in the complete definition and manifestation of narcissism and narcissistic personality disorder that leads to addressing the discrepancy in the diagnosis, assessment, and

treatment of narcissistic individuals as well as the victims and survivors of narcissistic abuse.

As mentioned, there is much controversy in the diagnosis of narcissistic personality disorder (NPD), in which there are inconsistencies and discrepancies in the diagnosis criteria, conceptualization, or treatment of NPD. Moreover, the underlying taxonomy of the diagnosis lacks structure, coherence, and theoretical foundation (Clark, 2007). The DSM-5 is being widely used as an official diagnostic and teaching tool around the world, and its limitations on nature (normal, pathological), phenotype (grandiosity, vulnerability), expression (overt, covert) and structure (category, dimension, prototype) of NPD (Pincus, 2010), may be systemically problematic. Furthermore, despite the widespread research and observations, the DSM rarely discusses the community and clinical samples involving the correlation with personality difficulties and narcissistic traits (Yakeley, 2018). Focus and awareness of these inconsistencies in the conceptualization of narcissism are significant, because the quality of education and treatment depends on the accuracy of the information being taught and practiced. Inconsistent information about narcissism and narcissistic dynamics may also lead to misdiagnosis and inappropriate treatment approach for individuals with a narcissistic personality type, in addition to misdiagnosis and misunderstanding of victims and survivors of narcissistic abuse. In this case, the lack of consistency in the assessment and treatment of individuals perpetrating narcissistic abuse, creates an urgency for sufficient support and treatment for victims and survivors. Misdiagnosis of victims and survivors of narcissistic abuse may unintentionally increase the harm of the very cycle perpetuated by the narcissist to invalidate victim's experiences. Similar to intimate partner violence

victims who may be misdiagnosed with non-intimate partner violence etiologies (Wu et al., 2010), victims and survivors of narcissistic abuse might seek therapists who have limited knowledge and expertise in narcissistic abuse recovery, leading to potential ineffective or harmful misdiagnosis and therapeutic practices.

Narcissism as a Personality or Character Style and Disorder

Robert Wälder (1925) was the first person who approached Narcissism as a personality disorder or character style. Wälder (1925) observed his patients and described such characteristic style and personality as grandiose, superior, self-centered and self-admiring, lacking empathy, and focused on sexual pleasure rather than emotional intimacy. This led to Freud's (1931/1950) updated paper on narcissism from a lens of a personality type that is focused on self-preservation and an inability to love others. Freud (1931/1950) mentioned how self-preservation led to aggression and a desire for constant admiration. Freud (1931/1950) also noticed a pattern of such characters being in leadership roles due to their extraversion and independence.

Freud's expansion of the narcissistic personality style led to Wilhelm Reich's (1933/1949) introduction of the "phallic-narcissistic character." Reich (1933/1949) explained that human character structures were organizations of resistance that help people avoid facing their neuroses. Reich further explained a phallic-narcissistic character, relating to Alfred Adler's (1910/1978) concept of masculinity, as an organization that creates a defense through superiority, power, strength, confidence, privilege, arrogance, provocativeness, coldness, and callous and aggressiveness when their ego was threatened, and self-esteem regulation was needed.

Horney (1939) introduced divergent manifestations of narcissism such as aggressive-expansiveness, perfectionistic, and arrogant-vindictive character traits. Horney (1939) distinguished between healthy self-esteem and unrealistic self-inflation. Horney (1939) further explained narcissist's suffering in the inability to accept and love all parts of themselves or anyone else. The lack of genuine self-love and self-acceptance was also confirmed by Donald Winnicott (1960) in understanding ego distortions such as the "true self" (an authentic experience that represented the real self) and the "false self" (defensive façade of self). This view differed from Freud's understanding of narcissists' lack of empathy and love for others due to excessive love for themselves; Horney believed the lack of love was towards self and others (Horney, 1939).

Annie Reich (1960) proposed early traumatic experiences to be the reason behind narcissistic individuals having a defense mechanism against feeling vulnerable. Reich (1960) further explained that the grandiose superior self is a protective strategy that creates a safe fantasy from weak and powerless parts of the self. Finally, Reich introduced "repetitive and violent oscillations of self-esteem" (p.224) to explain the narcissistic traits that showed no tolerance for being less than perfect, leading to a dramatic fluctuation of feelings of grandiosity, failure, and depression (Reich, 1960).

Nemiah (1996) coined the term narcissistic character disorder and emphasized that narcissism is more of a disorder than a character style. Nemiah (1996) described individuals with narcissistic character disorder as showing significant ambition and eagerness, exceedingly unrealistic standards, unwilling to accept failures, highly perfectionistic and intolerant of imperfections, and unappeasable need for admiration.

Nemiah (1996) emphasized that narcissists' actions are motivated and influenced by how they appear to others and how others can admire them.

Kernberg (1967) dedicated his work to ego psychology, object relations, borderline personality organization, and introduced narcissistic personality structure. Kernberg's (1967) work on narcissistic personality structure showed the self as an intrapsychic structure consisting of multiple self-representations. Kernberg (1970) further distinguished between normal and pathological narcissism by explaining narcissistic characteristics through pathological differentiation and integration of ego and superego structures that are the consequence of pathological object relationships. Kernberg (1970) explained pathological narcissism as a libidinal investment in the underdeveloped pathological structure of the self, which leads to high defenses against early self and object images.

In contrast, Heinz Kohut (1968) introduced narcissistic personality disorder, in which narcissistic adults alternate between an irrational overestimation of the self and irrational feelings of inferiority. In this way, narcissistic adults lean on others to manage their sense of value and self-esteem. Kernberg and Kohut differed in their observation of narcissism; Kernberg believed that narcissists develop a grandiose representation of self as a defense mechanism, and Kohut believed that narcissism was a normal development process that was interrupted by maladaptive parenting styles (Campbell and Miller, 2011).

Kernberg and Kohut have played a substantial role in the development of narcissistic personality disorder among psychoanalysis and contemporary personality theorists and the development of the Diagnostic and Statistical Manual of the American

Psychiatric Association (Campbell and Miller, 2011). Additionally, narcissism research and clinical and personality psychology ideas also aligned with critical social theory (Campbell and Miller, 2011). For example, the American journalist and writer Tom Wolfe (1976) called the 1970s “the Me Decade in America”, in which there was a rise of excessive focus on individual-celebration and self-focus instead of the values of connectedness and collectivism. The American historian and social critic Christopher Lasch (1979) published “The Culture of Narcissism,” describing the current state of American culture as an era of narcissistically entitled individualism and extreme decadence. Twenge and Campbell (2009) have extensively researched national trends to observe and diagnose an increasing societal epidemic of narcissism and ego inflation. Twenge and Campbell (2009) further discuss the detrimental increase and impact of narcissism in the culture, relationships, workplace, economy at large, schools, and even politics. Twenge and Campbell (2009) further suggest decreasing the growth of the epidemic of narcissism by identifying it, minimizing the forces that maintain and enhance it, and treating it to change familial roles that shift privileging self-expression and self-admiration.

History and Development of Narcissism and Narcissistic Personality Disorder

Research, mythological, biblical, and other religious writings and doctrines have discussed the harm of vanity and the focus on self-love while disregarding the love for others. The dangers of vanity have been expressed through paintings, plays, and stories and later presented in research, articles, studies of personality styles or disorders, and psychiatry. Understanding the historical roots of narcissism and the development of NPD

is crucial in understanding the impact, gaps in knowledge, and enhancement of the treatment of narcissism in addition to people impacted by narcissistic individuals.

The term ‘narcissism’ was originally derived from the Greek mythological character named Narcissus, which led to an evolution of an official psychiatric personality disorder, the coining of terms such as the culture of narcissism, me generation (Lasch, 1979; Wolfe, 1976, 1977), and the age of entitlement (Twenge & Campbell, 2009). The most used and best-known story of ‘Narcissus’ was written in the book *Metamorphoses* by a Roman poet named Ovid (1970) in 8 C.E. Ovid presented Narcissus as a youth admired for his beauty, which increased his ego to reject and ridicule many who adored him, including the nymph Echo. Echo was cursed to repeat the last words of speech said to her, leading her only to be able to communicate through the words of others instead of her own. After being rejected by Narcissus for his own image, Echo’s obsessive love of Narcissus and his rejection of her led her to perish away until all that remained was her echoing voice. Nemesis, a mythical God, punishes Narcissus with unrequited love, leading him to fall in love with his reflection in a pool of water. Paralyzed by the love of his own beauty, he was left empty in his futile love until death, hearing Echo repeating his last crying words (Ovid, 1970). This mythical story resonates with later developments on narcissism.

The clinical psychoanalysis of narcissism started with a British sexologist-physician named Havelock Ellis (1898), who referred to the narcissus myth as an abnormal self-focused autoerotic sexual condition named “auto-eroticism.” Ellis (1898) explained these “narcissus-like” tendencies to lead to individuals lose in self-admiration; “for the sexual emotions to be absorbed, and often entirely lost, in self-admiration.” Ellis’s

work led to Psychiatrist Paul Näcke's introduction of the term 'Narcimus' or 'narcissism' (Nacke, 1899). Näcke related narcissism to his observations of autoeroticism, explaining how the self is treated as a sexual object. Psychoanalyst Isidor Sadger (1908, 1910) elaborated on the concept of narcissism in his view of pathological forms of overvaluation of and overinvestment in one's own body compared to the normal levels of egoism and self-love. He explained that to experience mature sexual love, one must experience self-love but not be fixated on the love of self (Sadger, 1908, 1910). Otto Rank (1911/1971) was the first psychoanalyst to write a paper exclusively focused on narcissism, followed by his later ideas that narcissism was not exclusively sexual but rather that vanity and self-admiration served defensive functions.

Sigmund Freud (1914/1957), a neurologist and the founder of psychoanalysis, developed a comprehensive analysis of possible causes, functions, and the positive and negative components or effects of narcissism, explaining the issues of self-love and other-love. Freud rejected the relatability of autoeroticism to narcissism and instead described it as "libido that has been withdrawn from the external world has been directed to the ego and thus gives rise to an attitude which may be called narcissism" (Freud, 1914). Campbell and Miller (2011) explain Freud's view as varying from a sexual perversion and quality of primitive thinking to an object choice, mode of object relationship, and self-esteem (Pulver, 1970; cited in Campbell and Miller, 2011). Campbell and Miller (2011) add that Freud viewed narcissism as a universal stage of psycho-sexual development, an element of self-preservatory instincts, as well as a marker of a pathological character which later developed into avoidance of awareness of anything that would threaten one's sense of self (Freud, 1914/1957). Campbell and Miller

(2011), in their book “The Handbook of Narcissism and Narcissistic Personality Disorder: Theoretical Approaches, Empirical Findings, and Treatments,” concluded that:

In the course of his writings, Freud used the term narcissism to (a) describe a stage of normal infant development, (b) as a normal aspect of self-interests and self-esteem, and (c) as a way of relating in interpersonal relationships, especially those characterized by choosing partners based on the other’s similarity to the self [over-investment of self] rather than real aspects of the other person, and (d) a way of relating to the environment characterized by a relative lack of interpersonal relations. These multiple uses of the term narcissism have resulted in significant confusion about the concept, which persists even today (p. 13).

The development of pathological narcissism started with an association with envy and hostility toward love objects due to the individual’s past caregiving negative experiences (Abraham, 1919/1979). Then Alfred Ernest Jones (1913/1974) introduced the idea of the “God Complex,” in which he highlighted narcissist’s character as pathologically aloof, inaccessible, self-admiring, self-important, overconfident, exhibitionistic, and with fantasies of omnipotence and omniscience (as cited in Campbell and Miller, 2011). Jones (1913/1974) further explained that the god complex is a defense mechanism characterized by inflated feelings of personal privilege, superiority, and abilities. Later, Wilhelm Reich (1960) emphasized the compensatory narcissistic self-inflation, grandiosity, self-inflation, unnaturalized aggression, superego disturbance, approval from outside, and self-consciousness, among other narcissistic traits, to be a pathological form of protecting oneself and regulating one’s self-esteem. Since then,

many articles, as mentioned throughout this literature review, have been published describing the construct of narcissism and its' diverse and complex subtype variations.

Narcissistic Abuse and the Impact of Narcissism on Relationships

A clinical classification or definition of the term “narcissistic abuse” has not yet been established; however, the large body of professional and popular publications provided by mental health professionals and individuals who have witnessed or experienced such abuse has demonstrated a communal interest and thus worthy of further acknowledgment and research. The professional and popular publications have come to vaguely describe “narcissistic abuse” as any type of abuse that is perpetrated by an individual with a narcissistic personality type within any form of relationship including but not limited to intimate, parent or caregiver-child, peer to peer, or professional relationships (Day et al., 2022; Lance, 2016; Howard, 2019). However, the vague and informal descriptions published on anecdotal and popular publications has led to challenges in accuracy and consistency of information, potentially leading to more confusion in the victim’s experience.

Nevertheless, the literature on narcissistic personality disorder can offer some insight on the harms of the antagonistic and manipulative nature of narcissistic personality types, which can result in ‘narcissistic abuse.’ Interpersonal dysfunction and problems with psychosocial functioning is a well-documented aspect of pathological narcissism (Byrne & O'Brien, 2014; Grenyer, 2013; Kealy & Ogrodniczuk, 2011). Narcissistic abuse was initially understood as parent-to-child emotional abuse (Ferenczi, 1984; Miller, 1995). However, the term has now widely represented psychological and emotional abuse within all types of interpersonal relationships (Howard, 2019). Many

people have experienced narcissistic abuse, yet there is a paucity of empirical literature and research examining the depth of this abuse on the victims and how to treat this population. Since narcissistic abuse is under-recognized and understudied, as part of developing effective assessment and treatment interventions more empirical and clinical research is needed. Moreover, Arabi (2017) states that there is limited exposure that developing clinicians receive in their academic training. Further, this diagnosis is not represented in diagnostic manuals; however, narcissistic abuse is described in clinical books and articles as well as through written reports of survivor accounts (Arabi, 2017).

The research focused on people in relationships with individuals with pathological narcissism is needed so that the impact of narcissistic behavior can become better understood. Individuals with pathological narcissism present their antagonistic traits in interpersonal relationships, in which their emotional dysregulation, difficulties in identity, and narcissistic wounds are more openly expressed (Day et al., 2020; Pincus, 2005). Through focusing their research on understanding the experiences of the relatives of people high in narcissistic traits, Day et al. (2020) highlights the importance of considers narcissistic traits of both grandiosity and vulnerability. Moreover, relatives of narcissistic individuals described ‘grandiosity’ in their relative as requiring excessive admiration, displaying arrogant or haughty behaviors or attitudes, entitlement, envy, exploitativeness or taking advantage of others, grandiose and unrealistic fantasy, lack empathy, self-importance and interpersonal charm (Day et al., 2020). Additionally, relatives of narcissistic individuals also described ‘vulnerability’ of the relative as contingent on self-esteem and self-worth, hypersensitivity and insecurity, aggressiveness, affective instability, emotional emptiness and inability to emotionally connect, rage, devaluation,

hiding the self and victimhood charm (Day et al., 2020). In addition to grandiose and vulnerable characteristics, relatives reported perfectionistic, unrelenting high standards, vengeful, vindictive, antisocial, suspicious and paranoid others, and controlling character traits (Day et al., 2020). Although research has shown a wide range of narcissistic characteristics and personality types, there has been limited direct focus on how such antagonistic and coercive behaviors impact others.

Howard (2019) explains that a person with narcissistic personality disorder uses his/her victim as a narcissistic supply to enhance their sense of self, reality, and self-esteem (Howard, 2019). Howard (2019) further explains different traits and forms of Narcissistic abuse, which can include but are not limited to love bombing, pathological lying, presentation of a false self, criticism, the silent treatment, removing the victim from 'the pedestal' and devaluing the victim, gaslighting, abuse amnesia, pathological lying, exploitative behaviors, emotional and physical abandonment, triangulation, insulting and disrespecting behavior, and isolating victim to protect self-image and control (Howard, 2019).

As mentioned, despite the scarce academic and empirical attention on victims and survivors of narcissistic abuse, many professionals in the specialized field of NPD and narcissistic abuse have described the impacts of narcissistic abuse. There are professional and popular publications and internet-based resources attempting to explain the cycle of narcissistic abuse; for instance, mental health professionals Tanya Gaum, M.ED., M.A. and Barbara Herring, M.A., LMFT have created a diagram to explain and highlight important details of the Cycle of Narcissistic Abuse (2020). Victims tend to go through a narcissistic abuse cycle of idealization (honeymoon phase), devaluation (tension building

phase), and rejection (abuse escalation phase); a pattern of positive and negative experiences in which the narcissist confuses the victim through manipulation and calculated tactics aimed at making the victim question their sense of self and reality and live to maintain and appease the relationship and the narcissistic individual (Gaum and Herring, 2020). Psychological (or mental/emotional) abuse is one of the main manifestations of abuse in narcissistic dynamics. Psychological abuse Walker (1984) as any behaviors that negatively influence a person's self-esteem or sense of control and safety. Additionally, "psychological abuse is an ongoing process in which one individual systemically diminishes and destroys the inner self of another" (Loring, 1994).

As individuals with pathological narcissism mostly present their antagonistic traits in interpersonal relationships (Benjamin, 1996; Pincus, 2005), family and domestic violence literature can be used as potential proxy evidence of the impact of relational trauma of narcissistic abuse. Ledoom (2019) emphasizes the severity of relational trauma, which can include physical, psychological, financial, social, and emotional harm and trauma, in addition to the loss of one's dream of a life with a loving partner (Ledoom, 2019). Ledoom (2019) elaborates on the importance of a clinician's knowledge, competence, and empathetic expertise in assisting victims and survivors of intimate partner abuse to rebuild their lives, solve real-world problems, parent their children, and manage symptoms of PTSD and other trauma-related mental illnesses.

Durvasula (2015) is a licensed clinical psychologist who is on a mission to demystify and dismantle the toxic influence of narcissism through clinical, academic, and consultative work, in addition to writing books and offering educational training regarding the etiology and impact of narcissism on human relationships, mental health,

and societal expectations (<http://doctor-ramani.com>, n.d.). Durvasula (2015) states that narcissistic and antagonistic character traits have different impacts on different people. Moreover, Durvasula (2015) shares common feelings that may occur gradually and over time through relationships with a pathological narcissist as,

feeling not good enough, self-doubt and second-guessing, chronically apologetic, confusion and as though you are losing your mind, helplessness and hopelessness, feelings of sadness or depression, feeling anxious and worried, feeling unsettled, anhedonia (not being able to get pleasure out of life and activities that once gave you pleasure), feelings of shame, mental and emotional exhaustion (P. 140).

Additionally, Sandra Brown, M.A., is the Chief Executive officer (CEO) of The Institute for Relational Harm Reduction and Public Psychopathy Education, a resource that has presented research, literature, and training programs focused on relational harm being based on the issue of pathology (Brown, 2009). Brown and Young (2018) emphasize the importance of in dept understanding of the disorders of relational harm, pathological love relationships (PLR), cognitive dissonance, and the differentiation between typical and atypical trauma. Brown and Young (2018) mention that relationships with partners with psychopathic personality disorders (referred to pathological love relationships by the authors) can also cause symptoms of atypical trauma and persistent cognitive dissonance. Cognitive dissonance is an inconsistency between a survivor's thoughts, memory, judgment, reasoning, and/or actions; which results in an internal conflict regarding self, the abuser, and the relationship (Brown and Young, 2018). Brown and Young (2018) further describe that the impairment in the thinking process from both atypical trauma and cognitive dissonance is also harmful to the functioning the brain as an organ.

Moreover, prolonged trauma and/or dissonance can also change the physical health of the body leading to executive functioning, adrenal, thyroid, metabolic, and autoimmune disorders (Brown and young, 2018). Brown and Young further state that,

Cognitive problems of remembering, judging, and reasoning that start from trauma during the PLR and explode like a bomb during the devaluing and discarding/rejection phase, no doubt *magnify* the problems already being produced from cognitive dissonance. Survivors struggle with the difficulty of the mind or brain to be a supportive agent in their recovery because of the changes the brain goes through while under stress from trauma and the layers of dissonance. ... these long-term changes to the mind's functionality, either from stress, dissonance, or the resulting chemical imbalances, cause the brain systems responsible for its smooth operation to decline in areas of the brain that should be calm are anxious, areas of the brain that should help with rational decision making are impaired, areas of the brain that should stabilize feelings about the relationship are stimulated, producing craving for the traumatizing person who brought the survivor to this condition—a situation similar to betrayal and trauma bonding (p. 354-355).

Due to narcissistic behaviors such as lack of empathy, manipulation, invalidation, and projection, victims are led to doubt or shut down their feelings and emotions that are being neglected by the narcissist, which can lead to victims feeling emotionally empty and at fault (Durvasula, 2015). Due to the narcissistic tactics of projection and gaslighting, victims get into a repetitive cycle of self-blame, shame, and taking responsibility for the narcissist's reaction. The victim's feelings of "I am not good

enough” can be caused by having to perform perfectly to the narcissist’s standards, only to be invalidated and blamed (Durvasula, 2015). In other words, constant attempts of self-improvement to please the narcissist in the hopes of gaining narcissist’s attentiveness, presence, empathy, and emotionally connection is a universally acknowledged pattern among people in relationships with narcissistic partners (Durvasula, 2015). The experience of not being known as good enough by a partner and thus not feeling good enough can leave victims feeling inadequate and preoccupied with being chronically apologetic (Durvasula, 2015). Due to their incapacity to deeply listen, empathize, and care for others, narcissists begin to doubt and question their victims (Durvasula, 2015). This constant doubt and questioning lead victims to doubt and question themselves, lose self-confidence, and feel too inadequate and unworthy to change the situation or leave the relationship (Durvasula, 2015). Victims tend to be a constant state of confusion and fog due to narcissist’s inconsistency and intense fluctuation between superficial charm and regard (intense emotions) and antagonistic behavior (detachment) (Durvasula, 2015). The collection of narcissistic tactics can lead to victim’s experience of “learned helplessness,” in which the endurance of repeated unpleasant or aversive situations from which they cannot escape or change leads victims to become unable or unwilling to avoid or leave ongoing aversive situations (Seligman, 1967, as cited in Durvasula, 2015).

Moreover, the impact of learned helplessness can lead victims to experience apathy and depression. The chronic state of helplessness can lead to hopelessness and eventually cause dangerous behaviors, symptoms, and outcomes. As symptoms of mental and physical illness and distress increase gradually, the feelings of helplessness and being at fault makes it difficult for victims to find the right strategies to change their situation or

take care of themselves. The lack of a strategy and various tries to address the problems in the relationship with a narcissist can cause a lot of different emotions and a wide range of psychological symptoms (Durvasula, 2015).

Depression and anxiety have been some of the common mental illnesses caused by narcissistic abuse due to experiences such as a chronic sense of helplessness and lack of emotional reciprocity and mirroring in the relationship (Durvasula, 2015). The antagonistic relational stress can cause victims to isolate themselves from others, withdraw from daily responsibilities, and reduce their focus on essential self-care activities such as nutrition, exercise, and sleep. In addition, the antagonistic relational stress in narcissistic dynamics can lead victims to use harmful coping methods such as substance use, noncompliance with medical recommendations, and in severe cases, suicidal thoughts and behaviors, severe weight fluctuations, and even long-term psychiatric care and hospitalization (Durvasula, 2015). All forms of narcissistic relationships tend to destroy one's sense of self and their life (Durvasula, 2015).

Although posttraumatic stress disorder (PTSD) is a common experience in people who have been in relationships with narcissists, (Durvasula, 2015) describes Complex PTSD as more commonly related to the experiences of people who have had to maintain long-term relationships with narcissists. According to DSM-5, PTSD is a chronic impairment disorder that occurs after exposure to clearly defined traumatic events. It is organized into 20 symptoms within four clusters: intrusion, active avoidance, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity (American Psychiatric Association, 2013). On the other hand, Complex PTSD (C-PTSD) includes obsessive, anxious, and self-negating patterns due to harmful and entrapping

interpersonal traumatic events such as prolonged domestic violence, childhood sexual or physical abuse accompanying social, physical, psychological, and environmental constraints that make it difficult for the victim to escape (Cloitre et al., 2009; Cloitre et al., 2012).

In addition, C-PTSD often results in symptoms of emotion dysregulation, shame, feeling permanently damaged and ineffective, feelings of threat, social withdrawal, despair, hostility, and somatization (Bryant, 2010; Cloitre et al., 2011; Herman, 1992; Reed et al., 2016). Durvasula (2015) suggests that years of enduring narcissistic abuse such as gaslighting, invalidation, dehumanization, and emotional manipulation can lead to victims experiencing severe stress and symptoms of C-PTSD. Moreover, Bremner (2006) discusses that traumatic stress can negatively impact one's health and alter brain function, structure, and memory.

Research shows that narcissistic individuals are more likely to engage in physical aggression, violence, and assault. Additionally, narcissistic individuals commonly use psychological aggression such as threats of physical abuse, violence, jealousy, damage to property (Follingstad et al., 1990), intimidation, isolation, degradation, control, domination (Follingstad & Dehart, 2000), swearing at or insulting a partner, sulking or refusing to talk about an issue, storming out of a room/house, doing or saying something to spite the partner (Straus, Hamby, Boney-McCoy & Sugarman, 1996) emotional withdrawal, manipulation and callousness (Sullivan, Parisian and Davidson, 1991). Additionally, Elise (2019) shares through her literature review that narcissistic individuals are more likely to be sexually aggressive or coercive, construe sexual behavior as involving manipulation and power, focus more on physical pleasure

compared emotional intimacy, use arguments and pressure unwanted sexual activity, and react more negatively to sexual refusal (Elise, 2019). Moreover, sexual violence can lead to women experiencing PTSD, depression, anxiety, fear, alcohol/drug dependency, suicidal ideation or suicide attempts post-assault (World Health Organization, 2013, cited in Elise, 2019).

Gaps in Focus on Narcissistic Abuse

As mentioned, most research on narcissism has focused on the person with narcissistic traits or narcissistic personality disorder (Keller et al., 2014), and there has been little empirical research on people in relationships with narcissistic individuals and how these individuals are affected by narcissistic abuse. Due to scarce research and focus on victims and survivors of narcissistic abuse, there seems to be a gap in current evidence-based research, academic resources, knowledge, and clinical skills in assessing and treating victims and survivors of narcissistic abuse.

The gap in empirically acknowledging narcissistic abuse has restricted sufficient consistent information and training on the subject, leading to limited knowledge and expertise among mental health professionals. The gap in empirically acknowledging narcissistic abuse has also led to a body of professional and popular publications written by experienced mental health professionals and victims or survivors of narcissistic abuse, which would be benefitted by more evidence-based empirical research. Further research is significant because victims become aware of their abuse through stumbled upon professional and popular publications, social media, online forums, and seeking therapists.

The deep-rooted characteristic of a person with narcissistic personality disorder can cause long-lasting trauma to one's body and mind. In the article, *Recognizing Narcissistic Abuse and the Implications for Mental Health Nursing Practice*, Howard (2019) shares the lack of familiarity with the term and implications of narcissistic abuse and the importance of familiarizing, recognizing, and supporting the victims (Howard, 2019). Howard (2019) further explains that domestic abuse literature has only accepted emotional and psychological abuse as domestic violence in recent years, even though such abuse can be fatal, debilitating, and lead to a complex process of recovery (Howard, 2019). Howard (2019) further emphasizes the significance of educating the forefront multidisciplinary teams, particularly mental health nurses, about narcissistic abuse to provide proper support and treatment (Howard, 2019).

In order to treat a population that has experienced such complex relational trauma, it is important for clinicians, such as MFTs, to have the appropriate knowledge and clinical skills to provide effective services. Expertise in assessing, addressing, and treating this population is crucial because of the inconsistencies described above and discrepancies that have led to profound confusion for clients and clinicians, lack of knowledge and awareness of narcissistic abuse, victims being manipulated into self-blame, and the severe symptoms caused by narcissistic abuse.

Narcissistic Abuse and Domestic Violence

Interpersonal violence or abuse such as family and domestic violence (DV), elder abuse, rape or sexual assault (SA), adverse childhood experiences (ACEs) is a significant and pervasive public health, human rights, social, and developmental concern (Lewis et al., 2019; Rosenberg et al., 2006; Sumner et al., 2015). The World Health Organization

(WHO) defines violence as the intentional use of threat or act of power or physical force against oneself, another person, or against a group or community that can result in physical harm, psychological harm, mal-development, deprivation, or death (Krug et al., 2002).

Domestic and family violence includes patterns of abusive behaviors including a wide range of physical, sexual, psychological, emotional (CDC, 2020), economical (Adams et al., 2008), and coercive control to gain power, control, and authority (WHO, 1970). It has been reported for the impact of domestic violence to include injury, physical and mental health issues, trauma symptoms, safety concern, decreased quality of life, decreased productivity, negative emotions, law enforcement involvement, employment issues, and even mortality (Lemis et al., 2022).

Abusive behavior or trauma does not always involve tangible violence and does not only happen within family dynamics; interpersonal abuse can occur within different forms of dynamics including but not limited to intimate, parent or caregiver-child, friendship, and professional relationships. The impact of violence is a systemic issue because many forms of violence are interconnected at the individual level, across relationships and communities, and even intergenerationally (Sumner et al., 2015).

Though different categories of violence can have overlapping risk factors or protective factors, distinctions and recognition must be made between all different forms of abuse such as physical violence/abuse—traditionally, the most researched and detectable form—and emotional or psychological (Karakurt and Silver, 2003), sexual, spiritual, and financial abuse. For instance, perpetrators of different forms of violence can have certain characteristics, personality disorders, or neuropsychological deficits such as

hostile attributional biases, poor impulse control, or lack of empathy that can lead to distinct abusive behaviors (Sumner et al., 2015). Moreover, typically efforts to comprehend, prevent, and respond to interpersonal violence have been constrained by the way violence has been categorized—usually in terms of the relationship between the abuser and the victim or survivor (eg, peer to peer, parent or caregiver-child, intimate relationships) (Sumner et al., 2015). Yet, not all forms of abuse in interpersonal relationships have been equally investigated or officially defined, categorized, conceptualized, or empirically researched.

The traditional way of categorizing violence (e.g. domestic violence or child abuse) has detoured from the important distinction pathology may be contributing to the comprehension, prevention, and response of violence. Distinguishing other unique factors that contribute to violence, such as pathology (e.g. personality disorders), in categorizing violence may lead to the recognition and development of new defined forms of violence (e.g. narcissistic abuse). Social constructivism theory suggests that language and culture are the frameworks through which humans experience, communicate, and understand reality (Vygotsky, 1968); it is important to develop new language and culture that can lead to consistency in recognizing and addressing the needs, assessment, and treatment and services of variety of victims and their offenders.

One form of interpersonal abuse that has not been clinically classified or investigated is narcissistic abuse. Although narcissistic abuse can occur in any form of relationship that involves a person with narcissistic traits, the literature on DV and/or intimate partner violence (IPV) has provided much of the research to understand the cycle of narcissistic abuse in intimate relationships. Since pathological narcissistic

behavior is most manifested in intimate relationships, examining the abuse within DV/IPV literature can paint a picture of narcissistic abuse (Rakovec-Felser, 2014).

In the United States (US), many jurisdictions use a broad definition of domestic violence that mostly includes family and intimate partner violence reduced to a constructed formula story that excludes many of those who perpetrate and experience it (Barocas et al., 2016). Congress passed the Violence Against Women Act 1994 ("VAWA"), which recognized that domestic violence is a national crime and provided a comprehensive definition of domestic violence including emotional abuse, verbal abuse, and coercive control in intimate relationships (U.S. Dept. of Justice, 1996). VAWA states "Domestic violence is a pattern of abusive behavior in a relationship that is used by one partner to maintain power and control over another current or former intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person" (U.S. Dept. of Justice, 1996). However, the aforementioned definition does not reflect the legal definition of family and domestic violence used by states across US for criminalization or adjudication by the criminal justice system (Barocas et al., 2016). The variation in the state-by-state definition of domestic violence law has created an inconsistency in the services and criminalization of variety of offenders and protection for US citizens (Barocas et al., 2016). The current policy response to domestic violence in the United States is based on a violent incident model in most states, emphasizing on the threats or acts of isolated and physical instances of abuse and it's visible impact (Stark, 2012). The impact of other forms of abuse such as emotional (or psychological) abuse, occurring in chronic and repetitive episodes of coercive control and infringement upon personal freedom and

wellbeing, is not currently recognized or criminalized in most states in the US (Stark, 2012). Thus, coercive control and emotional (or psychological) abuse, being some of the most common forms of abuse used by a narcissistic individual, is not criminalized by most state laws.

One of the states that is known to support a comprehensive definition of domestic violence is California. California domestic violence laws define domestic violence as abuse against an intimate partner that can include physical, psychological, emotional, sexual, and coercive behaviors. In detail, the Family Code Division 10. Prevention of Domestic Violence [6203] includes that domestic violence can be defined as intentionally or recklessly causing or attempting to cause bodily injury, sexual assault, placing a person in reasonable apprehension of imminent serious bodily injury to that person or to another, engaging in any behavior that has been or could be enjoined pursuant to Section 6320 (California Family Code, 2015). Section 6320 includes molesting, attacking, striking, stalking, threatening, sexually assaulting, battering, or credibly impersonating (California Family Code, 2015). It also includes that abuse is not limited to the actual infliction of physical injury or assault; it can include disturbing the peace of the other party, isolating the other party from friends, relatives, or other sources of support, depriving the other party of basic necessities, controlling, regulating, or monitoring the other party's movements, communications, daily behavior, finances, economic resources, or access to services, and also compelling the other party by force, threat of force, or intimidation (California family code, 2020).

Although, the California Courts do not include the word "narcissistic abuse" as a criterion in their definition of domestic violence; the literature shows a lot of overlap that

can conclude that narcissistic abuse can be known as domestic violence, noting that a narcissistic perpetrator makes the nature of the abuse unique. Based on the aforementioned literature, studies have shown for domestic violence to be detrimental in physical, psychological, financial, sexual, and emotional health. There is a great deal of literature about the psychological and personality profiles of batterers of domestic violence; however, the list is diversified (Dixon and Browne, 2003) including but not limited to narcissistic/conforming personality styles, avoidant/depressive personality styles, passive aggressive/dependent personality styles, antisocial personality disorder, paranoid personality disorder, and borderline personality disorder (White and Gondolf, 2000).

The Cycle of Violence was first described by psychologist Lenore Walker in her book, *The Battered Woman* (1979). This model can be useful in understanding the complex dynamics that occur in abusive intimate relationships; however, Walker (1979) also emphasizes the likelihood of perpetrators of family violence to attempt aggressive acts outside of the family and in their community. Walker emphasized “Battered woman’s syndrome is the psychological effects of living with intimate partner violence; which is not a mental illness, but the result living with trauma (Walker, 1979). The Cycle of Violence has been described as having three stages: the tension building stage, the violent episode, and the honeymoon stage (Walker, 1979). The Tension building phase starts with an increase in hostility, stress, arguments, and/or limited abusive behaviors. These behaviors that resemble coercive control eventually lead to the violent episode entailing more serious abusive behaviors that most likely cause injury or harm (Walker, 1979). Walker further explains that most often, perpetrators shift the relationship to the

honeymoon phase by showing some type of remorse and promises of change, creating a cycle. These abusive phases include the different attempts a victim might make in order to stop the violence rather than ending the relationship, while the perpetrator puts in effort to normalize the cycle and convince the victim to stay in the relationship (1979). Although not all abusive relationships follow this cyclical pattern, the cycle of violence can help to explain an overall view of the abusive pattern.

In her book, *The Battered Woman Syndrome*, Walker (2000) adds that prevalent characteristics of male abusers in intimate partner abuse include controlling and manipulative behavior, intrusiveness, jealousy, vacillating between charming and seductive and mean and hostile (Walker, 2000). Walker's (2000) literature review suggests that perpetrators of intimate partner violence have some characteristics in common which may include verbal and behavioral aggression, unreasonable severe jealousy, externalizes and justifies problem, lies, demonstrates self-deprecation, suicidal threats and gestures, and depressive at times. Additionally, some other characteristics may include inconsistency in intimacy with others, lack of empathy, expecting unrealistic demands, substance abuse, lacking interpersonal effectiveness, demonstrating sociopathic and highly manipulative behavior, defying limits, and having low tolerance for stress, while denying or minimizing their violent behavior (Walker, 2000). Similarly, narcissistic individuals share a lot of the personality features that have been linked to perpetrators of intimate partner violence, especially psychological abuse (Byrne & O'Brien, 2014; Hockenberry, 1995). Though the specific effects of narcissistic behaviors on others have not been researched yet, the common characteristics of abusive partners and the pathological narcissism can help to understand the severe impact on the physical,

psychological, sexual, and financial wellbeing of victims and survivors of narcissistic abuse.

In her Master's Thesis, Elise (2019), concludes and discusses that there are unique abusive patterns perpetrated by narcissistic partners, directly connected to the criteria and manifestations of NPD, compared to abusive patterns perpetrated by non-narcissistic partners which makes the abuse unique (Elise, 2019). Research shows that a perpetrator with narcissistic patterns distinctively show a false persona and a false reality of their love, intentions, relationship, and a promising future masked with charm and/or grandiosity (Lamkin, Lavner & Shaffer, 2017; Miller et al., 2017; Pincus et al., 2009; Samuel et al., 2012). The distinct pattern of intentionally using charming tactics and showing a false persona seen in narcissistic perpetrators manipulates the victim's love and trust and deceives their perception of reality (Lamkin, Lavner & Shaffer, 2017; Miller et al., 2017; Pincus et al., 2009; Samuel et al., 2012). The repetitive manipulative and deceitful tactics caused by narcissistic abuse causes chronic and persistent cognitive dissonance, especially because most of the abuse is non-physical and invisible (Lamkin, Lavner & Shaffer, 2017; Miller et al., 2017; Pincus et al., 2009; Samuel et al., 2012). Brown and Young (2018) mention that chronic and persistent cognitive dissonance is a condition associated in part with brain functioning and hyper-neural activity causing emotional dysregulation and cognitive dysregulation leading to issues in executive functioning, cognitive problems, and overall ability to function in day-to-day activities.

Elise (2019) further concludes that there is less emphasis on physical abuse in narcissistic abuse, compared to other domestic violence literature. Non-narcissistic perpetrators might abuse their partners due to psychological conditions such as

depression, poor emotion regulation, addiction, or other personality disorders; however, narcissistic perpetrators indicate a high level of chronic manipulation, aggression, and antagonistic and coercive behavior that is intentional (Elise, 2019; Brown et al., 2009; Samuel et al., 2012). Furthermore, one of the DSM-5 criteria for narcissistic personality disorder is that the enduring behavioral patterns are not attributable to the physiological effects of a substance or another medical condition (American Psychiatric Association, 2013); which distinguishes it from those reasons non-narcissistic perpetrators offend and abuse.

Additionally, the unique pattern of narcissistic perpetrators is the lack of genuine empathy, remorse, and apology after abusive behavior (Brown et al., 2009; Samuel et al., 2012). Furthermore, the honeymoon stage in the cycle of narcissistic abuse is self-serving and is only done for narcissist's own benefit, convenience, and self-esteem. In domestic violence literature, a non-narcissistic perpetrator feels remorse and makes amends and apologizes in some ways during the honeymoon stage of the abuse cycle (Elise, 2019; Walker, 2000). The difference in narcissistic perpetrators is the lack of insight on self to take responsibility, accountability, and attentiveness to repair the harm imposed on their partner; hence, making their victims take accountability and blame for the problems in the relationship and the harms caused (Elise, 2019). Additionally, the nature of narcissism increases resistance to insight and change of self; therefore, therapy can be less effective compared to perpetrators of domestic violence that do not have personality disorders (Elise, 2019).

Similarly, the aforementioned literature showed that narcissistic individuals display characteristic traits and behaviors of aggression, rage, grandiosity, unempathetic,

inflated self-esteem, domineering, need for admiration and power, disinterest in the need of others, self-serving, and violent (Brown and Young, 2018; Lamkin, Lavner & Shaffer, 2017; Miller et al., 2017; Pincus et al., 2009; Samuel et al., 2012). These traits lead to psychological, sexual, and physical aggression which can include atypical trauma, coercive control, manipulation, blaming, derogating, devaluing, criticizing, controlling, deceiving, disrespecting, exploiting, stonewalling and punishing others (Brown and Young, 2018; Lamkin, Lavner & Shaffer, 2017; Miller et al., 2017; Pincus et al., 2009; Samuel et al., 2012). Therefore, based on the aforementioned literature, it can be concluded that narcissistic abuse falls under domestic violence or intimate partner abuse, even though it has not been officially recognized as such; however, narcissistic individuals have distinct deceitful characteristics that make their abusive patterns unique compared to non-narcissistic abusers. Hence, not every domestic violence perpetrator is narcissistic but narcissistic abuse in an intimate relationship is in fact domestic violence.

Licensed Marriage and Family Therapists

According to the American Association of Marriage and Family Therapy (AAMFT), marriage and family therapists (MFTs) are recognized as the five core mental health professions, along with psychiatrists, clinical psychologists, clinical social workers and psychiatric nurse specialists (2022). As MFTs are recognized by the U.S. Department of Health and Human Services and Health Resources and Services Administration to treat individuals, couples and families (AAMFT, 2022), they are one of the main lines of contact for consumers of mental health services. Especially due to their focus on understanding symptoms and diagnoses within interactions, relationships, and environmental and familial systems (AAMFT, 2022), MFTs should have sufficient

competence in treating individuals, couples, and families with relational issues such as relational trauma.

Moreover, it is crucial to understand and explore the knowledge and clinical skills of licensed marriage and family therapists (LMFTs) to understand the quality, gaps, and needs in treating victims and survivors of narcissistic abuse. Research has shown that therapists have a critical role in the therapy process and change; the therapist may often be the central figure in positive and negative therapeutic change (Blow et al., 2007; Wampold, 2001). Therefore, it is important to understand and explore the quality of therapy and therapists' level of competence in providing services to any vulnerable population. The American Association for Marriage and Family Therapy (AAMFT) is the professional association for the field of marriage and family therapy, representing more than 50,000 MFTs in the United States of America, Canada, and abroad (American Association for Marriage and Family Therapy, 2022).

According to AAMFT (2022), LMFTs must complete master's or doctoral degree in marriage and family therapy from a regionally-accredited or a COAMFTE-accredited program and get trained with a minimum of two years of supervised clinical experience. The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) is a specialized accrediting body that accredits master's degrees, doctoral degrees, and post-graduate degree clinical training programs in marriage and family therapy throughout the United States and Canada. Moreover, Council for Higher Education Accreditation (CHEA) is a non-governmental organization that recognizes accrediting bodies to ensure the quality of American post-secondary education (CHEA, 2021). CHEA recognizes COAMFTE as the only accrediting agency for a graduate

degree and clinical training programs in Marriage and Family Therapy in the United States and Canada (CHEA, 2021). Additionally, the Association of Specialized and Professional Accreditors (ASPA) is a non-profit organization that works towards improving the quality of higher education through specialized and professional accrediting agencies and ensures that accreditation bodies such as COAMFTE stay current, consistent, and innovative with the best accreditation practices (ASPA, 2021).

Since COAMFTE has been the most standard and recognized national accreditation, this study will initially focus on exploring the efficacy of COAMFTE accredited MFT program and therapists. It will then focus on interviewing mental health clinicians with a broad academic background to gain a well-rounded guide towards the needs, assessment, and treatment of narcissistic abuse. The qualifying terminal degree for marriage and family therapists to possess licensure and practice independently is a master's degree in marriage and family therapy. In other words, although a doctoral degree in MFT is available, the required terminal degree is at a master's level for licensed marriage and family therapists to practice independently. Additionally, MFT Supervisors must be Licensed Marriage and Family Therapists; no higher academic degree is required of them other than acquiring a two-year license, taking a six-hour supervision course every renewal period, and holding a valid license (Board of Behavioral Sciences, 2021). Therefore, master's level LMFTs have been acknowledged as competent to treat any population seeking mental health; however, they are responsible for extending their knowledge and research in the field.

The American Association for Marriage and Family Therapy (AAMFT) developed the Marriage and Family Therapy Core Competencies (2004) to define the

domains of knowledge and requisite skills for MFTs to ensure and improve the quality of mental health services. MFT programs must possess the core competencies so that licensed MFTs can follow this minimum requirement to practice independently (AAMFT, 2004). The 128 core competencies were categorized around six primary and five secondary domains for educators, trainers, regulators, researchers, policymakers, and the public. The primary domains include admission to treatment, clinical assessment and diagnosis, treatment planning and case management, therapeutic interventions, legal issues, ethics and standards, and research and program evaluation (AAMFT, 2004).

Additionally, conceptual, perceptual, executive, evaluative, and professional development are the more focused subdomains that include the type of skills or knowledge MFTs must possess. Although the MFT core competencies create a foundational framework for MFTs and educators, they can be broad in practical terms. For instance, domain 2.1.2 states that MFTs should “understand the major behavioral health disorders, including the epidemiology, etiology, phenomenology, effective treatments, course, and prognosis” (AAMFT, 2004, p. 2). However, this subdomain does not necessarily give direction on the extent of knowledge one must have about behavioral health disorders to provide effective and appropriate treatment. In other words, MFT Master’s degree programs provide a broad and general understanding of marriage and family therapy by design. Research has shown the importance of program core competencies in developing competent therapists; however, there is a need for more research on understanding therapist competency and improving existing MFT programs (Hardy & Laszloffy, 1995; Hines, 1996; Miller & Lambert-Shute, 2009; Miller et al., 2010; Mittal & Wieling, 2006; Nelson et al., 2007; Nelson & Graves, 2011; Northey,

2002; Rampage, 2014). Moreover, adequate MFT programs may enhance 'tudents' intellectual, cognitive, and skillset functioning in hopes of preparing entry-level therapists (Anderson, 1992; Cornille et al., 2003). Keeping therapist's nature and character traits in mind, it has been difficult to categorize graduates' levels of full competency and ability to apply learned material (Nelson et al., 2007).

Nelson and Graves (2011) researched the opinions of AAMFT Approved Supervisors on how well-prepared postgraduate trainees are compared to the MFT core competencies. Nelson and Graves (2011) shared the existence of a gap between the MFT trainee's level of mastery and the level desired by supervisors based on the MFT core competencies. These results correlated with previous suggestions indicating trainees' lack of adequacy for practice outside of their training programs (Dutton & Kohli, 1996; Hoge et al., 2004). Hoge et al. (2004) argued that the competency, accountability, and effectiveness required of post-graduate trainees are not supported by the level of teachings instructed in MFT programs. Furthermore, the ill-prepared trainees are accountable to clients, stakeholders, and insurance companies. Although MFT trainees may not have the same level of experience and competency compared to licensed MFTs, the mentioned gap between the MFT Core Competency (2004) and postgraduate trainee's competencies raises important information about the gap between training and what is needed of therapists.

The master's level MFT programs within COAMFTE accredited programs include a similar curriculum including but not limited to courses on law and ethics, theories and interventions, diversity and cultural competency, introduction to psychopathology, substance abuse, group therapy, parent-child therapy techniques,

trauma and crisis intervention, couples' therapy, research methods, assessment, psychopharmacology, sex therapy, and MFT practicum and internship (COAMFTE, 2021). Although the core competency and educational system for marriage and family therapists are known, what is not known is how sufficient the programs are for therapists to treat special populations. For example, although personality disorders, such as narcissistic personality disorder (NPD), are taught in assessment and psychopharmacology courses via the Diagnostic and Statistical Manual of Mental Disorders (DSM), MFT master's degree courses are not designed to focus on specialties.

Since schools are basing diagnosis and assessments on the DSM, it is important to point out discrepancies and inconsistencies in the NPD criteria in the DSM. The DSM-5 criteria of NPD provide a narrow definition of narcissistic personality disorder focused on grandiose features of narcissism, leaving out vulnerable psychological features of the disorder mentioned by many psychologists and experts (Caligor et al., 2015). Caligor et al. (2015) add that because DSM-5 criteria are, a priori, limited to observable features of psychopathology, the underlying psychological structure and dynamic of NPD is not presented in the DSM. Thus, therapists trained to assess, diagnose, and treat clients and families based on the DSM might not have sufficient information to competently and accurately conceptualize the various presentations of the disorder and dynamic.

The COAMFTE-approved curriculums showed a lack of training or information on people in relationships with individuals high in narcissism or narcissistic personality disorder. Additionally, it is difficult to assess if Domestic Violence or intimate partner violence courses and professors teach about narcissistic abuse and its impact on others since domestic violence does not include "narcissistic abuse" in its definition. For

instance, in California, the Family Code Division 10 (California Family Code, 2015). Prevention of Domestic Violence [6203] includes that domestic violence can be defined as intentionally or recklessly causing or attempting to cause bodily injury, sexual assault, placing a person in reasonable apprehension of imminent serious bodily injury to that person or another, engaging in any behavior that has been or could be enjoined under Section 6320 (California Family Code, 2015; NCSL, 2019).

Moreover, clinical and professional resources have shown that narcissistic abuse can occur in all relationships, including but not limited to parent-child, intimate relationships, friendships, work-environment relationships, and even politician-civilian dynamics (Day et al., 2022; Lance, 2016; Howard, 2019). Therefore, even if narcissistic abuse is explained in different terms, such as coercive control or psychological abuse in domestic violence courses, the full manifestation of narcissistic abuse in all relational dynamics would not be fully discussed. On the other hand, research and academia have been more focused on the characteristics of NPD rather than its impact on others in relationship with them (Keller et al., 2014). Therefore, MFTs would naturally miss the opportunity to learn about the victims and survivors of narcissistic abuse. Additionally, since narcissistic abuse and related terms are not officially coined or published academically and empirically, they are not present in the MFT curriculum and are not being taught. A large body of mental health professionals and coaches, in addition to victims and survivors of antagonistic relational dynamics, such as narcissistic abuse, have created common terms to describe narcissism and the narcissistic dynamic beyond its' acknowledgement in academic and empirical resources. Professional and clinical resources such as books written by experienced mental health professionals have

increased awareness of terms such as narcissistic abuse, the narcissistic abuse cycle, narcissistic dynamic, gaslighting, flying money, grey rocking, love bombing, hoovering, narcissistic supply, and narcissistic family system to voice a common language in describing such antagonistic relational dynamics (Durvasula, 2014). The various narcissistic related terminology and descriptions have played a positive role in increasing awareness, validation, and advocacy for victims; there is a benefit to having a common language in describing constructs that have not yet to be officially acknowledged. On the other hand, the use of informal terminology has caused inconsistency and inaccuracy in descriptions and information, possibly adding to the confusion in the victim's experience.

Moreover, with the introductory level and board overview of narcissistic personality disorder covered in COAMFTE accredited master's level MFT programs, MFTs may need to make intentional efforts to search for alternative sources to improve their knowledge and clinical skills in narcissism as well as narcissistic abuse. One problem with this is that if MFTs have been taught limited information by their trusted MFT programs, they might lack awareness of the limitations in their knowledge and clinical skills. Clinicians might be able to increase their awareness in their limited knowledge and clinical skills through intentional and evaluative conversations with clients and colleagues as well as staying updated with professional and popular publications in the field of MFT.

Some professional and popular publications, continuing education courses and trainings, podcasts, conferences, etc., provide information and teachings on narcissism, narcissistic personality disorder, and narcissistic abuse. However, the quality and accuracy of such resources might not have been tested or supported by clinical trials or

empirical research. Therefore, therapists can intentionally strive to learn more about victims and survivors of narcissistic abuse, narcissism, and NPD if they are able, willing, and trusting of the available resources. However, the challenges with training and post-graduate resources may include barriers in availability, accessibility, and acceptability due to time and financial restrictions.

Current Training on Narcissistic Abuse

Google is an internet search engine that many people use to retrieve relevant sources; upon searching google for narcissistic abuse training, the search engine provides a collection of books, articles, YouTube videos, podcasts, continuing education workshops and training, and uncertified and unaccredited training and workshops. There seems to be a gap between the need for education focused on narcissistic abuse and its availability, accessibility, and acceptability. Upon reviewing such vast information, it is difficult to trust the quality of what is available since many sources are not necessarily supported by empirical research, academic approval, and appropriate accreditation. Upon searching Google, there seems to be a limited amount of available resources for clinicians on the assessment and treatment focused on the victims and survivors of narcissistic abuse. However, compared to the complex needs of victims and survivors of narcissistic abuse and the lack of teachings in the academic curriculum, the number of the available, accessible, and acceptable trainings and courses for clinicians seem to be limited in quantity and comprehensiveness. However, there seem to be some mental health professionals who self-identify as specializing in narcissistic abuse and offer and market workshops and training.

Most mental health professionals must complete continuing education hours to receive their license renewal. Based on their personal and professional interest, each clinician can attain such hours from approved and/or accredited programs that offer continuing education workshops, training, and/or seminars. Websites such as Pesi.com, PsychotherapyNetworker.com, and other organizations offer educational services such as workshops, training, and seminars that often are accredited by numerous national, state and local licensing boards and professional organizations as approved continuing education sources. Upon searching online organizations such as PESI Inc, the following training are offered, but are not limited to, a 2-Day Intensive Training on Narcissistic and Psychopathic Abuse: The Clinicians Guide to the New Field of Traumatic Pathological Love Relationships (Brown et al., 2021) and Narcissistic Abuse and Gaslighting Treatment Course: Help Clients End Emotional Manipulation and Reclaim Their Lives from Toxic Relationships (Durvasula et al. 2022).

Brown et al. (2021) outlined the training by focusing on the definition and identification of the different stages of Pathological Love Relationships (PLR), Cluster B personality disorders, psychoeducation for survivors about personality disorders, victim/survivor personalities and targeted traits, investigate common mistakes made by practitioners, trauma symptoms, and trauma-informed treatment including but not limited to understanding Atypical trauma and chronic and persistence cognitive dissonance. Additionally, Brown et al., (2021) inform clinical treatment on differentiating narcissistic abuse from other domestic violence, addictive, co-dependent, or dysfunctional relationships. Brown et al., (2021), emphasizes the importance of in dept understanding of the disorders of relational harm, pathological love relationships (PLR), cognitive

dissonance, and the differentiation between typical and atypical trauma. The training outlines clinicians need to understand and address the negative impacts of cognitive dissonance and atypical trauma on brain functioning, physical health, and executive functioning (Brown et. al., 2021).

On the other hand, Durvasula et al. (2022) outlines the training by focusing on identifying different types of narcissism and narcissistic abuse, identification of covert abusive tactics like gaslighting, avoiding clinical missteps that could alienate clients, establishing effective boundaries, helping clients safely leave abusive situations, ending client's self-blame and self-shame, regaining client's personal power, and helping clinicians disarming the narcissist in couples' therapy. Additionally, Durvasula et al. (2022) provide information on the different subgroups of clients who typically present with narcissistic abuse and the differential needs of these groups by providing psychoeducation tailored to clients based on their presentation, history and the nature of the narcissistic presentations they are facing.

Although there are similarities between the available continuing education trainings (Brown et al., 2021; Durvasula et al. 2022), there seem to be some differences in their approach and belief system. Therefore, clinicians might need to evaluate and choose each resource to the best of their knowledge and practice.

As mentioned, individuals that have suffered from narcissistic abuse experience a variety of physical and psychological symptoms and illnesses, including but not limited to depression, anxiety, PTSD, Complex PTSD, neurological issues, medical issues, eating disorders, substance abuse, suicidality, self-harm, sleep disorders, persistent cognitive dissonance (Brown and Young, 2018; Howard, 2019; Leedom, 2019; Day et al., 2020).

Since these symptomologies and disorders are common to other mental illnesses and are experienced by a variety of clients with different mental health concerns, clinicians can increase their knowledge and clinical skills by gaining additional training on the aforementioned issues. Thus, although there do not seem to be sufficient evidence-based and standardized one-stop resources for clinicians to become proficient in the needs, assessments, and treatment of narcissistic abuse, there are helpful resources covering the aforementioned symptoms and disorders commonly experienced by individuals suffering from mental health issues.

Additionally, there are available professional and popular publications such as blogs, books, articles, podcasts, and videos presented by mental health professionals and individuals who have experienced or witnessed such abuse. Most of these professional and popular resources seem to target the victims and survivors of narcissistic abuse rather than providing clinical guidance for professionals treating this population. However, the professional and popular resources can help clinicians in enhancing their awareness and knowledge about this population. The quality and accuracy of such resources is difficult to assess and evaluate as this is an understudied construct and the resources might have little to no empirical research and academic support backing up their curriculum.

Additionally, based on the researcher's current knowledge, the available training or treatment resources for narcissistic abuse recovery in the US have yet to have gone through experiential research and clinical trial process in order to evaluate their efficacy. Therefore, clinicians, including LMFTs, may need to personally and intentionally strive to learn more about narcissistic abuse beyond their academic program as well as evaluate

the current literature and training resources. Moreover, professional and clinical resources can be costly, creating a possible barrier of acceptability of the services.

Due to the complex symptoms caused by narcissistic abuse, victims and survivors need comprehensive treatment services that meet every area of their needs. Based on the literature, it can be concluded that the treatment services provided for victims and survivors of narcissistic abuse would generally have to entail modalities that support their psychological, physical, spiritual, sexual, social, neurobiological and somatic needs. Therefore, it can be concluded that any training and resource must have the internal and external capacity to include extensive knowledge, clinical skills, and referral resources to cover services and modalities that meet the population's needs.

CHAPTER THREE

CONCEPTUAL FRAMEWORK

Social Constructivism

Based on the gap in current evidence-based research, academic resources, knowledge, and clinical skills in treating victims and survivors of narcissistic abuse, some professionals, such as licensed marriage and family therapists, might not have sufficient competency to assess, diagnose, and treat this population. Certain shifts need to occur in order for systemic change to occur in the field of therapy. Social constructivism brings a systemic model to create understanding and change in systemic learning. Social constructivism focuses on the construction of how humans create meaning, generate truth, and perceive and interpret information in a systemic way (Gehart, 2016). Psychologist Lev Vygotsky developed social constructivism as a theory that acknowledges the collaborative nature of living in relationships and learning.

Vygotsky (1978) emphasized that all cognitive functions develop in social interactions, and thus, our functionality is a product of social interactions. Additionally, Vygotsky (1978) argued that learning was not just about constituting the assimilation and accommodation of new knowledge but about how learners are merged into a knowledge community. Moreover, social constructivism supports the idea that learning is a collaborative process and human motivation is both extrinsic and intrinsic. Moreover, people go through learning and growth as they interact and make meaning of their lives and experiences; learners can be motivated by community reward, inner drive, and psychological self (Vygotsky, 1978).

One of the main concepts Vygotsky focused on was how social interactions play a substantial role in cognitive growth. Based on the idea that individuals learn through interaction with others in their communities, Vygotsky (1978) determined that authorities such as teachers can have much control and influence in educational settings. Vygotsky (1978) shared that teachers, peers, adults, teachers, and other mentors can have an impact on ones learning, tasks, behavior, and responses. Therefore, interactive activities, productive discussions, constructive feedback, and collaboration with others create a common language and culture that could promote cognitive growth (Vygotsky, 1978). Additionally, Vygotsky (1978) shared the importance of culture as the primary determinant of knowledge acquisition, including the beliefs and attitudes modeled by a culture. Social constructivism showed that language is the basis of learning due to its support in activities such as reading and writing and communicating, reasoning and reflecting. As such, Vygotsky formed three main concepts that explained cognitive development and learning culture is significant in learning, language is the root of culture, and individuals learn and develop within their role in the community (Vygotsky, 1978).

As mentioned, there is a dearth in the systemic lack of focus on victims and survivors of narcissistic abuse and a lack of consistent and complete presentation of narcissism in academia, research, and the DSM-5. Due to this gap, some LMFTs might not have had the foundation or learning environment to sufficiently learn or understand the significance of the unique narcissistic dynamic and the language that supports it. Academia, research, and the DSM-5 are fundamental tools that therapists follow

collectively. If everyone uses similar limited teaching tools and resources, clients might be in danger of receiving ineffective and limited treatment.

Some of the methods therapists can learn clinical knowledge and competency are through their academic experience, supervision, continuing education units (CEUs), and post-graduate training. Though an academic degree, supervision, licensure process, and CEUs are required to become a licensed marriage and family therapist, post-graduate and specialty training are not mandatory. Therefore, if therapists decide not to increase their knowledge and clinical expertise in a population, their knowledge is only dependent on their knowledge from their academic, supervisory, clinical and networking experience. However, LMFTs are allowed to treat all mental health populations, which in this case can create barriers and harm clients who trust the available services as sufficient for their needs.

As social constructivism suggests, culture and language and interaction play a role in learning; therefore, therapists can improve their knowledge and clinical skills by joining the communities and colleagues who are more knowledgeable in the field of narcissism and narcissistic abuse. However, there seems to be a dearth of sufficient availability, accessibility, and acceptability of such resources. As mentioned, since narcissistic abuse and related terms are not officially coined or published academically and empirically, they are not present in the MFT curriculum and are not taught in schools. However, a large body of mental health professionals and coaches and victims and survivors of narcissistic abuse have created common terms to describe narcissism and the narcissistic dynamic beyond its' acknowledgement in academic and empirical resources.

Professional and popular publications such as books written by experienced mental health professionals have increased awareness of terms such as narcissistic abuse, the narcissistic abuse cycle, narcissistic dynamic, gaslighting, flying money, grey rocking, love bombing, hoovering, narcissistic supply, and narcissistic family system to voice a common language in describing such antagonistic relational dynamics (Durvasula, 2014). Moreover, social constructivism suggests that individuals are active participants in creating their knowledge, and most learning occurs in social and cultural settings (Schreiber & Valle, 2013). As social constructivism suggests, culture and language and interaction play a role in learning; therefore, therapists can also improve their knowledge and clinical skills by joining the communities and colleagues who are more knowledgeable in the field of narcissism and narcissistic abuse. However, there seems to be a dearth of sufficient availability, accessibility, and acceptability of such supportive and educational community resources for clinicians treating victims and survivors of narcissistic abuse.

Additionally, the significance of supervision amongst mental health professionals has been evident; effective clinical supervision ensures that clients are competently served, and therapists improve their clinical knowledge and skills. In addition, effective supervision can increase treatment effectiveness, client retention, and staff satisfaction. (Bernard & Goodyear, 2009; Pearson, 2000; Reid et al., 1999; Spence et al., 2001;). Even though supervision is valuable in the field of therapy, the approach, clinical focus, and intensity of supervision can vary (Bernard & Goodyear, 2009; Sexton, 1998; Spence et al., 2001). Therefore, the knowledge and clinical skills on narcissism and narcissistic abuse can vary in supervisory dynamics.

The lack of a consistent definition, measurement, and lack of consistent knowledge of narcissism and narcissistic abuse within academia, supervision, and post-graduate training have tremendous implications for the quality of work being offered to clients.

Moreover, such a systemic gap can limit practitioners' clinical knowledge, skills, confidence, and reflectivity. The limitation of knowledge and clinical skills for narcissism and narcissistic abuse is a collective problem that needs collaborative change to shift the teaching and learning of the population. Social constructivism also suggests collaborative learning methods to advance teamwork skills, emphasizing the positive correlation of individual learning to the success of group learning (Vygotsky, 1978). In other words, therapists involved in additional readings and personal and clinical experiences have and can play a substantial role in increasing awareness and promoting more research and teachings on narcissism and narcissistic abuse. Increasing such discussion and communities among highly experienced clinicians can also highlight the similarities and differences in their approaches, which can lead to valuable learning experiences and improvement in the current approach.

As Vygotsky's model and research were focused on children's development, he argued that a lot of what children learn is based on their social interactions, having a role model that promotes proper behavior and instructions through cooperative or collaborative dialogue (Vygotsky, 1978). Similarly, there have been a lot of interactions between therapists and victims that have awakened the significance of learning about narcissism and narcissistic abuse. Social constructivism theory is relevant in that, although there have been limitations in the higher-level teachings and research of

narcissism and narcissistic abuse, mental health professionals have learned substantial context through personal experience, interactions with victims and survivors, and professional and popular publications readings. However, many might have different perspectives due to the lack of common sufficient learning sources. Thus, the variety of non-evidence-based perspectives and approaches among mental health professionals can increase deficient learning and teaching resources. This highlights the need LMFTs might have for further evidence-based research, common diagnosis, etiology, vocabulary, and teachings and training focused on victims and survivors of narcissistic abuse. Vygotsky's research showed that children seek to understand modeled behaviors and instructions, internalize the information, and learn how to guide or manage their own behavior (Vygotsky, 1978). In other words, cognitive functions and understandings can be changed based on social interactions and collaboration. Therefore, the understanding of narcissism and narcissistic abuse can change based on safely facilitated collaboration and interactions between experts in the field of narcissism and higher education authorities. The social negotiation through learning by the construction of knowledge creates change in the competency of LMFTs, clients, and the education system.

Identifying the needs, assessments, and treatment advised by clinicians who treat narcissistic abuse victims can help identify gaps in higher education and policy making, program development and evaluation, and a standardized diagnosis, assessment, and treatment. Therefore, this study can play a role in the fundamental therapeutic recommendations for treating victims and survivors of narcissistic abuse based on clinicians who self-identify as having competent, proficient, and expert-level of knowledge and clinical skills in working with this population. Noting the viewpoints and

expertise of clinicians familiar with this delicate and complex subject of narcissistic abuse can substantially increase systemic knowledge and insight into a collective and standardized diagnosis, assessment, and treatment attuned to the peculiarities exhibited by victims and survivors of narcissistic abuse.

CHAPTER FOUR

METHODOLOGY

Overview

This needs assessment aims to identify the knowledge and clinical skills recommended by clinicians who treat victims and survivors of narcissistic abuse to identify some needs, assessments, and treatment practices that can guide licensed marriage and family therapists (LMFTs) in treating this population. This needs assessment used qualitative thematic analysis to conduct a 60-90-minute virtual semi-structured interview with 14 mental health clinicians who self-identify as having competent, proficient, or expert levels of knowledge and clinical skills in treating victims and survivors of narcissistic abuse. It aimed to provide recommendations for Marriage and Family Therapists in treating this population. We aimed to answer the following research question: what do clinicians who treat victims and survivors of narcissistic abuse consider as the needs, assessments, and treatment of victims and survivors of narcissistic abuse?

The subjects were recruited through multiple outlets, including directly emailing clinicians who self-advertised as narcissistic abuse service providers, publishers, and instructors, and submitted online flyers on social media to recruit a broad range of subjects. As an initial invitation, the researcher either directly sent a detailed email to subjects or included specific structures on online social media flyers for subjects to apply for participation. The initial invitation email (Appendix A) and online flyer (Appendix D) included information regarding the aim and purpose of the research, specific participation criterion and requirements, interview process, sign-up instruction, and a Qualtrics Link to

invite clients to apply for participation in the study by completing the Informed Consent Form (See Appendix B) and Demographic Questionnaire (See Appendix C).

Based on 25 recipient responses to the demographic questionnaire and inclusionary criterion, the researcher selected and sent eligibility invitation email (see Appendix E) to the 21 eligible clinicians. The subjects identified as licensed clinicians who were competent, proficient, or expert (based on the Dreyfus Model of skill acquisition, see appendix H) in treating victims and survivors of narcissistic abuse. As a result, 14 of the 21 clinicians successfully scheduled and completed confidential virtual semi-structured interviews that each lasted about 50 to 90 minutes. The data for non-eligible and non-responsive subjects were deleted from Loma Linda University Email and Qualtrics. The interviews took place through a cloud-based video conferencing tool called Zoom. The interviews were recorded and then transcribed verbatim with personal information de-identified.

After de-identification, the researcher deleted all video and audio recordings for privacy purposes. Appropriate privacy and security procedures were followed throughout the study to ensure participant confidentiality and safety. The method used to analyze this qualitative study was thematic analysis to identify common themes regarding clinicians' recommendations in the needs, assessment, and treatment of victims and survivors of narcissistic abuse. The researcher coded each transcription and created themes that described common patterns and meaning within the data. The meaning of the results was described in an analysis report that included mind maps and tables to illustrate the description and meaning of the data within the existing literature on the topic.

Clinicians as Participants

Many people have experienced narcissistic abuse, yet there is little official peer-reviewed or academic research done to explain the debt of this abuse on the victims and survivors and how to treat this population. Since narcissistic abuse is under-recognized and understudied, it lacks proper statistical and empirical conceptualization. Therefore, it is important to explore the collective and common approaches used by clinicians who report having competent, proficient, or expert knowledge in the needs, assessment, and treatment of narcissistic abuse. In addition, clinicians' recommendations can help other mental health professionals, including LMFTs, to enhance their competency in assessing and treating victims and survivors of narcissistic abuse. Moreover, social constructivism suggests that individuals are active participants in creating their knowledge, and most learning occurs in social and cultural settings (Schreiber & Valle, 2013). Thus, recommendations of clinicians with a competent, proficient, and expert understanding of the population, the terms and language, and narcissistic abuse can spark a culture of learning and growth in the topic.

In order to provide a common definition of a clinician's level of knowledge and clinical skills, this study used the Dreyfus model of skill acquisition in describing participant inclusion. The Dreyfus model describes how individuals learn by progressing through various levels of knowledge and skills acquisition (Benner, 2004; Dreyfus and Dreyfus, 1980; Lyon, 2014; Pena, 2010). The various levels of learning and progression through the acquisition of skills include novice, advanced beginner, competent, proficient, and expert (Dreyfus and Dreyfus, 1980; Dreyfus and Dreyfus, 1986). Although the Dreyfus model has not been adapted or explained in the mental health clinical context, it has been adapted by nursing educators in explaining the development

of clinical nursing skills (Benner, 2004). To define inclusion, current research may be sufficient for this study.

In the novice stage, a learner has no prior experience and focuses on following rules and protocols without keeping the context in mind. Novice individuals use analytic reasoning and rules to link cause and effect and feel a lack of responsibility to anything other than the protocol and rules (Benner, 2004; Dreyfus and Dreyfus, 1980; Lyon, 2014; Pena, 2010). In the advanced beginner stage, the learner has some experience but still has limited situational perception. An advanced beginner can sort through information and rules to decide what is relevant based on past experience. An advanced beginner can mentally organize and synthesize presenting problems and comprehend them into a succinct, unified explanation of the problem using analytic reasoning and pattern recognition (Dreyfus and Dreyfus, 1980; Benner, 2004; Lyon, 2014; Pena, 2010).

Competence develops after having considerable consistent and repeated experience while accurately identifying and assessing patterns and presenting problems. A competent learner uses analytic and nonanalytic reasoning to recognize efficient and accurate diagnoses and patterns, and has emotional buy-in on the subject, which leads to an appropriate level of responsibility. A competent learner still requires reliance on analytic reasoning while treating complex or uncommon problems (Benner, 2004; Dreyfus and Dreyfus, 1980; Lyon, 2014; Pena, 2010). A proficient learner has vast experience, has a systemic view of the situation, and can easily perceive deviations from normal patterns and develop their own rules to formulate alternative plans. Proficiency is shown when individuals respond to cases intuitively and can work effectively in unfamiliar contexts (Dreyfus and Dreyfus, 1980; Benner, 2004; Lyon, 2014; Pena, 2010).

Unconscious and automatic performance are associated with individuals in the expert phase; expert individuals are no longer dependent on explicit knowledge. Experts have the highest level of performance, and their thoughts, feelings, and actions align with intuitive problem recognition and intuitive situational responses and management. Experts have a perceptive insight into discriminating features that do not fit a recognizable pattern or protocol (Dreyfus and Dreyfus, 1980; Lyon, 2014; Pena, 2010).

Inclusion/Exclusion

The inclusionary criteria included clinicians who were currently licensed in their respected state as either a Licensed Professional Clinical Counselor (LPCC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT) holding a Masters or Doctorate in Marriage and Family Therapy (DMFT), or a Clinical Psychologist holding a Doctorate in Philosophy (PhD) or a Doctorate in Psychology (PsyD). The purpose of including clinicians from various schools of practice was to understand different views and approaches to provide efficient and well-rounded recommendations for the needs, assessments, and treatment of victims and survivors of narcissistic abuse. Clinicians must have graduated from accrediting commissioning bodies approved by the state of licensure where the clinician was currently practicing. Clinicians must have treated or been treating at least six primary narcissistic abuse cases within the past year of practice. Additionally, clinicians must have had enhanced knowledge and clinical skills in treating victims and survivors of narcissistic abuse based on at least two of the following criteria:

- Completed related academic courses

- Read an ample amount of related anecdotal sources such as books, journals, articles, etc.
- Read and reviewed an ample amount of related empirical resources and research
- Attended ample amount of related conferences, workshops, or structured training
- Instructed ample amount of related conference presentations, structured training, or workshops
- Published related books
- Published related blogs, articles, and research studies

Subject Recruitment

Subjects were recruited in multiple ways. Initially, the researcher recruited subjects through a google search to find clinicians who advertised as treating victims and survivors of narcissistic abuse. Based on the Google search results, the researcher reached out to candidates through a detailed initial invitation email (Appendix A). The researcher also used google.com to email professionals from narcissistic abuse-related recovery forums, publications, and professionals in the field who might have led to other referrals. Finally, the researcher emailed recipients an Initial invitation (Appendix A) that included the aim and purpose of the research, specific participation criterion and requirements, interview process, sign-up instructions, a Qualtrics link to informed consent and a demographic questionnaire.

Another way the researcher recruited subjects was by providing an online flyer (Appendix D) to the Loma Linda University School of Behavioral Health (LLUSBH) for

the department to post the flyer on SBH social media accounts such as Facebook. The researcher then re-shared the LLUSBH post on other Facebook groups related to narcissistic abuse with instructions to email the researcher for more information and to complete the informed consent (Appendix B) and demographic questionnaire (Appendix C) provided on the Qualtrics link. Upon contact, the researcher responded to the email with an invitation that included the aim and purpose of the research, specific participation criterion and requirements, interview process, sign-up instructions, a Qualtrics link to informed consent, and a demographic questionnaire.

Specific Recruitment Steps

Recruitment took place in various ways:

- The researcher E-mailed individual clinicians who advertised as treating victims and survivors of narcissistic abuse on their professional webpage.
- The researcher submitted an online flyer (Appendix D) to LLUSBH, requesting for the department to post the flyer on SBH social media accounts such as Facebook.
- The researcher re-shared the LLUSBH post on other Facebook groups related to narcissistic abuse with instructions to email researcher for more information and/or to complete the informed consent and demographic questionnaires. (e.g., Surviving Abuse – Narcissistic, mental, emotional Facebook group).
- The researcher E-mailed speakers and organizers in the narcissistic abuse related workshops (e.g. Narcissistic Abuse and Gaslighting Summit).
- The researcher E-mailed book publishers

- The researcher E-mailed blog or article publishers (e.g., The Day You Discover You're a Victim of Narcissistic Abuse by Claire Jack, Ph.D.)
- The researcher E-mailed instructors who teach about narcissism and narcissistic abuse (e.g., 2-Day Intensive Training on Narcissistic and Psychopathic Abuse: The Clinicians Guide to the New Field of Traumatic Pathological Love Relationships)

Screening and Selection Process

Clinicians of any age, sex, race, ethnicity, sociocultural background, and years of experience in the field were welcomed in this study. The Researcher provided a demographic questionnaire (Appendix C) to gain background information on participants and monitor for any thematic data analysis in the form of cross tabulations to compare survey data across multiple demographics. Based on 25 recipient responses to the demographic questionnaire and inclusionary criterion, the researcher selected and sent an eligibility invitation email (see Appendix E) to the 21 eligible licensed clinicians. They identified as competent, proficient, or expert (based on the Dreyfus Model of skill acquisition, Appendix H) in treating victims and survivors of narcissistic abuse. The eligibility invitation email (Appendix E) was sent to the 21 selected participants to schedule their interview; the email included instructions to call or email the researcher to schedule a 60-90-minute interview.

After the subjects scheduled their interview, the researcher sent an email with a zoom link (Appendix F) with interview information and instructions. The researcher sent follow-up emails if there was a lack of recipient response, a need for follow-up, or related questions at any point in the recruitment, screening, or selection process. In addition, 14

of the 21 clinicians successfully scheduled and completed confidential virtual semi-structured interviews that lasted about 50 to 90 minutes.

Informed Consent Process

The instructions to complete the informed consent form (Appendix B) were included in the initial invitation email (Appendix A) and online flyer (Appendix D) through a Qualtrics link. The subjects were required to complete the informed consent and demographic questionnaire to be considered interview participants. The informed consent included the study purpose, procedures, confidentiality, participation risk, rights, and benefits approved by The Institutional Review Board at Loma Linda University. At the beginning of the scheduled interview, the Researcher briefly reviewed the informed consent of the 14 participants and provided an opportunity for them to ask any questions or withdraw their participation before starting the interview. Participants were informed that prematurely withdrawing from the interview did not reduce the compensation amount. In addition, the researcher informed participants that breaks are allowed as needed.

Risk and Injury

The informed consent form included the possible risks and injury of participation. The risk for participation in this study was minimal. The participants were allowed to withdraw from this study at any time; however, no participant requested a withdrawal. Therefore, this study posed no greater risk to participants than they routinely encountered daily. Due to the fact that participants were being questioned about their knowledge and

clinical skills, they were informed that they might experience negative feelings about themselves or the study if they did not know the answer or felt unable to provide clinical recommendations. Other discomforts might have included boredom or fatigue due to the 50-90-minute duration of the interview.

The informed consent included steps the researcher planned to take in order to prevent or minimize risks by screening to reassure an appropriate selection of participants, sound research design and interview questions, providing an opportunity for verbal feedback from participants, and informing participants of the risk and the purpose of the interview questions as well as ensuring that the study is not an evaluation of their knowledge and clinical skills as clinicians.

Security Plan

The Principal and Researchers utilized Loma Linda University's (LLU) secured cloud, OneDrive, for all research data storage. This platform was selected because the Researcher lives and works away from the LLU area. Therefore, only the Principal and Researchers had access to identifiable data. The Researcher used LLU's Microsoft Outlook Web App (e-mail) to contact participants for secure and HIPAA-compliant communication. For a secure method to collect data, the Researcher used LLU's Qualtrics account to collect the participant's informed consent, demographics, and contact information. The Researcher also used a HIPAA-compliant video platform through LLU, Zoom, for participant interviews. Zoom is a cloud-based video communications app that allows for virtual video and audio conferencing with recording capabilities. All Zoom recordings were saved on LLU's Zoom cloud for secure storage until the Researcher deleted them upon completing the video transcription. Finally, the

Researcher utilized a secure laptop to analyze the data in a private location. Again, data was accessed and saved only on LLU's OneDrive. The data analysis was done using qualitative analysis software, NVIVO, which LLU provided.

Confidentiality

The researcher took proper measures to ensure security and confidentiality. All records and research materials containing participant identities were stored and kept confidential. Any published document resulting from this study will not disclose any identity without permission. Identifiable information was only available to the study personnel. The virtual interviews were recorded, stored, transcribed, and organized in a password-protected device with exclusive exposure to the study personnel.

Furthermore, all electronic data (i.e., transcripts, coding, analysis) were kept safe on Loma Linda OneDrive (Alase, 2016; Rubin & Rubin, 2012). The video and audio recordings were transcribed verbatim and de-identified using pseudonyms for each participant. The de-identified transcriptions were analyzed using a qualitative data analysis software, NVIVO. All interviews were conducted through an institutional review board-approved and HIPAA-compliant platform (i.e., Loma Linda Zoom Account). A separate document with the correlated pseudonyms was stored on the HIPAA-compliant cloud, OneDrive, through Loma Linda University. The researcher maintained human subject protection by destroying the recorded video and audio after being transcribed for the participant's security and safety.

Moreover, the participants were given a new zoom meeting ID link with an individualized passcode for their interviews. Having a passcode for each meeting prevented uninvited guests from accessing the interview. Upon creating the scheduled

zoom meeting, the researcher provided the meeting ID link and passcode to the participant through the Loma Linda Encrypted and HIPAA compliant e-mail. The researcher was the only individual with access to the meeting passcodes. After the zoom recordings were transcribed word-for-word and de-identified, the researcher deleted the zoom recordings for additional participant protection. Only the de-identified transcription was stored on Loma Linda's OneDrive.

Benefits

Although participants may have not personally or directly benefited from this study; they were involved in an innovative research that may change the treatment of victims and survivors of narcissistic abuse. Through offering knowledge and clinical skills, participants might play a role in encouraging a larger pool of like-minded colleagues to collaborate to provide appropriate care for victims and survivors of narcissistic abuse. In addition, this study can help mental health professionals and policymakers, including LMFTs, improve their knowledge and clinical skills regarding the needs, assessment, and treatment of victims and survivors of narcissistic abuse. Therefore, providing clinicians' knowledge and clinical skills can become a part of a larger systemic change in the quality of treatment of victims and survivors of narcissistic abuse.

Compensation

Participants were paid a lump sum of \$50 for attending the interview. Participants were informed that premature withdrawal from the interview process did not reduce the compensation amount. Due to participants being professionals and having high hourly

rates as clinicians, participants might not have been willing to volunteer without comparable compensation. Therefore, the researcher provided compensation for their time with a \$50 check directly payable to the participants. At the beginning of the interview, the researcher confirmed the participant's address and full name, which was provided through Qualtrics. Then, the researcher sent a \$50.00 check directly to the participant's address. The copy of the check in the student researcher's chequebook was shredded and destroyed immediately after it was written. Checks were directly payable to the participant; there was no written description associated with research on the check for confidentiality purposes.

Data Collection

Data collection included two parts. The first part was collecting information from licensed clinicians who self-identified as competent, proficient, or expert in knowledge and clinical skills in treating victims and survivors of narcissistic abuse. The clinicians communicated with the researcher through the Loma Linda email regarding recruitment, eligibility, and scheduling. The email (Appendix A) included information about the aim and purpose of the research, specific participation criterion and requirements, interview process, and sign-up instruction, in addition to a Qualtrics link in order to complete the demographic questionnaire (Appendix C) and informed consent (Appendix B). After selecting the eligible participants, the second part of data collection was through virtual confidential individual semi-structured interviews. The researcher conducted 14 virtual semi-structured interviews, lasting approximately 50 to 90-minutes, through a cloud-based video conferencing tool called Zoom. The interviews were recorded and then

transcribed verbatim with personal information de-identified. After de-identification, the researcher deleted all video and audio recordings for privacy purposes.

Data Analysis

The method used to analyze this qualitative study was thematic analysis to identify common themes regarding clinicians' recommendations in the needs, assessment, and treatment of victims and survivors of narcissistic abuse. Qualitative research methods are useful in the research of mental health context due to being oriented toward understanding meanings and experiences (Crowe et al., 2015). Moreover, qualitative methods provide new insights and knowledge in poorly understood and complex areas in the mental health context, such as understanding subjective experiences of mental health issues and their treatments (Fossey et al., 2002). Qualitative methods allow researchers to study concepts based on the interpretation and meanings people bring to them (Denzin and Lincoln, 2003).

Additionally, thematic analysis is a method used in qualitative research that enable the researcher to capture the meanings by providing a strategy for organizing and interpreting the qualitative data (Crowe et al., 2015). The thematic analysis allows researchers to create a narrative understanding of the commonalities and differences in participants' descriptions of their subjective context (Crowe et al., 2015). The thematic analysis includes specific steps in identifying codes, categories, and themes within the data to find patterns of meaning across the data that lead to developing a narrative describing the results (Crowe et al., 2015). Braun and Clarke (2006) describe the process of thematic analysis as a theoretically flexible method that organizes, describes, and interprets qualitative data. Braun and Clarke (2006) describe the steps in the thematic

analysis as becoming closely familiar with the data, generating initial codes, clustering the codes into ideas that are related, creating and defining themes that are illustrated regarding the transcripts, and at last, synthesizing the results by exploring the relationship of the themes to each other and to the socio-cultural context within which they emerged.

To begin the analysis, the researcher de-identified and transcribed the recorded interviews through Zoom Video Communications. After the transcriptions were completed, the recordings were deleted to secure confidentiality. The transcriptions were analyzed using a qualitative data analysis software called NVivo. NVivo helps qualitative researchers to organize, analyze and find insights in unstructured or qualitative data like interviews. The researcher became familiar with the data by reading and re-reading the interview transcripts to create initial codes. Next, the researcher-generated specific codes based on the research question as the main focus. The research question was identified as follows: what do clinicians who treat victims and survivors of narcissistic abuse consider as the needs, assessments, and treatment of this population?

Based on the generated codes, the researcher clustered them into ideas and categories that were related in order to search for themes. Next, all the data relevant to each theme were extracted. A system was developed to ensure all the relevant data was associated first with individual codes and then with the themes. Once themes were identified, the themes were defined and named in relation to the overall meaning of the data. Once each theme was clearly defined and described, it was illustrated with reference to the transcripts by selecting specific quotes that captured the essence of the theme.

Braun and Clarke (2006) describe that even though transcript data are required to arrive at the themes, it is not necessary to use all the data and/or multiple quotes to

illustrate single facets or aspects of the theme. Therefore, the researcher selected some quotes that most captured discrete aspects of the themes. To increase the validity and reliability of the codes and themes (Creswell & Poth, 2018), the researcher worked on a process of writing and re-writing to develop an in-depth level of examining the relationships between themes and drawing together a narrative. The final phase included a process of synthesis that explored the relationship of the generated themes to each other and the socio-cultural context within which they emerged. Braun and Clarke (2006) describe the process of synthesis as a process that makes an argument in relation to the research question and shifts the findings from description to creating meaning. This analytic argument was described in an analysis report that included mind maps and tables to illustrate the description and meaning of the data within the existing literature on the topic.

The researcher used memo write-ups for every interview done in order to increase self-awareness and track biases and assumptions that may influence the findings and interpretations (Creswell & Poth, 2018). The validity of data analysis was considered through using an outside independent reviewer in order to determine whether the themes accurately reflect the meanings evident in the data set as a whole (Braun & Clarke, 2006). Although a second coder is recommended to ensure validity and reliability of thematic analysis (Creswell & Poth, 2018), researcher was only able to seek a reviewer (not a coder) due to the substantial number of transcribed lengthy interviews. The independent reviewer (experienced in thematic analysis) reviewed the transcripts, codes, and themes in the early and late stages of data analysis, in order to provide an objective review of the study and analysis process and highlight the study's strengths and weaknesses (Creswell

& Poth, 2018). To ensure transparency and minimize bias, the independent reviewer was not involved in the data collection process or interviews in order ensure a fresh outside perspective. The reviewer asked precise questions about the methods, meanings, and interpretations and provided feedback on addition, deletion, and modification of codes and themes. The researcher was better informed of any conflicting results with respect to any codes or themes that were suggested to be added or removed by the independent reviewer (Miles & Huberman 1994; Hosmer 2008). Upon concluding an agreement on the final codes and themes, the researcher wrote the final results write-up. To ensure the validity of the results and the accurateness of the thematic analysis, researcher restricted the amount of information shared with the participants during the semi-structured interview to make sure that the research was not biased with preconceived notions of the respondents. Further, the validity of the questionnaire was established by gaining feedback from the research committee members.

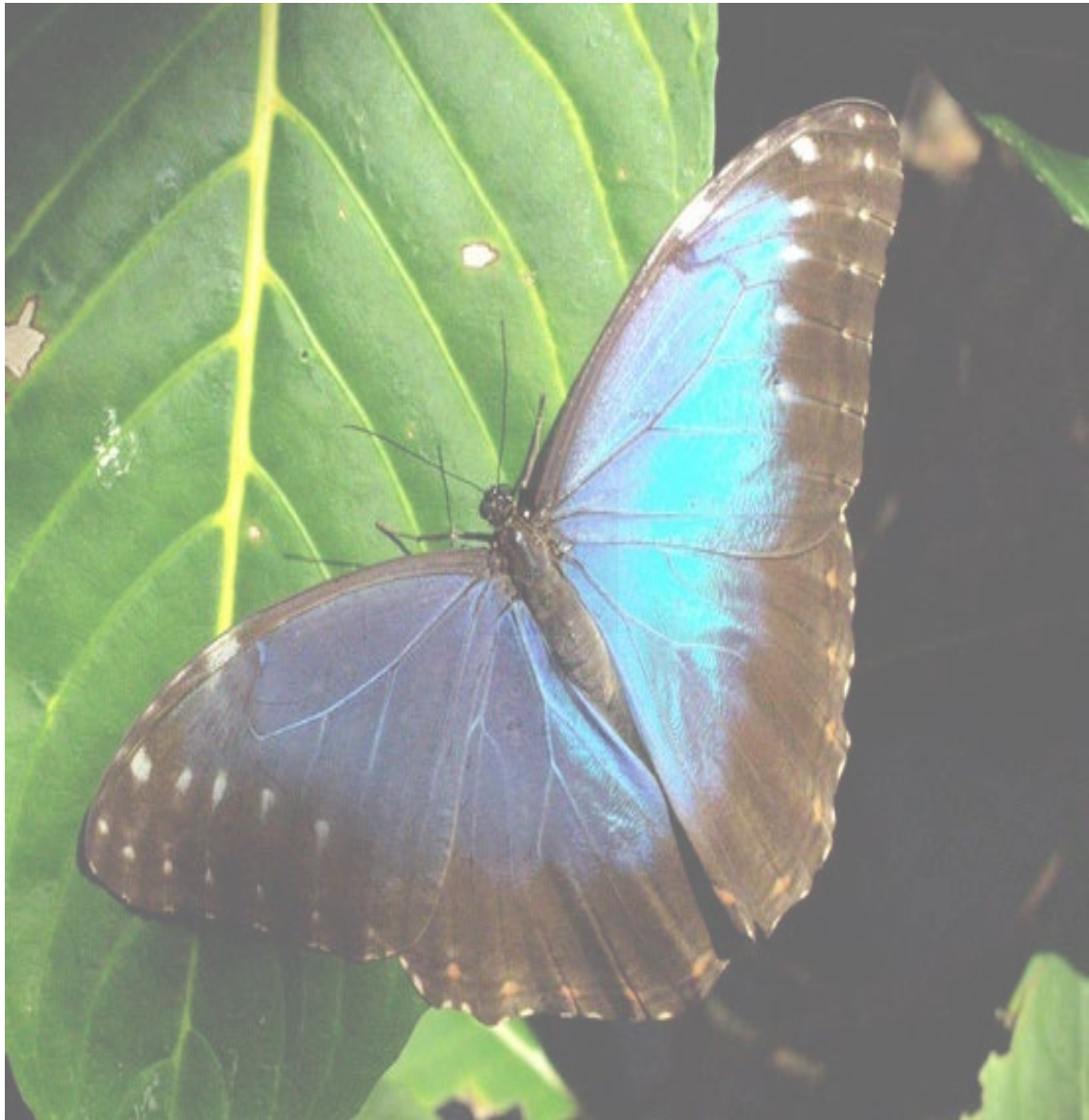
To ensure reliability, the researcher used tables to create a simpler process of navigating and sorting through large amounts of data, allowing for the examination of the data from multiple and diverse angles. Tables improve validity by helping the researchers condense, organize and interpret data, and to communicate research findings in an organized and reader-friendly manner (Cloutier& Ravasi, 2021).

NEEDS ASSESSMENT

Sadaf Shalchian, LMFT, DMFT

Doctoral Project

**Clinician's Recommendations
in Treating Victims and Survivors of Narcissistic Abuse**



CHAPTER FIVE

PROJECT OUTCOME

Overview

There are gaps and discrepancies in the fundamental understanding of the construct of narcissism, narcissistic personality disorder, narcissistic abuse, and the impact of this personality type on people in any form of relationships with them.

Although the body of research has grown in understanding narcissism and Narcissistic Personality Disorder (Larson et al., 2015; Miller et al., 2010; Ronningstam, 2005), currently there is a dearth of empirical research, evidence-based programs and modalities, academic and clinical resources, diagnosis, assessment, and treatment models focused on individuals who are in any form of relationship with a person who has a narcissistic personality type.

A clinical classification or definition of the term “narcissistic abuse” has not yet been formally established; however, the large body of professional and popular publications provided by mental health professionals and individuals who have witnessed or experienced such abuse has proven for narcissistic abuse to be of communal interest, importance, and worthy of further acknowledgment and research. The term “narcissistic abuse” has come to mean any type of abuse perpetrated by a person who has a narcissistic personality type, whether it be coercive control, psychological, physical, sexual, spiritual, or financial (Brown and Young, 2018; Day et al., 2020; Durvasula, 2022; Howard, 2019; Leedom, 2019; MedCircle, 2020).

Through history, narcissism and narcissistic personality disorder has gone through an evolving definition and description. The Diagnostic and Statistical Manual of Mental

Disorders (5th ed.; DSM–5; APA, 2013) is the most current and widely accepted nomenclature used by clinicians and researchers to classify mental disorders. According to the DSM-5, Narcissistic Personality Disorder (NPD) is “a personality style characterized by grandiosity, self-importance, a sense of entitlement, a need for admiration, a lack of empathy, interpersonal exploitation, irrationality, arrogance, haughtiness, disdain, patronizing, and a lack of relational reciprocal interest” (American Psychiatric Association, 2013). Although DSM-5’s focus on the grandiosity features are indeed a core component of narcissistic personality, a rich literature focused on the phenotypic descriptions of pathological narcissism across clinical theory, social-personality psychology, and psychiatric diagnosis reveals expanded criteria and understanding of narcissism that includes different subtypes of narcissistic personality disorder (Cain et al., 2008; Caligor et al., 2015). The diagnostic criteria for NPD in DSM-5 includes overt grandiose features, leaving out vulnerable manifestations of the disorder that include instances of depressed mood, insecurity, hypersensitivity, shame and identification with victimhood (Caligor et al., 2015).

Narcissistic personality disorder is one of the least studied personality disorders, though it is prevalent, highly comorbid with other disorders and causes functional and psychosocial impairment (Miller et al., 2007; Grant et al., 2008). Therefore, there is confusion regarding the reliability, validity, specificity, and sensitivity of diagnostic criteria, as well as the prevalence of the disorder, or the efficacy of any treatment for the disorder (Caligor et al., 2015). This inconsistency has played a negative role in the understanding and identification of individuals with a narcissistic personality type as well as the victims in an interpersonal relationship with them. Therefore, there is a gap in the complete

definition and manifestation of narcissism and narcissistic personality disorder that leads to discrepancy in the diagnosis, assessment, and treatment of narcissistic individuals as well as victims and survivors of narcissistic abuse.

Victims tend to go through a narcissistic abuse cycle of idealization, devaluation, and rejection; a pattern of positive and negative experiences in which the narcissist confuses the victim through manipulation and calculated tactics aimed at making the victim question their sense of self and reality and live to maintain and appease the relationship and the narcissistic individual (Gaum and Herring, 2020). Howard (2019) explains that a person with narcissistic personality disorder uses his/her victim as a narcissistic supply to enhance their sense of self, reality, and self-esteem (Howard, 2019). Howard (2019) further explains different traits and forms of Narcissistic tactics, which can include but are not limited to love bombing, pathological lying, presentation of a false self, criticism, the silent treatment, idealizing and then devaluing the victim, gaslighting, abuse amnesia, exploitative behaviors, emotional and physical abandonment and abuse, triangulation, sexual and financial abuse, insulting and disrespecting behavior, and isolating victim to protect self-image and control (Howard, 2019).

Despite the scarce academic and empirical attention on victims and survivors of narcissistic abuse, many experienced professionals in the field of NPD and narcissistic abuse have described narcissistic abuse to be drastically impactful and traumatic on one's emotional, psychological, physical, financial, and spiritual well-being (Brown and Young, 2018; Day et al., 2020; Durvasula, 2022; Howard, 2019; Leedom, 2019; MedCircle, 2020). The impact of narcissistic abuse on victims can cause a variety of issues including but not limited to depression, anxiety, cognitive dissonance, shame,

confusion, PTSD, Complex PTSD, helplessness, emotional dysregulation, executive dysfunction, confusion, somatization, despair, and loss of sense of self and reality (Brown and Young, 2018; Day et al., 2020; Durvasula, 2022; Howard, 2019; Leedom, 2019; MedCircle, 2020).

Although the impact of narcissistic abuse is life-altering, there is little to no focus on victims and survivors in empirical research, academic and educational sources, clinical training, and evidence-based treatment models and programs. Although victims and survivors of narcissistic abuse have been recognized in professional and popular publications, the paucity of academic and empirically peer-reviewed resources on this population has become problematic in ways that has affected the development of a standardized and consistent diagnosis, terminology, treatment, and clinical and societal acknowledgement of narcissistic abuse. Therefore, there is a systemic gap in the understanding, impact, and official clinical and academic classifications of narcissistic abuse leading to limited awareness, advocacy, and services for this population. Moreover, there is a dearth of sufficient availability, accessibility, and acceptability of clinical and therapeutic support and services, treatment programs, and educational and training resources for clinicians who treat victims and survivors of narcissistic abuse. There is also a gap in the awareness and advocacy of narcissistic abuse in intimate relationships being acknowledged as domestic violence, leaving perpetrators justified and victims invalidated and unsupported in the law enforcement and court system.

Moreover, academic and clinical programs, including MFT programs and the DSM-5, have not covered the identification, needs, assessments, or treatment of victims and survivors of narcissistic abuse. The aforementioned gap has led to limited and

insufficient teaching and training in the subject, which has led to limited knowledge and clinical skills in the mental health field. For instance, COAMFTE-accredited Master's level Marriage and Family Therapy programs do not place an emphasis on the identification, assessment, or treatment of victims and survivors of narcissistic abuse (COAMFTE, 2017). However, Licensed marriage and family therapists (LMFTs), being one of the main lines of contact for of mental and relational health services, are required to have sufficient knowledge and clinical skills to treat victims and survivors of narcissistic abuse. As social constructivism suggests, culture and language and interaction play a role in learning; the interactions between clinicians and their competent colleagues and supervisors can play a role in improving their knowledge and clinical skills.

Identifying common knowledge and clinical skills in the needs, assessment, and treatment of narcissistic abuse among competent, proficient, and expert level clinicians can help in developing appropriate services, resources, and academic curriculum and training for clinicians who treat this population. This needs assessment aimed to identify the knowledge and clinical skills recommended by clinicians who treat victims and survivors of narcissistic abuse to identify some needs, assessments, and treatment practices that can guide Licensed Marriage and Family Therapists in treating this population. This needs assessment explored current literature, research, and academic and clinical resources focused on narcissism and narcissistic abuse followed by interviewing 14 self-identified competent, proficient, or expert level clinicians who treat victims and survivors of narcissistic abuse. The researcher conducted 60-90-minute virtual semi-structured interviews with 14 mental health clinicians and transcribed each interview. Thematic analysis was used to identify codes, categories, and themes within the data to

find patterns of meaning across the data that led to developing a narrative describing the results (Crowe et al., 2015) The thematic analysis allowed the researcher to create a narrative understanding of the commonalities in participant's descriptions of their subjective context (Crowe et al., 2015). The collected themes and codes aimed to provide recommendations for clinicians, including marriage and family therapists, in treating victims and survivors of narcissistic abuse.

Summary of Findings

As a result of 14 interviews with clinicians that self-identified as competent, proficient, and expert in treating victims and survivors of narcissistic abuse, the researcher used thematic analysis to identify and summarize key themes that best represent clinician's recommendations in the needs, assessments, and treatment of this population. The interviews were transcribed, coded, and themes were generated to form an analysis write-up that resulted in the following tables. The following summary of themes and codes are viewed as essential knowledge and clinical skills recommended by clinicians in treating victims and survivors of narcissistic abuse.

We aimed to answer the following research question: what do clinicians who treat victims and survivors of narcissistic abuse consider as the needs, assessments, and treatment of victims and survivors of narcissistic abuse?

Four main categories were developed to represent the major themes of clinician's recommendations. The first Category, "*Clinician's Required Knowledge and Clinical Skills,*" provides specific details within themes of clinician's required knowledge and understanding, clinical skills, and awareness of common terminologies describing the narcissistic dynamic. The second category, "*Assessment of Victims and Survivors of*

Narcissistic Abuse,” provides specific details within themes of common symptoms, identification factors, assessment methods and tools, common diagnoses, and common risks and crises experienced by victims and survivors of narcissistic abuse. The third category, “*Treatment of Victims and Survivors of Narcissistic Abuse,*” provides specific details within themes of common clinical needs of the population, effective clinical theories and modalities, common treatment plans, and effective interventions in treating victims and survivors of narcissistic abuse. The fourth category, “*Clinician’s Resources,*” provides specific details within themes of ways to increase proficiency and specialization, available resources to improve skills and knowledge, and gaps and needs within the field of narcissistic abuse recovery.

Each category is gearing towards creating a fundamental list of recommended knowledge and skills in the needs, assessment, and treatment of victims and survivors of narcissistic abuse. The results can be a stepping stone in the development of further research, diagnosis, assessment, treatment, program development as well as progress and change in areas of academia, training, policy making, clinical practice, law enforcement, legal field and court system, and the public at large.

Theme 1

Clinician's Required Knowledge and Clinical Skills

Table 1.1. Required Knowledge and Understanding

1.1 Required Knowledge and Understanding	Narcissistic Family Dynamics
	Narcissistic Abuse Cycle
	Personality Disorders
	Power and Control Cycle
	Coercive Control
	Cycle of Violence
	Family Dynamics
	Sexual Coercive Behavior in Narcissistic Individuals
	Narcissistic Abuse & Domestic Violence
	Extensive knowledge and skills in multiple therapeutic modalities
	Chronic & Persistent Cognitive Dissonance
	Connection between Mind & Body
	Somatic Work
	Holistic Knowledge
	Understanding co-dependency
	Misconception of co-dependency
	Root causes of co-dependency
	Music Therapy
	Trauma-Informed Therapy
Pathological Love Relationships	
Victim's Experience of Love and abuse	

1.1 Required Knowledge and Understanding of Narcissistic Abuse

As presented on Table 1.1 below, there are some important required knowledge and understanding a clinician should attain in order to provide services for victims and survivors of narcissistic abuse.

In general clinicians suggested knowledge and clinical skills beyond the general and insufficient information taught in academic programs. Clinicians mentioned the importance of competently and extensively understanding and identifying narcissistic family dynamic, narcissistic abuse cycle, power and control cycle, cycle of violence, family dynamics, coercive control, and sexual coercive behavior in narcissistic individuals. Knowing this information can help in understanding, assessing, advocating, and educating clients in their hidden abuse. Clinicians emphasized the importance of identifying signs of hidden abuse, such as coercive control, even though the client might not be verbally expressing the presenting problem as such. Many clinicians especially made an emphasis on the importance of recognizing narcissistic abuse within intimate relationships as domestic violence; although, they mentioned for domestic violence literature and legal policies to not acknowledge narcissistic abuse as domestic violence. However, a few clinicians had reservations about fully defining narcissistic abuse as domestic violence, as they stated for there to be some similarities and differences between the two. For instance, one participant suggested for further training in understanding the delineation between narcissistic abuse and domestic violence, stating

“And then I think clinicians also need to understand maybe the delineation between narcissistic abuse and domestic violence, because I think oftentimes those two, in certain ways overlap. And then in other ways, there are some differences. Yeah, so I feel like there needs to be kind of a maybe training or an understanding of some of those factors” (P2234).

Clinicians suggested for extensive knowledge of personality disorders beyond the information provided by the DSM-5. Multiple clinicians mentioned that in order to provide appropriate treatment to victims and survivors of narcissistic abuse, one must have extensive knowledge and skills in multiple therapeutic modalities that covers the wide range of the client's complex symptoms and experience. Clinicians emphasized the importance of extensive training in trauma-informed therapy. Clinicians also mentioned benefits of alternative therapy models, such as music therapy, to be of additional help alongside other therapeutic modalities. For instance, one of the participants stated,

I think it's just really about being able to be more holistic. And, you know, I mean, I think that all clinicians should be doing a lot of the, a lot of training, postgraduate in a lot of different models, to be able to become well-rounded clinicians (P13234).

Results also suggested that due to the negative impact of narcissistic abuse on client's physical, psychological, emotional, and spiritual wellbeing, clinicians should have well-rounded holistic knowledge, understand the connection between mind and body, and be able to perform somatic therapy in order to help relieve trauma and assist the body renegotiate traumatic experiences on a body-mind level.

One of the most frequent topics emphasized by clinicians was the importance of understanding chronic and persistent cognitive dissonance and its impact on individuals. Cognitive dissonance was mentioned to be an important aspect of trauma bonding, self-blame, confusion, and denial of abusive experience. For instance, one participant stated, "So they would need to understand that, and how to work with the cognitive dissonance in the realm of this kind of relationship" (P14234). Results show that clinicians must

know how to treat clients with chronic and persistent cognitive dissonance, as this experience impacts many aspects of the client's experience, disruptive and intrusive symptoms, and decision-making.

There was a high frequency of the construct of codependency in the results; all clinicians mentioned the importance of understanding codependency and how it could be a common experience of victims and survivors of narcissistic abuse. However, it was also mentioned that clinicians should not be quick to label victims and survivors of narcissistic abuse, as codependency could be a trauma response to narcissistic abuse. Clinicians suggested that some clients could have already had codependency patterns prior to narcissistic abuse; however, many clients might be presenting codependency patterns due to the impact of narcissistic abuse. For instance, one of the participants mentioned,

And we as mental health professionals, depending on our level of training or expertise, might just stick with codependency as a way to describe somebody's behaviors, but I think it's so important to get to the root, and go underneath and see what's causing codependent behavior (P14234).

Therefore, results suggested for clinicians to become highly aware of root causes of codependency as well as misconceptions of codependency. Clinicians suggested that mislabeling clients can reinforce their trauma cycle, invalidate their experience, and provoke self-blame and shame.

Some clinicians suggested deeper understanding of pathological love relationships and the reasons behind the start, maintenance, and end of such relational dynamics. Some clinicians also mentioned the importance of understanding characteristic patterns of

victims and an understanding of the victim's experience of love and abuse. For instance, a clinician mentioned that there are different groups within this population, victims who have had childhood adverse experiences and on the other hand victims that show no history of trauma but show common specific character proclivities and elevations. A participant mentioned that personality proclivities that are consistently high on agreeableness and conscientiousness but vary on neuroticism and extraversion tend to enter or stay in narcissistically abusive dynamics. Understanding the victim's patterns can help clinicians in developing a personalized treatment plan.

Table 1.2. Required Skills

1.2 Required Skills	Empathy
	Meeting clients where they are
	Being a Flexible Clinician
	Developing Strong Therapeutic Alliance
	Being able to do comprehensive and systemic evaluation
	Being able to intuitively understand the context from a systemic lens
	Being Informed about pathology
	Being Skeptical of the surface presenting problems
	Remaining Focused
	Self-Regulation

1.2 Required Skills

Multiple clinicians mentioned that in order to provide appropriate treatment to victims and survivors of narcissistic abuse, one must have high skills of empathy, intuition to meet clients where they are, and a flexible attitude towards client's personal experience and context. One of the most frequent skills mentioned by clinician was the importance of developing a strong therapeutic alliance. For instance, one of the participants mentioned

I'm a solid container, I'm not gonna think you're making it up, I'm not gonna think you're crazy. I'm not going to think you're stupid for having stayed. because these are the anxieties that people have, when they seek care. Like, they're already distraught, they're ashamed. They're judging themselves. So for me, it's about the relationship, building that relationship in those early contacts, rather than, like, if I were going to do some formal assessment, I would wait till probably six weeks in, quite frankly. So that the person does not feel like they're under a microscope, or they have to pass a test or anything. Like it's just really important for me to offer survivors a place where they're seen where they're heard because in relationships that are narcissistically abusive, they are not seen and they're not heard. And so that's what I learned (P11234).

Therefore, it is important to have patience and respect for client's level of insight, readiness, and willingness in all stages of therapy.

Clinicians also suggested to have the ability to do a comprehensive and systemic evaluation, intuitively understand the context from a systemic lens, and be skeptical of the surface presenting problems. Results show that a clinician has to use their intuitive skills and a comprehensive systemic lens to see and evaluate beyond the problem verbalized by the client; such skills takes training and experience. For instance, one participant suggested to have awareness of client's overall experience within their context,

Are they in survival mode? Like, even though they may not look like it... I'm not talking about being on the streets, I'm talking about like, are they always living as

though the other shoe is gonna drop? So that kind of hypervigilance or insecurity, even when they're in a secure situation? (P11234).

Results showed a lot of emphasis for clinicians to acquire skills in order to remain focused and self-regulated while in a therapy session. Due to client's complex trauma and experience, it is important for clinicians to increase their awareness of self in therapy. Such skills require extensive experience, supervision, personal therapy, and expanding ones' education and knowledge.

Table 1.3. Awareness of Common Terminology

1.3 Awareness of Common Terminology	Addiction
	Blame Shifting
	Co-dependent Behavior
	Coercive Control
	Cognitive Dissonance
	DARVO
	Deception
	Emotional Invalidation
	Flying Monkeys
	Gaslighting
	Ghosting
	Grey Rock
	Hoovering
	Love Bombing
	Mirroring
	Narcissistic Abuse
	Narcissistic Personality Disorder
	Smear Campaign
	Stonewalling
	Trauma Bonding
Triangulation	
Walking on Eggshells	

1.3 Awareness of Common Terminologies

Results showed the importance of having knowledge and understanding of common terms being used to describe the construct of narcissistic abuse and related experiences. Clinicians suggested that there are common narcissistic-related terms being used among blogs, books, google, movies, social media, YouTube, and Tiktok, etc. However, most terms have not yet been classified or defined as clinical terminology. The data showed such commonly used terms and experiences to include flying monkeys, gaslighting, ghosting, grey rock, hoovering, love bombing, mirroring, narcissistic abuse, narcissistic personality disorder, smear campaign, stonewalling, trauma bonding, triangulation, walking on eggshells, addiction, blame shifting, co-dependent behavior, coercive control, cognitive dissonance, DARVO, deception, and emotional invalidation.

Clinicians explained that there are advantages and disadvantages to some of these terms. The various terminology and descriptions have played a positive role in increasing awareness, validation, and advocacy for victims. Clinicians mention that there is a benefit to having a common language in describing constructs that have not yet to be officially acknowledged. For instance, one participant stated,

I think it's helpful to give people that kind of framework like yes, gaslighting does occur, yes, this is what it is. And like, it's almost like, it doesn't matter what some of these things are called. hoovering or grey rocking. Because grey rock also doesn't always work for everyone. Like in a parental custody, grey rocking is not okay. You have to be cordial you have to respond. You can't grey rock because then you're considered to be alienating. So these terms kind of get stuck on people. And so I get a little like, you can use them but know what you're saying

before you say that, know when to use them. I guess that is kind of the point, to know when to use them (P12234).

On the other hand, clinicians also shared that the use of informal terminology has caused inconsistency and inaccuracy in descriptions and information, possibly adding to the confusion in the victim's experience. For instance, a participant stated,

the cons, I think, is that they're so odd. Like I looked some up because I couldn't remember, I've never even heard ... there's one called Flying Monkeys. There's the gray rock one where I'm like, okay. sometimes I'm like, what is that? It's very confusing. So I think the con would be like, that I get confused, and I think it can be confusing for other people (P10234).

Discussion of Theme 1

The required knowledge and understanding, required skills, and awareness of common terminology recommended by clinicians was an important overview of what knowledge and clinical skills are needed to provide services for victims and survivors of narcissistic abuse. As confirmed in the literature review, it is evident that there is a dearth between the recommended knowledge and clinical skills and the material being taught in academia and marriage and family programs. Hoge et al. (2004) argued that the competency, accountability, and effectiveness required of post-graduate trainees are not supported by the level of teachings instructed in MFT programs.

As mentioned in the literature review, MFTs are one of the main lines of contact for consumers of mental health and they are recognized to treat individuals, couples and families (AAMFT, 2022). Especially due to their focus on understanding symptoms and

diagnoses within interactions, relationships, and environmental and familial systems (AAMFT, 2022), MFTs should have sufficient competence in treating clients with relational issues such as relational trauma.

If providing services to victims and survivors of narcissistic abuse requires the extensive knowledge and clinical skills mentioned in the results (*Theme 1*), then it is crucial for clinicians (such as LMFTs) to have the level of competence this vulnerable population requires. Furthermore, the ill-prepared clinicians are accountable to clients, stakeholders, and insurance companies to provide effective treatment; yet, required knowledge and clinical skills mentioned in the results, such as the narcissistic abuse cycle, have not been a part of the academic teaching curriculum.

Additionally, unlike narcissistic abuse, most types of abuse such as physical or psychological abuse, have an agreed-upon definition. Narcissistic abuse, among some other terminologies mentioned in the results (Table 1.3), have not yet been classified or defined as clinical terminology. Therefore, such terms have been used in informal means that might have led to discrepancies and misrepresentation in the definition of the terminology and the context of its experience. However, the presence of such terms might have played a crucial role in having a common language to describe and validate the common experiences faced by victims and survivors of narcissistic abuse. The data showed that the presence of current terminologies representing the narcissistic dynamic has created discrepancies in the definition and misrepresentation of experiences of the population; yet, the same terminologies have created an opportunity for the population to have a common language that generally validates and describes their experiences in a narcissistic dynamic.

Vygotsky (1978) formed three main concepts of social constructivism theory: cognitive development and learning culture is significant in learning, language is the root of culture, and individuals learn and develop within their role in the community (Vygotsky, 1978). As mentioned, there is a dearth in the systemic lack of focus on victims and survivors of narcissistic abuse and a lack of consistent and complete presentation of narcissism and narcissistic abuse in academia, research, and the DSM-5. Due to this gap, some LMFTs might not have had the foundation or learning environment to sufficiently learn or understand the significance of the unique narcissistic dynamic and the language that supports it. Academia, research, and the DSM-5 are fundamental tools that clinicians follow collectively. If everyone uses similar limited terminology and teaching tools and resources, clients might be in danger of receiving ineffective and insufficient treatment. Additionally, such a systemic gap can limit practitioners' clinical knowledge, skills, confidence, communication, and reflectivity.

Therefore, while waiting on policy and program development or changes, it is important for clinicians to develop or attend a community that can work towards a consistent language, knowledge, and clinical skills associated with treating victims and survivors of narcissistic abuse. Increasing such discussion and communities among highly experienced clinicians can also highlight the similarities and differences in their use of terminology and therapeutic approaches, which can lead to valuable learning experiences and improvement in the current approach. Clinician's efforts in developing or attending communities focused on narcissistic abuse can create some positive changes in the knowledge and clinical skills of clinicians.

Theme 2

Assessment of Victims and Survivors of Narcissistic Abuse

Table 2.1. Common Symptoms Experienced by Victims and Survivors

2.1 Common Symptoms Experienced by Victims and Survivors of Narcissistic Abuse	Experience of gaslighting
	Anxiety
	Atypical Trauma
	Being Bullied
	Bipolar Disorder
	Chronic and Persistent Cognitive Dissonance
	Co-dependency
	Eating Disorder
	Biopsychosocial Issues
	Employment Issues
	Experience of Lack of Empathy
	Feeling of depression
	Feeling of losing mind
	Feeling of losing one's sense of self and reality
	Feeling of shame
	Feelings of sadness
	Financial Problems
	Intimate Partner Issues
	Isolation
	Learning Difficulties at School
	Medical & Physical Problems
	Parent-Child Relational Issues
	Personality Disorder
	Problems with Friends
PTSD	
Complex PTSD	
Sexual Challenges	

2.1 Common Symptoms experienced by Victims and Survivors

The results showed that the common symptoms experienced by victims and survivors of narcissistic abuse include experience of gaslighting, anxiety, atypical

trauma, being bullied, bipolar disorder, chronic and persistent cognitive dissonance, co-dependency, eating disorder, employment issues, experience of lack of empathy, feeling of depression, feeling of losing mind, feeling of shame, feelings of sadness, financial problems, intimate partner issues, isolation, learning difficulties at school, medical & physical problems, parent-child relational issues, personality disorder, problems with friends, PTSD, Complex PTSD, and sexual challenges.

The clinicians mentioned the importance of having awareness of client's symptoms and understanding underlying causes of such symptoms. Clinicians emphasized being cautious with conceptualizing and diagnosing clients based on their symptoms; oftentimes, such symptoms are only a result of the abuse. For instance, clinicians should work on validating client's symptoms as a result of abuse instead of client's personal failure, fault, or predisposed diagnosis.

There was an emphasis on Atypical trauma, complex PTSD, and cognitive dissonance to be some of the most impactful experiences on client's biopsychosocial wellbeing. A participant mentioned, "So, psychosocial issues, you know, would be that they're not able to hold a job, it's affecting all domains of their life. It's very difficult for them, you know, to function" (P16234). Additionally, a participant explained that because the abuse is hidden and manipulative (entailing a mixture of abuse and love bombing), it is difficult for clients and others to recognize the cycle of abuse. The participant explained that the inconsistencies in beliefs and actions in a narcissistic abuse cycle results in cognitive dissonance and Atypical trauma; in which traumatic triggering by negative memories is accompanied by triggering intrusive positive memories, effecting their executive functioning and sense of self. "then there are those Atypical

PTSD symptoms that are really important to assess for. So you know, the positive kinds of memories. The intrusive thoughts, the real worries all the time” (P14234).

The feeling of losing one’s mind and a sense of self and reality were also frequently mentioned in the results. One participant mentioned that it is very easy for therapists to miss one of the most important factors experienced by clients, which is their ruminating thoughts being hijacked by conflicting positive and negative memories of their abuser, which causes the cognitive dissonance and Atypical and complex trauma. She suggests that treatment approach needs to change to focusing on working on the intrusive positive memories instead of focusing only on healing the trauma caused by negative experiences.

And a lot of times - and therapists miss this a lot - this is part of what we identified as a-typical trauma. Intrusive memories are very problematic: it’s not just the negative memories, it is all the positive memories that are confusing! Victims are not talking about how the abuser devalued or lied or hurt them in some way! a lot of times - because they expects that abuse on that slide, we know why that's hurtful - what is so confusing and also most intrusive is all the positive memories or perceived positive experiences as what we call them and so that's often a big portion of that and the therapists miss why that would be traumatic to them to experience if they don't understand that, that is an a-typical trauma presentation, or you know pathological relationships in general. And even if the therapist recognizes the trauma and maybe begins to work with the negative typical trauma memories; what's never worked with is the Atypical trauma, which is caused from cognitive dissonance, which is the positive memories. And so the

positive memories are the least likely to have ever been reduced, which is why they stay so intrusive as memories (Participant 6234).

Table 2.2. Identification of Victims and Survivors of Narcissistic Abuse

2.2 Identification of Victims and Survivors of Narcissistic Abuse	Monitor for coercive control
	Monitor for hierarchy in the family dynamic
	Combined Therapy Meetings
	Individual Therapy Meetings
	Monitor for emotional abuse
	Monitor for sex addiction
	Monitor for sexual manipulation
	Monitor for Narcissistic child abuse
	Psychological Issues with Children
	Visible Symptoms of Narcissism in Couples
	Discrepancy in words and actions
	Frequent Sessions are needed
	History of trauma
	Identification of Cognitive Dissonance
	Isolated & Low Self-Esteemed individuals
	Personality Disorders
Trauma Symptoms	

2.2 Identification of Victims & Survivors in Therapy

It is important for clinicians to be able to identify victims and survivors of narcissistic abuse even if they do not present as one. In addition to other indicators mentioned in other themes in the data, the results show some points to consider while identifying and evaluating clients such as hold both combined and individual therapy

meetings, monitor for coercive control, monitor for hierarchy in the family dynamic, monitor for emotional abuse, monitor for sex addiction, monitor for sexual manipulation, monitor for narcissistic child abuse, monitor for psychological issues with children, monitor for visible symptoms of narcissism in couples. Additionally, the results suggest some points to consider while identifying victims and survivors of narcissistic abuse: to increase awareness and curiosity in individuals who present discrepancy in words and action, who have a history of trauma, who present as having cognitive dissonance, who are isolated and have low self-esteem, who seem to have personality disorders, and who show symptoms of trauma.

Since the abuser is usually not present in a therapy session and the clinician is unable to evaluate a person outside of therapy, results show that clinicians have to intuitively listen and monitor for the common symptoms that are the result of the impact of hidden narcissistic abuse. Therefore, clinicians have to intuitively monitor and identify client's presentation, story-telling, expression of self, and perception of their relationships.

Table 2.3. Ways to Assess Victims and Survivors of Narcissistic Abuse

2.3 Ways to Assess Victims and Survivors of Narcissistic Abuse	Interviews
	Intuitive Conversation with the Client
	Own Experience
	Self-Made Assessments
	Trusting the intuition
	Adult Substance Use Survey (ASUS)
	Assess for DARVO
	Beck Depression Inventory (BDI)
	Circumplex Model
	Cognitive Dissonance Assessment
	Complex PTSD
	Comprehensive understanding of red flags and signs
	Patient Health Questionnaire (PHQ-9)
	PTSD Checklist for DSM-5 (PCL-5)
	The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)
	The Gottman Assessment
The Minnesota Multiphasic Personality Inventory (MMPI)	
Trauma assessment	
Understanding of Adverse Childhood Experiences (ACE)	

2.3 Ways to Assess Victims and Survivors of Narcissistic Abuse

Assessment is the process done by clinicians in gathering and integrating necessary information in order to evaluate client’s behavior, abilities, characteristics, and systemic context and background for the purposes of developing diagnosis and treatment. The results suggest that there is not an assessment tool that has been developed specific to victims and survivors of narcissistic abuse. However, clinicians have used other assessments that have been helpful in better understanding the clients’ symptoms as a result of narcissistic abuse. Results show that assessing clients requires for the clinician to have intuitive conversations with the client, trusting ones’ intuition,

use ones' own experience, and have a comprehensive understanding of red flags and signs associated with narcissistic abuse.

Other assessments that were reported to be helpful in understanding client's symptoms associated with narcissistic abuse include interviews, Self-Made Assessments, DARVO, Beck Depression Inventory (BDI), Circumplex Model, Cognitive Dissonance Assessment, Complex PTSD, Substance Use Survey (ASUS), Patient Health Questionnaire (PHQ-9), PTSD Checklist for DSM-5 (PCL-5), The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), The Gottman Assessment, The Minnesota Multiphasic Personality Inventory (MMPI), Trauma assessment, Understanding of Adverse Childhood Experiences (ACE). It is important to note that such assessment tools are helpful in understanding and gaining direction for treatment associated with clients' symptoms due to narcissistic abuse; however, such assessment tools were not developed to assess for presence of narcissistic abuse.

Table 2.4. Common Diagnosis of Victims and Survivors of Narcissistic Abuse

2.4 Common Diagnosis of Victims and Survivors of Narcissistic Abuse	Lack of a Comprehensive Diagnosis
	Anxiety Disorders
	Attention deficit hyperactivity disorder (ADHD)
	Bipolar Disorder
	Borderline Personality
	Complex Grief
	Depression Disorders
	Post-traumatic stress disorder (PTSD)

2.4 Common Diagnosis of Victims and Survivors of Narcissistic Abuse

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (APA, 2013), is the widely accepted manual for classification and diagnosis of mental disorders used by clinicians, providers, researchers, institutions, and agencies. Based on the DSM-5, results show some common diagnosis that victims and survivors of narcissistic abuse are commonly diagnosed with. Results showed that there is no diagnosis specified for classifying victims and survivors of narcissistic abuse. However, the mentioned diagnoses are used to classify the clients' common symptoms for insurance and/or treatment purposes, whether or not they have been caused by narcissistic abuse. Clinicians mentioned that victims and survivors of narcissistic abuse commonly get diagnosed with Anxiety Disorders, Attention deficit hyperactivity disorder (ADHD), Bipolar Disorders, Borderline Personality Disorder, Complex Grief, Depression Disorders, and Post-traumatic stress disorder (PTSD).

Clinicians highlighted that there is not a specific diagnosis that accurately represents the complex experience of victims and survivors of narcissistic abuse. Rather, when clients are diagnosed, they are often labeled with a diagnosis that represents a cluster of symptoms associated with the outcomes of abuse, such as post-traumatic stress, generalized anxiety disorder, or depression. Utilizing a variety of diagnoses focused on different clusters of symptoms fails to capture the client's experience of Atypical complex trauma associated with narcissistic abuse. In addition, a lack of an appropriate diagnosis and focus on symptom clusters may increase and reinforce more self-blame and provoke shame. For instance, a participant mentioned "You know somebody can have trauma and not meet criteria by the DSM. This is where some experience, you know as a

therapist, helps when you know damn well, they're traumatized, no matter what the DSM says” (P 6234).

Table 2.5. Common Risks and Crisis Experienced by Victims and Survivors of Narcissistic Abuse

2.5 Common Risks and Crisis Experienced by Victims and Survivors of Narcissistic Abuse	Substance abuse
	Cognitive and Executive Functionality
	Fear of Disappointing
	Financial dependence and risks
	Inadequate Treatment
	Lack of Support System
	Medical Risks
	Narcissist’s manipulative tactics to maintain relationship
	Poor self-esteem and self-worth
	Post Separation Abuse
	Premature treatment termination
	Safety Risks
	Suicidal ideation

2.5 Common Risks and Crisis Experienced by Victims and Survivors of Narcissistic Abuse

In addition to indicators mentioned in other data themes, there are some common risks and crisis experienced by clients who go through narcissistic abuse. Due to narcissistic abusers antagonistic, manipulative, and coercive tactics, victims and survivors suffer from multiple risks and crises that impact their life at large. Results show that such risks and crises include but are not limited to substance abuse, problems with cognitive and executive functionality, fear of disappointing, financial dependence and risks, receiving inadequate treatment, lack of support system, medical risks, narcissist’s manipulative tactics to maintain relationship, poor self-esteem and self-worth, post-separation abuse, premature treatment termination, safety risks, and suicidal ideation.

The results show that risks and crises experienced by victims and survivors of narcissistic abuse impact their biopsychosocial and executive functioning; therefore, it is important for them to gain services and support that is highly equipped in meeting their complex needs.

Discussion of Theme 2

Although some common symptoms, identification factors, assessment tools and methods, common diagnosis, and common risks and crises of victims and survivors of narcissistic abuse was mentioned by clinician participants; it is evident that the lack of academic and communal focus on the population has disabled the presence of a standardized and official classification and assessment of this population.

Due to such broad and impactful symptoms as well as complex experiences among this population, it is important for clinicians to identify and assess clients comprehensively and beyond their academic training. Due to the high multifaceted risks and crises experienced by this population, clinicians will not only need efficient training and education but also substantial support and collaboration within a treatment team as well as a whole system. Moreover, stakeholders and training programs should also take such common symptoms, diagnosis and misdiagnosis, experiences, and risks and crisis in consideration while developing policies, diagnoses, treatment programs, or educational sources.

Additionally, in order for victims and survivors of narcissistic abuse to be consistently and accurately identified and assessed, the system as a whole has to change. General Systems Theory states that systemic change generally requires adjustments or

transformations in the parts involved (Bertalanffy, 1968). Therefore, the policies, practices, power dynamics, social norms or mindsets that underlie the dearth in narcissistic abuse recovery would need to collaboratively change. A change in the system as a whole could include change in service policy, implementation, and delivery within academia and educators, legal field and court system, law enforcement, and mental and physical health agencies as a systemic whole. Such systemic change can play a role in acknowledging and officially classifying narcissistic abuse.

Theme 3

Treatment of Victims and Survivors of Narcissistic Abuse

Table 3.1. Common Clinical Needs of Victims and Survivors of Narcissistic Abuse

3.1 Common Clinical Needs of Victims and Survivors of Narcissistic Abuse	Child mental health services experienced in narcissistic abuse
	Child protective services
	Childcare
	Client Led Therapy
	Empathic & Reflective Support
	Harm Reduction Intervention
	Psychosomatic Therapy
	Help to Manage Coercive Control
	Legal resources familiar with narcissistic abuse
	Psychoeducation
	Referral for financial support
	Support System
	Safety Planning
Validation	

3.1 Common Clinical Needs of Victims and Survivors of Narcissistic Abuse

As for the needs of victims and survivors of narcissistic abuse, clinicians mentioned some common needs that should be considered when providing services to this population. The results include such services to be child mental health services, experienced therapy in narcissistic abuse, child protective services, childcare, client led therapy, empathic & reflective support, harm reduction interventions, psychosomatic therapy, help in managing coercive control, referrals to legal resources who are familiar with narcissistic abuse, psychoeducation, support system, referral for financial support, safety planning, and validation.

The results suggested that clients need to learn survival tactics, stabilization techniques, and symptom management in order to withstand narcissistic trauma. Two of the most frequent client's needs shown in the results was psychoeducation and safety planning; clinicians emphasized that psychoeducation about narcissism and narcissistic abuse cycle is one of the most important parts of treatment; many people, including clients, might not have knowledge or awareness of narcissistic abuse and fall into attribution biases and blame themselves for the abuse. On the other hand, many clients are unaware of ways they can stay safe from the abuse or how to respond to abuser. Therefore, clinicians would need to have extensive knowledge on narcissism and narcissistic abuse, as well as strategies to assist clients in safety planning.

Another frequent result was the importance of client-led therapy and empathetic, reflective, and validating support. For instance, a clinician mentioned “Don't exploit therapy and make it go slower or faster than it needs to. But have it be really client-led” (P12234). Results suggested that due to client's complex trauma response and persistent

cognitive dissonance, it is important for clinicians to patiently work with client’s trauma symptoms and reduce cognitive dissonance, in order to increase client’s openness, insight, and willingness in therapy. Recognizing, addressing, and teaching trauma reduction, skill building, and symptom management for both typical and atypical trauma including symptoms of persistent cognitive dissonance, were some of the important needs mentioned in the result.

Table 3.2. Effective Theories and Modalities

3.2 Effective Theories and Modalities	Art Therapy
	Attachment-Based Theories
	Cognitive Behavioral Therapy (CBT)
	Component Based Psychotherapy (CBP)
	Dance Therapy
	Dialectical behavior therapy (DBT)
	Eye Movement Desensitization and Reprocessing (EMDR)
	Somatic Therapy
	Hakomi Therapy
	Internal Family System (IFS)
	Music therapy
	Person-Centered Therapy
	Relational Therapy
	The Gottman Method
	The Trauma Resiliency Model (TRM)
Trauma-Informed therapy	

3.2 Effective Theories and Modalities

As evident in the mentioned literature review and supported by this research data, providing services for victims and survivors of narcissistic abuse requires well-rounded and comprehensive knowledge and multiple systemic therapeutic skills and modalities. There is a consistent theme of clinicians recommending for therapists to gain knowledge

and skills from multiple modalities as the client's experience could be very complex and require knowledge and skills beyond what general therapy programs teach. It is important to note that clinicians discouraged from using one specific modality and emphasized on the importance to combining modalities that fit each client best in their unique context. Clinicians suggested a combination of deep-rooted modalities that help clients in a deeper and more client-centered and systemic manner including The Trauma Resiliency Model (TRM), Trauma-Informed therapy, Attachment-Based Theories, Psychodynamic Therapy, EMDR, Internal Family System (IFS), Person-Centered Therapy, Component Based Psychotherapy (CBP), Dance Therapy, Art Therapy, Dialectical behavior therapy (DBT), Hakomi Therapy, Music therapy, Relational Therapy, The Gottman Method. The results proved for clinicians to discourage from primarily only using cognitive or behavioral therapies, such as CBT, in a manner that increase shame and blame of their own emotions, thoughts, and behaviors instead of holding the abuser responsible. However, they encouraged using CBT alongside other modalities in a skillful manner where it provides clients the skillset to regulate and manage emotions, thoughts, and behaviors that reduce self-blame and shame and increase self-validation and self-acceptance.

Some of the most frequent theories and modalities recommended by clinicians were Attachment-based theories, Internal Family System, Trauma-informed therapy, and EMDR. For instance, a clinician mentioned "Attachment theory! when somebody comes to me like, they're an adult and they had a narcissistic parent; we always end up talking about attachment and teaching about how to create secure attachment" (P11234). And another participant shares the importance of trauma-related theories, "EMDR is one that

we are really looking at is fairly effective. I think again, that trauma-based treatments can help with the trauma aspects of it. So EMDR, brain spotting, internal family system, and somatic experiencing are really the top things that I would recommend for somebody” (P14234).

Table 3.3. Common Treatment Plan

3.3 Common Treatment Plan	Building a Support System
	Calming the Nervous System
	Customized and person-centered treatment plan
	Empowerment
	Maintaining and Holding Boundaries
	Self-Compassion
	Stages of Change Model
	Therapeutic and personal goal setting

3.3 Common Treatment Plan

According to the textbook, *Theory and Treatment Planning in Family Therapy: A Competency-Based Approach*, treatment plans are helpful in guiding the therapist to map treatment, monitor progress, and adjust treatment when necessary in order to assist the client in reaching therapy goals (Gehart, 2016). The results suggest that having a comprehensive treatment plan that meets all the needs of the client and their overall wellbeing is important to their mental health. In addition to the modalities mentioned in other results sections, clinicians recommended for the treatment plan to also be customized and person-centered and include strategies that would assist with building a support system, calming the nervous system, empowerment techniques, maintaining and holding boundaries, self-compassion, stages of change model, and therapeutic and personal goal setting. Clinicians emphasized the importance of survivor’s stabilization

through trauma education, symptom management, and skill building. Additionally, providing interventions that include education about harm reduction and trauma worsening behaviors can help clients in increasing insight about how to regulate their symptoms of trauma. For instance, one of the participants mentioned “calming the nervous system is much needed; so mindfulness training, breath-work training, walking, getting people to go outside, getting them to do the things that we know calm the human nervous system” (P11234). Some clinicians also shared the importance of providing education on pathology, cognitive dissonance, and trauma in order to increase client’s insight of their abuser and their openness and willingness in therapy. Some clinicians emphasized the importance of focusing on psychoeducation in the form of cognitive dissonance and pathology in order to help clients in understanding their abuser’s disorder, influences on relational dynamics, impact to their resulting forms of trauma (typical and atypical), its influences on trauma enhancement, and its reduction to executive functioning.

It is crucial to note that a few participants highlighted the importance for clinicians in expanding their knowledge of cognitive dissonance, complex and atypical trauma, and the impact of the experience on neurology and executive functioning beyond current academic programs. For instance, a clinician mentioned that one of the main pitfalls of ineffective treatment is the clinician’s lack of understanding and training of the depth of cognitive dissonance resulting in client’s lack of symptom improvement even years after their trauma. A couple of clinicians mentioned that it takes additional specific training to understand the depth of treating and reducing cognitive dissonance; they referred to resources presented on The Institute for Relational Harm Reduction (2022)

and the book *Women Who Love Psychopaths, Third Edition* (Brown and Young, 2018) as informative resources for clinicians to learn about pathological relational dynamics, cognitive dissonance, and atypical trauma beyond what is provided in current academic programs. Brown and Young (2018) mention that chronic and persistent cognitive dissonance is a condition associated in part with brain functioning and hyper-neural activity causing emotional dysregulation and cognitive dysregulation leading to issues in executive functioning, cognitive problems, and overall ability to function in day-to-day activities.

Clinicians emphasized the importance of customizing person-centered treatment plans and modifying them as needed per client's level of readiness and willingness; clinicians mentioned that the treatment plan has to meet the client where they are at and a lot of it has to do with increasing awareness of their experience. For instance, a clinician mentioned

they can't even identify that they need to leave, you know! For five minutes, they think they need to leave, and then five minutes later, they think they need to stay. So that is an underlying theme of my treatment plan from beginning to end. To meet them where they are at! in the beginning, it's more of gaining awareness, can they recognize or identify that they're experiencing narcissistic abuse? (P14234).

Table 3.4. Effective Interventions

3.4 Effective Interventions	Clinicians' self-awareness and self-acknowledge
	Cognitive distortion reduction
	Connection with the Client
	Empty Chair Technique
	Expert-level group therapy focused on narcissistic abuse recovery
	Family Dynamics
	knowledge of Client's systemic context and background
	Journaling and Letter Writing
	Mindfulness Exercises
	Peer Support
	Play Therapy
	Psychoeducation
	Referrals
	Relational Trauma
	Spiritual practices and support
	Trauma Timeline
	Unconditional positive Regard
Understand the pathological love relationship model and dynamic	
Validation	
Yoga	

3.4 Effective Interventions

American Psychological Association defines intervention as an action on the part of a psychotherapist to deal with the issues and problems of a client, guided by the nature of the problem, the orientation of the therapist, the setting, and the willingness and ability of the client to proceed with the treatment (APA, 2022). In other words, therapeutic interventions are interactions and techniques that are used to initiate improvement in how the client feels, thinks, and behaves. The results suggest that in addition to commonly used interventions, some interventions can be especially helpful in treating victims and survivors of narcissistic abuse. Clinicians shared common interventions including but not

limited to clinicians' self-awareness and self-acknowledge, cognitive distortion reduction, connection with the client, empty chair technique, expert-level group therapy focused on narcissistic abuse recovery, family dynamic interventions, knowledge of client's systemic context and background, journaling and letter writing, mindfulness exercises, peer support, play therapy, psychoeducation, referrals, relational trauma interventions, spiritual practices and support, trauma timeline, unconditional positive regard, understanding of the pathological love relationship model and dynamic, validation, and yoga. Clinicians suggested that having multifaceted interventions play a substantial role in therapy.

The most frequent interventions recommended by clinicals were regarding client's nervous system regulation and their safety whether they decide to stay or leave a narcissistic dynamic. For instance, a participant shared the importance of knowing how to help clients leave their relationships safely,

I always, you know, help them prepare for how risky it is to leave. And I suggest, you know, like I do the emotional piece like domestic violence agencies do a great job of assessing lethality. So I always recommend that that's part of this as well, when they're thinking about leaving. I have the benefit of hearing all these nightmare stories about, you know, when a narcissist gets left, they go apeshit, excuse my language, and destroy social security cards and passports and they hide things (P5234).

Results suggested for clinicians to be aware of useful safety interventions that would specifically be geared towards interacting with a person who has a narcissistic personality. Therefore, clinicians must learn narcissistic abusive tactics in order to

recommend helpful interventions and stay away from interventions that might cause more harm in the client's unique context.

Discussion of Theme 3

Due to the client's complex experience and symptoms, results show for treatment to be client-centered, versatile, and comprehensive and multifaceted. Victims tend to go through a narcissistic abuse cycle of idealization, devaluation, and rejection; a pattern of positive and negative experiences in which the narcissist confuses the victim through manipulation and calculated tactics aimed at making the victim question their sense of self and reality and live to maintain and appease the relationship and the narcissistic individual (Gaum and Herring, 2020). narcissistic abuse can be drastically impactful and traumatic on one's emotional, psychological, physical, financial, and spiritual well-being (Brown and Young, 2018; Day et al., 2020; Durvasula, 2022; Howard, 2019; Leedom, 2019; MedCircle, 2020). Therefore, clinicians who provide therapy for such specialized population would need to have extensive treatment abilities that would meet client's multifaceted needs. Thus, it can be concluded that the treatment offered to this population would require additional specialized training and experience beyond their academic general curriculum. Clinicians must have competency in the narcissistic abuse therapeutic recovery in order to prevent further harm and reinforcement of the client's trauma cycle.

Theme 4
Clinician's Resources

Table 4.1. Ways to increase Proficiency and Specialization

4.1 Ways to Increase Proficiency and Specialization	Appropriate Education
	Gaining highly experienced and specialized supervision
	Learn from Personal Experience & Clinical Practice
	Listen to the experiences of victims and survivors of narcissistic abuse
	Through Professional and popular publications
	Through Courses & Training

4.1 Ways to Increase Proficiency and Specification

Clinicians emphasized that to the best of their knowledge, there are no institutional specialization programs that can certify and/or evaluate clinician's therapy quality or competence in narcissistic abuse recovery. Clinicians also mentioned that although there are some available resources to increase proficiency and competency in treating victims and survivors of narcissistic abuse, they are limited in amount and contain gaps and insufficiencies. For instance, most clinicians mentioned that they have not come across a one-stop resource that is comprehensive and sufficient enough to cover the full construct of narcissistic abuse recovery. Most clinicians shared that they had to put in a lot of effort to find appropriate research, read, and take additional trainings in order to enhance their proficiency; "I think that I've done so much research on this topic, and I researched it and wrote a book on it, like, I know what's out there and what isn't out there. And I really think that the information is so crucial" (P14234).

The required knowledge and clinical skills in treating victims and survivors of narcissistic abuse, calls for clinicians to pursue additional educational resources beyond

their academic program. Moreover, results suggested that such additional education can be sought from gaining highly experienced and specialized supervision, proactively learning from personal and clinical experience and practice, actively listening to victim’s experience of narcissistic abuse with the intention of learning from them, and learning through appropriate education and professional and popular publications in addition to courses and trainings associated with narcissism and narcissistic abuse.

Some clinicians shared their hope for additional resources associated with increasing proficiency,

And I think in an ideal world, if there was some way to have a peer mentor or a mentor of some kind to partner with and really do case consults with and supervision that way. In an ideal world, that would be great. To be able to just get support for somebody that does hear it, and then help you navigate what you hear and what you don't hear and what you're missing (P12234).

Table 4.2. Available Resources to improve Skills and Knowledge

4.2 Available Resources to Improve Skills and Knowledge	Blogs
	Books
	Podcasts
	Training and courses specific to common symptoms of victims and survivors of narcissistic abuse
	Limited training and courses specific to narcissistic abuse
	YouTube Videos

4.2 Available Resources to Improve Skills and Knowledge

The results suggested that the current available resources for clinicians are blogs, books, podcasts, YouTube videos, training and courses specific to common symptoms of victims and survivors of narcissistic abuse, and a limited amount of training and courses

specific to narcissistic abuse. It is important to note that although clinicians mentioned such resources, they talked about the need for further comprehensive resources that are based on research and evidence as well as a standardized model that is consistent in information among all trainings. Some clinicians mentioned that based on their knowledge, there is no available resource that contains a comprehensive standardized training model that covers the totality of narcissistic abuse recovery. Additionally, clinicians mentioned that there are discrepancies and differences in views between some available trainings.

The most frequent resources and professionals associated with available trainings and resources mentioned in the data included Pesi.com, Dr. Ramani Durvasula, Ph.D., Sandra L. Brown, M.A., Lindsay Gibson, Psy.D., Gregory W. Lester, Ph.D. For instance, a clinician mentioned

Sandra Brown has been working on a training that will be put out soon, while there's already part one of the training, about how to work with pathological love relationships. And then there is the second part, which is very specific to therapists, which will be released sometime in the next several months. So once that comes out, I think honestly, that is the only thing I have seen that looks at the research that is out there, which we know is limited and is specific to this. So um, you know, that is one resource, generally speaking (P14234).

It is important to note that most clinicians mentioned the presence of available resources (books, podcasts, blogs, social media sources) and coaching services that have been provided by individuals who do not have proper clinical education and clinical expertise,

has been harmful. Clinicians mentioned that proper education and clinical expertise is crucial in treating traumatized populations. For instance, a clinician mentioned

there's also this trend right now where there is a ton of what we'd call survivors-turned-experts. So a ton of people who've been through narcissistic abuse, who are coaching, who don't really have any clinical expertise and they're dealing with highly traumatized people. And I'm not saying that what you know a lot of their work I think is really helpful, but it can also be damaging or not get people the actual treatment that they need because they're kind of regurgitating the same information that they're all sharing on social media, which is really concerning. From the trauma-level, people relapsing into these relationships again and again, because they're not really getting accurate information or healing from their trauma. But there is a big community of people dealing with this (P14234).

Table 4.3. Gaps and Needs

4.3 Gaps and Needs	lack of standardized and official clinical terminology
	Lack of clinical support system and community
	Lack of clinical assessment tools specific to narcissistic abuse
	Limited, insufficient, and costly Trainings
	Lack of an evidence-based standardized training model and certification program
	Lack of Graduate & Post Graduate courses
	Insufficient academic and peer-review literature
	Insufficient empirical research
	Presence of harmful therapy and coaching services for clients
	Limited referral system
	Insufficient training leading to Insufficient treatment
	Lack of a treatment model/program focused on narcissistic abuse
	Inconsistency in acknowledging narcissistic abuse as domestic violence
	A Diagnosis in the DSM for victims and survivors of narcissistic abuse
	A complete manifestation of narcissistic personality disorder (NPD) diagnosis in the DSM.

4.3 Gaps and Needs

The aforementioned data on required knowledge and clinical skills versus the available and accessible resources for victims and clinicians, highlights some important gaps in clinician’s resources in treating this population. The results showed the gaps and needs to include lack of standardized and official clinical terminology, lack of clinical support system and community for victims and clinicians, and lack of clinical assessment tools specific to narcissistic abuse. Additionally, the clinicians suggested that there are limited, insufficient, and costly trainings focus on narcissistic abuse. For instance, a clinician stated “it’s so expensive to be able to like do those trainings fully,

you know, and it's not super accessible to everybody” (P10234). Moreover, the results suggested a lack of an evidence-based standardized training model and certification program, lack of graduate & post-graduate courses, insufficient academic and peer-review literature, and insufficient empirical research. For instance, a clinician mentioned “there's very limited training available, it's not something we get in grad school” (P14234).

Some clinicians emphasized on the presence of harmful therapy and coaching services for clients; highlighting the importance of proper education and extensive training in complex trauma healing and narcissistic abuse recovery. For instance, a clinician mentioned

Well, for example, a good majority of therapists or coaches focus on codependency as the issue. And that goes back to what I just talked about, like, how do you know that? I mean, most of them don't talk about the fact that it could be a personality trait, they don't know the research that shows how you know that, or at least they don't know about the research to even assess to see what this person really needs... And if they're not trauma therapists, how do they know how to help with trauma? And because we know the nature of trauma, it could have happened 20 years ago, and they're still experiencing PTSD because it was never treated. So that's the concern for me is that either therapists who don't recognize the atypical symptoms, or don't recognize narcissism at all, you know, and can do more damage, because they don't understand that this person's describing narcissistic abuse. or the therapist is doing couples therapy, God forbid, and fall for the charismatic kind of stuff of the narcissist themselves. But

yeah, people can go untreated and have symptoms of PTSD that are debilitating and not even know that they have that. It's very sad (P14234).

In other words, clinicians suggested cautionary evaluation of the available trainings or treatments offered by professionals that have not had the proper background in education, experience, or training. Due to the intense complex trauma experienced by this population, clinicians mentioned that proper education and clinical expertise is crucial in treating traumatized populations. Moreover, some clinicians added that coaches most often do not have the clinical trauma training and education to help clients with healing their trauma or mental health issues, though quality coaching services could be an additional support to therapy treatment. Additionally, another clinician mentioned,

Narcissistic abuse is one of those topics in psychology, where it grabs the popular attention or the popular imagination, and a whole bunch of information is put out there on it. And that's mostly a good thing. But it can also be kind of a bad thing. Because, you know, you see all these people that are like self-publishing these books about narcissistic abuse, and it's just like, it seems like anything could be considered narcissistic, creating misinformation ... and you see people saying they're narcissistic abuse recovery coaches who have no education or training in that particular area. So, I think consuming information is good. But being skeptical, and having a healthy sense of skepticism around consuming information on this topic is also good. You know, hopefully listening to people who have licenses or degrees as opposed to just somebody who says they're an expert, who doesn't seem to have any sort of way of backing that up (P1234).

In other words, personal experience of narcissistic abuse, alone, does not equate to having adequate experience or competence in helping others heal through their trauma.

Additionally, results showed the gaps and needs to also include limited referral systems, insufficient training leading to insufficient treatment, lack of a treatment model/program focused on narcissistic abuse, and inconsistency in acknowledging narcissistic abuse as domestic violence. The results also showed the gap and needs to include a lack of diagnosis in the DSM for victims and survivors of narcissistic abuse, as well as a lack in the complete manifestation of narcissistic personality disorder (NPD) diagnosis in the DSM. For instance, a clinician mentioned

But there's definitely a gap. Because speaking from my own grad school experiences, I was definitely taught about psychopathology, at least as defined in the DSM. I was taught about physical abuse, sexual abuse, verbal abuse, all that stuff, but like, I never got any sort of education or if I did, it was extremely minor, on psychological manipulation and exploitation and coercive control. And, you know, I would lump narcissistic abuse into that. that was not something I really got a lot of education on, that stuff I've had to learn along the way (P1234).

Discussion of Theme 4

The data showed that clinicians who provide services to victims and survivors of narcissistic abuse need to have extensive knowledge and clinical skills in order to competently and sufficiently provide quality care and services to this population. Upon reviewing the results in Clinician's Resources (theme 4), it can be concluded that the available methods and resources to increase proficiency, knowledge, and clinical skills in

the needs, assessment, and treatment of victims and survivors of narcissistic abuse are limited in quantity, comprehensiveness, and cohesiveness and consistency among training models. Moreover, the gaps and needs suggested by clinicians supported the literature review in this needs assessment. In other words, as mentioned in the literature review, some continuing education courses, trainings, podcasts, conferences, books, and professional and popular publications, etc. provide information and teachings on narcissistic abuse; however, the quality and accuracy of such resources is difficult to assess and evaluate as this is an understudied construct and the resources might have little to no empirical research and academic support backing up their curriculum. Additionally, based on the researcher's current knowledge, the available training or treatment resources in narcissistic abuse in the US have yet to have gone through experiential research and trial process to evaluate their efficacy. Therefore, therapists may need to personally strive to learn more about narcissistic abuse beyond their academic program, if they are able, willing, and trusting of the available resources. The data showed that there is a dearth in the required knowledge and clinical skills of clinicians and the availability, accessibility, and acceptability of current resources to address the needs, assessment, and treatment of this population.

According to Kohn et al., (2018), a crucial public health concern in America remains to be the treatment gap for mental health. Therefore, a high proportion of adults, children, and indigenous individuals with serious mental illness remains untreated and treatment gap reduction progress has been very slow. Treatment gap in America can result in an elevated prevalence of mental disorders and global burden of disease. Moreover, Olfson (2016) recommends that in order for the mental health workforce to

improve in providing services for people with serious mental health needs, several policy changes must occur. In order to make a change in the therapy quality and therapist competency, systemic policy changes must occur, as it is a difficult and long-term task for individual therapists to take on all the responsibility to learn and provide appropriate services to meet the client's needs without sufficient accessible, available, and acceptable resources. According to Fairburn and Cooper (2011), there are large number of therapists who have expressed desire to receive additional training in order to improve their therapeutic deliverance in treatment; however, current methods of training have their limitations in suiting this task due to reasons including but not limited to high costs and requiring of scarce expertise. Therefore, Fairburn and Cooper (2011) recommend the development of new forms of training at a more cost-effective and scalable state in addition to developing new strategies and procedures for evaluating training outcomes. Fairburn and Cooper (2011) further recommend such programs and evaluative strategies to be capable of assessing the therapist's knowledge of the treatment and its use, as well as the therapist's ability to apply this knowledge in clinical practice. Therefore, further program developments should include strategies that focus on improving therapist delivery in addition to their knowledge and clinical skills.

Based on the literature review and interview results, it could be concluded that systemic change needs to occur. Systemic change is crucial because without improving awareness, access, and advocacy of narcissistic abuse within the whole system, trauma can be reinforced and victims can be left unsupported and untreated within a systemic cycle. Addressing the gaps in the needs, assessment, and treatment can increase awareness, access, and advocacy focused on victims and survivors of narcissistic abuse

among a large system; including but not limited to academia and educational sources, research, clinical practices, providers and professionals, law enforcement, the court system (Mediators attorneys, and judges), and the public at large.

Recommendations

Recapitulation

The needs assessment highlighted important gaps in the needs, assessment, and treatment of victims and survivors of narcissistic abuse. There is a dearth of empirical research, academic and clinical resources, evidence-based training and treatment models, and evidence-based programs and modalities focused on victims and survivors of narcissistic abuse. The dearth in awareness and advocacy of this population has led to discrepancies and insufficiencies in developing standardized diagnoses, terminology, clinical training, treatment, societal validation and acknowledgement, policy making, and laws supporting victims and survivors of narcissistic abuse.

Academic and clinical programs, including MFT programs and the DSM-5, have not sufficiently covered the identification, needs, assessments, or treatment of victims and survivors of narcissistic abuse. However, there are some available and accessible continuing education courses and trainings offered through US accredited agencies focused on narcissistic abuse recovery. Yet; compared to the complex needs of victims and survivors of narcissistic abuse and the lack of teachings in the academic curriculum, the number of the available, accessible, and acceptable trainings and courses for

clinicians seem to be limited in quantity, comprehensiveness, and consistency and cohesiveness among training models.

Additionally, there are available professional and popular publications such as blogs, books, articles, podcasts, videos focused on narcissistic abuse presented by mental health professionals and individuals who have experienced or witnessed such abuse. However, since they are not evidence-based, the quality and accuracy of such resources is difficult to assess and evaluate.

Additionally, there are also abundant resources and trainings that are targeted at common mental illnesses and symptoms that oftentimes can also be experienced by victims and survivors of narcissistic abuse. Therefore, clinicians can use these alternative sources to improve their knowledge and clinical skills.

Recommendations were considered based on the aim to identify the required knowledge and clinical skills recommended by clinicians who treat victims and survivors of narcissistic abuse to identify some needs, assessments, and treatment practices that can guide Licensed Marriage and Family Therapists (LMFTs) in treating this population. Recommendations were created based on the results of the needs assessment and highlighted gaps in order to indicate the specific measures and directions a LMFT can take in the needs, assessment, and treatment of victims and survivors of narcissistic abuse.

Clinician's Required Knowledge and Clinical Skills

1.1 Required Knowledge and Understanding

When interviewing clinicians who self-identified as being competent, proficient, and expert in treating victims and survivors of narcissistic abuse; it was evident that clinicians, including LMFTs, need to attain extensive and specialized knowledge and clinical skills beyond the general education provided by their academic program and the DSM-5. Due to the insufficiencies in academic and evidence-based clinical resources focus on narcissistic abuse, it is recommended for clinicians to immerse themselves in the limited existing literature and alternative available professional and popular publications and continuing education trainings focused on narcissism, narcissistic abuse, and the symptoms common to the victims and survivors of narcissistic abuse. Based on the results, it is recommended that clinicians would need to attain extensive knowledge and clinical skills in the cyclical nature of narcissistic abuse, coercive control, and different forms of abusive dynamics and behaviors.

It is recommended that clinicians understand the distinct tactics, impact, and interventions and treatment specific to the distinct narcissistic behavior and abuse compared to other forms of abuse. It is crucial for clinicians to understand the severity of long-term psychological and executive functioning effects of narcissistic abuse and consider extensive therapeutic approaches. It is recommended for clinicians to understand the insidious and cult-like nature of narcissistic abuse and the gradual decline of self and the relationship.

According to the marriage and family therapy (MFT) core competencies (2004), LMFTs must know the existing MFT literature, research, and evidence-based practice in

order to practice independently. Thus, it is recommended that clinicians make intentional efforts to learn from the current existing literature, research, evidence-based practice, and training on different forms of trauma (including complex and atypical trauma) and its impact on client's biopsychosocial wellbeing. In order to understand client's patterns and their relational dynamics as well as increase their insight about their abuser's patterns, it is recommended for clinicians to research and gain training on personality pathology and proclivities.

It is also highly recommended for clinicians to do a thorough investigation and analysis of root causes and misconceptions of codependency and cognitive dissonance and its impact on client's systemic experience, disruptive and intrusive symptoms, and executive functioning as well as its role in the start and maintenance of abusive relational dynamics. In specific, it is important for clinicians to be cautious about labelling clients behavior as co-dependent; by labelling behaviors as co-dependent it can obscure behaviors the women are already using as a way of resisting mistreatment. Labeling clients as codependent can potentially increase their sense of blame, shame, and disempowerment; which reinforces their experience of being gas-lit and blamed for what the abuse inflicted. Therefore, it is highly recommended for clinicians to be cautious when exploring co-dependent behaviors.

Due to the gaps and discrepancies in the delineation of narcissistic abuse (within family and intimate relationships) as domestic violence, it is recommended for clinicians to practice their executive core competence of conducting empirical research (AAMFT, 2004) to suggest the distinctions between different forms of abuse and to collect evidence to legitimize narcissistic abuse. Additionally, it is recommended for clinicians to practice

their executive core competence as critiquing the existing limited literature and assessing the quality of current research studies, program evaluation, and professional and popular publications (AAMFT, 2004) regarding domestic violence and hidden or narcissistic abuse. Additionally, Critiquing the current publications and resources can suggest for improvement of clinical practices despite limitations in literature and law.

1.2 Required Skills

Additionally, it is recommended for clinicians to intentionally and continuously work towards developing and practicing empathy, flexibility, and client-centered therapeutic alliance. It is recommended for clinicians to use their experience and intuition to comprehensively evaluate client's systemic context beyond the client-reported presenting problem. It is recommended for clinicians to take intentional measures to process therapist's use of self in therapy and remain focused, self-regulated, and unbiased in the therapeutic dynamic.

1.3 Awareness of Common Terminology

It is recommended for clinicians to increase their awareness and understanding of narcissistic-related clinical and informal terminologies available on professional and popular publications. Moreover, due to the advantages and disadvantages of informal terminologies, it is also recommended for clinicians to practice their professional core competence of contributing to the development of new knowledge (AAMFT, 2004) by collaborating with other experts in the field to develop an official and standardized glossary of narcissistic related terms. As social constructivism theory suggests, learning

is a collaborative process and all knowledge develops as a result of social interaction and language use and it results from many social processes and interactions (Vygotsky, 1978).

Assessment of Victims and Survivors of Narcissistic Abuse

2.1 Common Symptoms Experienced by Victims and Survivors of Narcissistic Abuse

Clinicians would need to be able to identify and assess victims and survivors of narcissistic abuse beyond the client's presenting problem. It is recommended for clinicians to be aware of common symptoms and signs experienced by victims and survivors of narcissistic abuse. Common symptoms and manifestations caused by narcissistic abuse can include but not limited to a variety of manifestations of different mental illnesses such as depression disorders, anxiety disorders, ADHD, post-traumatic stress disorder, complex post-traumatic stress disorder, sexual disorders, personality disorders, and mood disorders. It is recommended for clinicians to be highly aware of dysregulated and insecure emotional, behavioral, attachment, and dependency patterns in clients. It is recommended for clinicians to be aware of the causes, patterns, and impact of chronic and persistent cognitive dissonance, intense experience of shame, isolation, and executive functioning. It is recommended for clinicians to identify and address client's sense of self, identity, worth, and reality.

2.2 Identification of Victims and Survivors of Narcissistic Abuse

Clinicians would have to be able to recognize signs that can help in identifying victims and survivors of narcissistic abuse in therapeutic settings. In order to identify clients, it is recommended for clinicians to use their intuition and knowledge to obtain frequent therapy sessions in order to monitor for signs of imbalance of power and control in the client's relational dynamics outside of session. It is recommended for clinicians to become highly competent and experienced in identifying manifestations of coercive control and abuse, addictive behaviors, and history of trauma.

2.3 Ways to Assess Victims and Survivors of Narcissistic Abuse

Due to the lack of a standardized assessment tool to identify the presence or severity of narcissistic abuse and its impact, it is recommended for clinicians to use intuitive talk therapy to assess client's experience and context. Additionally, based on the social constructivism theory, it is also recommended for clinicians to practice their professional core competence of contributing to the development of new knowledge (AAMFT, 2004) and collaborate with other expert colleagues and professionals in developing an assessment tool focused on the needs, assessment, and treatment of victims and survivors of narcissistic abuse. On the other hand, in order for clinicians to assess client's symptoms, it is recommended for clinicians to make use of available assessment tools such as trauma and DARVO assessments, Adult Substance Use Survey (ASUS), Beck Depression Inventory (BDI), Circumplex Model, Patient Health Questionnaire (PHQ-9), PTSD Checklist for DSM-5 (PCL-5), The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5), The Gottman Assessment, The Minnesota

Multiphasic Personality Inventory (MMPI), and Understanding of Adverse Childhood Experiences (ACE).

2.4 Common Diagnosis of Victims and Survivors of Narcissistic Abuse

Due to the lack of a diagnosis specific for victims of narcissistic abuse, it is recommended that clinicians take cautionary actions to prevent mislabeling and misdiagnosing clients. When a diagnosis is required, it is recommended that clinicians use a DSM-5 diagnosis that represents the cluster of symptoms associated with the outcomes of abuse, such as disorders related but not limited to trauma, anxiety, depression, and mood. It is recommended that clinicians process diagnoses with the clients in order to prevent reinforcing their trauma cycle of shame and self-blame.

2.5 Common Risks and Crisis Experienced by Victims and Survivors of Narcissistic Abuse

In order to identify common risks and crisis experienced by victims and survivors of narcissistic abuse, it is recommended that clinicians take personal initiative to assess and address client's need beyond self-reported presenting problems. It is recommended for clinicians to learn about common risks such as substance abuse, cognitive and executive functioning, financial difficulties, lack of support system, poor self-esteem and self-worth issues, physical and medical risks, and safety risks and suicidal ideation. Additionally, it is recommended for clinicians to become well-versed and trained (later mentioned in theme 4) in psychoeducation regarding strategies to cope, heal, and respond specific to narcissistic tactics. It is recommended that clinicians make intentional efforts

to assess, identify, learn, and address client's risks and crises issues as well as refer, collaborate, and connect with other professionals in providing alternative resources and services.

Treatment of Victims and Survivors of Narcissistic Abuse

3.1 Common Clinical Needs of Victims and Survivors of Narcissistic Abuse

It is recommended that clinicians become familiar with common and specific needs of clients, in order to provide best treatment practices and referral resources. It is recommended that clinicians become familiar with agencies and resources that address and provide services helpful to victims and survivors of narcissistic abuse such as harm reduction and safety strategies and programs, child protective services, adult and child welfare services, legal resources familiar with narcissistic abuse, financial support tactics and agencies, and domestic violence resources and support. As social constructivism confirms, it is recommended for clinicians to interact and collaborate with other professionals to increase awareness, understanding, and advocacy of the needs of victims and survivors of narcissistic abuse.

3.2 Effective Theories and Modalities

In order to provide therapy for victims and survivors of narcissistic abuse, it is recommended for clinicians to gain knowledge and skills in a combination of multiple therapeutic modalities to address each client's complex needs based on their context. It is recommended for clinicians to become well-versed and trained in systemic and trauma-informed modalities that help clients in deeper healing rather than focusing only on

behavioral or cognitive change. It is recommended that clinicians gain training on theories such as The Trauma Resiliency Model (TRM), Trauma-Informed therapy, Attachment-Based Theories, Psychodynamic Therapy, EMDR, Internal Family System (IFS), Person-Centered Therapy, and Component Based Psychotherapy (CBP). Modalities such as Somatic Therapy, Dance Therapy, Art Therapy, Dialectical behavior therapy (DBT), Cognitive Behavioral Therapy, Hakomi Therapy, Music therapy, Relational Therapy, and The Gottman Method are among theories that are recommended to be a great addition for symptom management, emotional regulation, skill building, and executive functioning.

3.3 Common Treatment Plan

In order to build a collaborative and person-centered treatment plan with the client, it is recommended for clinicians to focus on client's personal needs, psychoeducation, nervous system management, support system, empowerment techniques, boundaries, self-compassion, stages of change model, and therapeutic and personal goal setting. It is recommended for the treatment plan to include strategies rich in survivor's stabilization and harm reduction through trauma education, symptom management, and skill building.

3.4 Effective Interventions

In order to provide effective treatment to victims and survivors of narcissistic abuse, it is important for clinicians to take intentional efforts in learning comprehensive and multifaceted interventions to meet their client's complex needs. It is recommended

for clinicians to educate themselves on interventions that address client's safety, complex trauma, symptom management, emotion regulation, nervous system management, and awareness of narcissistic tactics and dynamic. It is recommended for clinicians to attain experience and training (later mentioned in theme 4) on interventions that assist clients in psychoeducation of narcissistic abuse dynamic, recovery, and effective strategies that assist in learning how to interact and respond to narcissistic clients. The recommended interventions for clinicians to include in the treatment plan of victims and survivors of narcissistic abuse include but are not limited to clinician's self-awareness and use of self in therapy, cognitive distortion reduction, building empathetic and flexible therapeutic alliance, empty chair technique, expert-level group therapy focused on narcissistic abuse recovery, family dynamic interventions, knowledge of client's systemic context and background, journaling and letter writing, mindfulness exercises, peer support, play therapy, psychoeducation, referrals, relational trauma interventions, spiritual practices and support, trauma timeline, unconditional positive regard, understanding of the pathological love relationship model and dynamic, validation, and yoga.

In specific to narcissistic abuse recovery, clinicians must become highly trained in cognitive dissonance reduction, healing complex and atypical trauma, emotional and cognitive dysregulation, and executive functioning.

Clinician's Resources

4.1 Ways to Increase Proficiency and Specialization

There is insufficiency in the quantity, comprehensiveness, and consistency of the available academic and evidence-based clinical resources focus on the needs, assessment, and treatment of victims and survivors of narcissistic abuse. Therefore, it is recommended for clinicians to immerse themselves in the limited existing literature, highly specialized supervision, multifaceted continuing education courses and trainings, and alternative available professional and popular publications focused on narcissism, narcissistic abuse, and the symptoms common to the victims and survivors of narcissistic abuse. Though there is no certification or standardized program to be acknowledged as a specialized narcissistic abuse recovery clinician, it is recommended for clinicians to practice their executive core competence of reading the related current MFT and other professional literature, using current MFT and other research to inform their clinical practice (AAMFT, 2004).

4.2 Available Resources to Improve Skills and Knowledge

Due to the insufficiency in the quantity, comprehensiveness, and consistency of the available academic and clinical resources focus on the needs, assessment, and treatment of victims and survivors of narcissistic abuse, it is recommended for clinicians to intentionally search for and learn from quality clinical and academic literature, training and courses specific to narcissistic abuse, and training and courses offered in other topics which are still helpful in addressing the common symptoms experienced by victims and

survivors of narcissistic abuse. Additionally, it is recommended that clinicians intentionally and discreetly review and immerse themselves in the current related professional and popular publications and internet-based information such as books, articles, blogs, podcasts, social media accounts, and YouTube videos. However, it is recommended that clinicians practice the executive core competence of critiquing and assessing the quality and accuracy of the available resources and program evaluation, in addition to determining the effectiveness of the current available clinical practice and techniques (AAMFT, 2004).

4.3 Gaps and Needs

Due to their responsibility to the field of marriage and family therapy based on the MFT core competencies, MFTs are to maintain competency and involvement in admission to treatment, clinical assessment and diagnosis, treatment planning and case management, therapeutic interventions, legal issues, ethics, standards, and research and program evaluation (AAMFT, 2004). Therefore, based on the social constructivism theory and the gaps and needs mentioned in the results, it is recommended that clinicians collaborate with experts and appropriate professionals to take action in addressing the aforementioned gaps and needs. Being one of the main mental health providers, MFTs are exposed to client's experiences; therefore, it is recommended that MFTs involve themselves in conducting empirical research and developing evidence-based programs focused on the construct of narcissistic abuse.

As social constructivism suggests, culture and language and interaction play a role in learning; therefore, MFTs can also improve their knowledge and clinical skills by

joining colleagues and developing communities to improve collective knowledge, awareness, and advocacy of narcissistic abuse recovery and services. It is recommended that clinicians collectively network in order to create standardized clinical terminology, assessment tools, evidence-based clinical training models and certification programs, scaling tools for therapy quality and therapist competency, and evidence-based treatment models and programs focused on narcissistic abuse. The development of a community of professionals focusing on the improvement of services can also lead to the development of a directory of professionals who treat victims and survivors of narcissistic abuse.

CHAPTER SIX

SUMMARY AND APPLICATIONS

Summary of Project Outcomes

This needs assessment explored current literature, research, and academic and clinical resources focused on narcissism and narcissistic abuse followed by interviewing 14 clinicians who self-identify as treating victims and survivors of narcissistic abuse at a competent, proficient, or expert level. This needs assessment aimed to identify the required knowledge and clinical skills recommended by clinicians who treat victims and survivors of narcissistic abuse to identify some needs, assessments, and treatment practices that can guide Licensed Marriage and Family Therapists in treating this population.

The literature and the thematic analysis of the 14 interviews showed systemic gaps and discrepancies in the current available and accessible information regarding the construct of narcissism, narcissistic personality disorder, narcissistic abuse, and the impact of this personality type on people in any form of relationships with them. Although the body of research has grown in understanding narcissism and Narcissistic Personality Disorder (Larson et al., 2015; Miller et al., 2010; Ronningstam, 2005), currently there is a dearth of empirical research, evidence-based programs and modalities, academic and clinical resources, diagnosis, assessment, and treatment models focused on individuals who are in any form of relationship with a person who has a narcissistic personality type. Although victims and survivors of narcissistic abuse have been recognized in professional and popular publications, the paucity of academic and

empirically peer-reviewed resources on this population has become problematic in ways that has affected the development of standardized diagnosis, terminology, treatment, or clinical and societal validation of the experience.

Moreover, academic and clinical programs, including MFT programs and the DSM-5, have not covered the identification, needs, assessments, or treatment of victims and survivors of narcissistic abuse. The aforementioned gap has led to limited and insufficient teaching and training in the subject, which has led to limited knowledge and clinical skills in the mental health field. For instance, COAMFTE-accredited Master's level Marriage and Family Therapy programs do not place an emphasis on the identification, assessment, or treatment of victims and survivors of narcissistic abuse (COAMFTE, 2017). However, Licensed marriage and family therapists (LMFTs), being one of the main lines of contact of mental and relational health services, are required to have sufficient knowledge and clinical skills to treat victims and survivors of narcissistic abuse.

In addition to their academic degree, mental health professionals must complete continuing education courses to receive their license renewal. There are some available and accessible continuing education courses and trainings offered through US accredited agencies focused on narcissistic abuse recovery. However, compared to the complex needs of victims and survivors of narcissistic abuse and the lack of teachings in the academic curriculum, the number of the available, accessible, and acceptable trainings and courses for clinicians seem to be limited in quantity, comprehensiveness, and consistency and cohesiveness among training models. Additionally, there are available professional and popular publications such as blogs, books, articles, podcasts, videos

presented by mental health professionals and individuals who have experienced or witnessed such abuse. Most of these professional and popular publications seem to target the victims and survivors of narcissistic abuse rather than giving therapeutic guidance for professionals treating this population. However, the professional and popular publications can help professionals in enhancing their awareness and knowledge about this population. The quality and accuracy of such resources is difficult to assess and evaluate as this is an understudied construct and the resources might have little to no empirical research and academic support backing up their curriculum. Additionally, based on the researcher's current knowledge, the available training or treatment resources in narcissistic abuse in the US have yet to have gone through experiential research and trial process to evaluate their efficacy. Therefore, clinicians, including LMFTs, may need to personally strive to learn more about narcissistic abuse beyond their academic program, if they are able, willing, and trusting of the available resources.

Due to the complex symptoms caused by narcissistic abuse, victims and survivors need comprehensive treatment services that meet every area of their needs. Treatment services provided for victims and survivors of narcissistic abuse would have to entail modalities that support their psychological, physical, spiritual, sexual, social, neurobiological and somatic needs. As a result of 14 interviews with clinicians that self-identified as competent, proficient, and expert in treating victims and survivors of narcissistic abuse, the researcher used thematic analysis to identify and summarize key themes that best represent clinician's recommendations in the needs, assessments, and treatment of this population. Four main categories were developed to represent the major themes of clinician's recommendations. The first Category, "*Clinician's Required*

Knowledge and Clinical Skills,” provided specific details within themes of clinician’s required knowledge and understanding, clinical skills, and awareness of common terminologies describing the narcissistic dynamic. The second category, “*Assessment of Victims and Survivors of Narcissistic Abuse,*” provided specific details within themes of common symptoms, identification factors, assessment methods and tools, common diagnoses, and common risks and crises experienced by victims and survivors of narcissistic abuse. The third category, “*Treatment of Victims and Survivors of Narcissistic Abuse,*” provided specific details within themes of common clinical needs of the population, effective clinical theories and modalities, common treatment plans, and effective interventions in treating victims and survivors of narcissistic abuse. The fourth category, “*Clinician’s Resources,*” provided specific details within themes of ways to increase proficiency and specialization, available resources to improve skills and knowledge, and gaps and needs within the field of narcissistic abuse recovery.

The needs assessment highlighted important gaps in the needs, assessment, and treatment of victims and survivors of narcissistic abuse. This needs assessment provided recommendations in areas of clinician’s required knowledge, clinical skills, and clinical resources in addressing the needs, assessment, and treatment of victims and survivors of narcissistic abuse. Recommendations were created based on the results of the needs assessment and highlighted gaps, in order to indicate the specific measures and directions a LMFT can take in the needs, assessment, and treatment of victims and survivors of narcissistic abuse.

Revisiting the Gap in Literature

Definition of Narcissism and Narcissistic Personality Disorder

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; APA, 2013) is the most widely accepted nomenclature used by clinicians and researchers to classify mental disorders. According to the Diagnostic and Statistical Manual of Mental Disorders, (DSM-5, a person who is diagnosed with narcissistic personality disorder (NPD) has a personality style that includes grandiosity, self-importance, sense of entitlement, need for admiration, lack of empathy, interpersonally exploitative, erraticism, arrogance, haughtiness, disdainfulness, patronizing, and has a lack of relational reciprocal interest (APA, 2013).

Although DSM-5's focus on the grandiosity features are indeed a core component of narcissistic personality, a rich literature focused on the phenotypic descriptions of pathological narcissism across clinical theory, social-personality psychology, and psychiatric diagnosis reveals expanded criteria and understanding of narcissism that includes different subtypes of narcissistic personality disorder (Cain et al., 2008; Caligor et al., 2015). The diagnostic criteria for NPD in DSM-5 includes overt grandiose features, leaving out vulnerable manifestations of the disorder that include instances of depressed mood, insecurity, hypersensitivity, shame and identification with victimhood (Caligor et al., 2015). Research shows the personality variations of narcissistic individuals to be “grandiose or self-loathing, extraverted or socially isolated, captains of industry or unable to maintain steady employment, model citizens or prone to antisocial activities” (Caligor et al., 2015, p.416).

Such variable presentation and characterization of narcissistic pathology has created diagnostic treatment confusion and discrepancy, especially due to the gaps in the criteria in the DSM-5 (Caligor et al., 2015). Narcissistic pathology can appear and be described in a wide variety of ways, which has led to diagnostic uncertainty in light of the DSM-5's gaps (Caligor et al., 2015).

Additionally, the discrepancy in the description of narcissism and NPD has become problematic in providing support and services to victims and survivors of narcissistic abuse. The gap in the awareness of the full manifestation of narcissism and NPD has played a negative role in the identification and awareness of the experiences faced by victims and survivors of narcissistic abuse.

In conclusion, there is a gap in the complete definition and manifestation of narcissism and narcissistic personality disorder (NPD) that leads to discrepancy in the diagnosis, assessment, and treatment of narcissistic individuals as well as victims and survivors of narcissistic abuse. Based on the results, this needs assessment recommends for clinicians to become intentional about staying up to date with current research, literature, and resources in order to improve their knowledge and clinical skills on the construct of narcissism beyond what is covered on the NPD diagnosis on the DSM-5 and the academic MFT program. This needs assessment also recommends for clinicians to collectively network and collaborate in order to improve their knowledge and clinical skills regarding the construct of narcissism.

The next steps to address the need for a complete and consistent definition of NPD on the DSM-5 could include for clinicians to conduct further empirical research and randomized clinical trials as supporting evidence for the different phenotypic subtypes of

pathological narcissism, it's assessment, and it's treatment. The empirical research and randomized clinical trials may also aim to find the evidence to suggest the importance of improvements in the validity of the NPD diagnosis, evidence of reliability and clinical utility, and the potential deleterious consequences of the current NPD criteria.

Additionally, a proposal for making changes to the diagnosis of NPD in the DSM can be submitted to the American Psychiatric Association, when required evidence have been concluded.

Narcissistic Abuse and the Impact of Narcissism on Relationships

A clinical classification or definition of the term “narcissistic abuse” has not yet been established; however, the large body of professional and popular publications provided by mental health professionals and individuals who have witnessed or experienced such abuse has proven for narcissistic abuse to be of communal interest, importance, and worthy of further acknowledgment and research. The term “narcissistic abuse” has come to mean any type of abuse perpetrated by a narcissist, whether it be coercive control, psychological, physical, sexual, spiritual, or financial abuse (MedCircle, 2010; Russ and Shedler, 2013; Skodol et al., 2014; King et al., 2020). Victims tend to go through a narcissistic abuse cycle of idealization, devaluation, and rejection; a pattern of positive and negative experiences in which the narcissist confuses the victim through manipulation and calculated tactics aimed at making the victim question their sense of self and reality and live to maintain and appease the relationship and the narcissistic individual (Gaum and Herring, 2020). The various descriptions or definition of narcissistic abuse have played a positive role in increasing awareness, validation, and advocacy for victims and survivors. However, the inconsistency in descriptions on

different sources has led to challenges in explaining the abuse, providing accurate and consistent information, support and treatment, and most importantly adding to the confusion in the victim's experience.

Howard (2019) further explains different traits and forms of Narcissistic abuse, which can include but are not limited to love bombing, pathological lying, presentation of a false self, criticism, the silent treatment, removing the victim from 'the pedestal' and devaluing the victim, gaslighting, abuse amnesia, exploitative behaviors, emotional and physical abandonment and abuse, triangulation, insulting and disrespecting behavior, and isolating victim to protect self-image and control (Howard, 2019). Additionally, Durvasula (2015) shares common feelings that may occur gradually and over time through relationships with a pathological narcissist as

feeling 'not good enough,' self-doubt and second-guessing, chronically apologetic, confusion and as though you are 'losing your mind,' helplessness and hopelessness, feelings of sadness or depression, feeling anxious and worried, feeling unsettled, anhedonia (not being able to get pleasure out of life and activities that once gave you pleasure), feelings of shame, mental and emotional exhaustion (P. 139).

As mentioned, despite the scarce academic and empirical attention on victims and survivors of narcissistic abuse, many professionals in the specialized field of NPD and narcissistic abuse have describe narcissistic abuse to drastically impactful and traumatic on one's emotional, mental, psychological, physical, financial, spiritual, or sexual well-being.

Many people have experienced narcissistic abuse, yet there is a lack of official peer-reviewed, or academic research done to explain the depth of this abuse on the victims and how to treat this population. Since narcissistic abuse is under-recognized and understudied, it lacks proper statistical and empirical conceptualization. Moreover, Arabi (2017) states that there is a lack of expanded academic teachings in schools or diagnostic manuals; however, narcissistic abuse is evident in expert books and survivor accounts (Arabi, 2017). Most research has focused on the person with narcissistic traits or narcissistic personality disorder (Keller et al., 2014), and there has been little to no empirical research on people in relationships with narcissistic individuals and how these individuals are affected by narcissistic abuse. Due to scarce research and focus on victims and survivors of narcissistic abuse, there seems to be a gap in current evidence-based research, academic resources, knowledge, and clinical skills in assessing and treating victims and survivors of narcissistic abuse. The gap in empirically and academically acknowledging narcissistic abuse has restricted sufficient consistent teachings and training on the subject, leading to limited knowledge and expertise among mental health professionals. The gap in empirically acknowledging narcissistic abuse has also led to a body of professional and popular publications written by experienced mental health professionals and victims or survivors of narcissistic abuse, which has not been supported by academia or evidence-based empirical research.

In conclusion, there is a systemic gap in the understanding, impact, and official clinical and academic classifications of narcissistic abuse. Moreover, there is a gap in the awareness, advocacy, and services focused on victims and survivors of narcissistic abuse in empirical research, academia, DSM-5 diagnosis, clinical community, law enforcement

policy, and the court system. Additionally, there is a lack of sufficient availability, accessibility, and acceptability of clinical and therapeutic support and services, treatment programs, and educational resources focused on victims and survivors of narcissistic abuse.

This needs assessment recommended for clinicians to involve themselves in conducting empirical research and developing evidence-based programs specifically focused on the victims and survivors of narcissistic abuse to address the needs, assessment, and treatment of the population. It is recommended for clinicians to collaborate with colleagues and develop communities to improve collective knowledge, awareness, and advocacy of narcissistic abuse recovery and services. It is recommended that clinicians collectively network in order to create standardized clinical terminology, assessment tools, evidence-based treatment models and programs focused on narcissistic abuse recovery. The development of a community of professionals focusing on the improvement of narcissistic abuse recovery services can also lead to the development of a comprehensive directory of professionals available to victims and survivors of narcissistic abuse.

Narcissistic Abuse and Domestic Violence

Narcissistic abuse occurring in intimate or family relationships has not been officially acknowledged as Domestic Violence in USA; yet, a review of the descriptions on professional and popular literature suggests for narcissistic abuse to overlap with domestic violence literature, even if in some cases there is no physical battery. The National Domestic Violence Hotline website defines domestic violence as “a pattern of behaviors used by one partner to maintain power and control over another partner in an

intimate relationship” (National Domestic Violence Hotline, as cited in Peck, 2022). In a similar approach, narcissistic abuse can be linked to the unique ways a narcissistically characterized individual acts to gain coercive control using a variety of abusive tactics (Milstead, 2018).

The literature review showed that narcissistic individuals display characteristic traits of aggression, grandiosity, unempathetic, inflated self-esteem, domineering, need for admiration and power, disinterest in the need of others, self-serving, and violence. These traits lead to psychological, sexual, and physical aggression including manipulation, blaming, derogating, devaluing, criticizing, controlling, deceiving, disrespecting, exploiting, stonewalling and punishing others. Therefore, based on the literature review, it can be concluded that narcissistic abuse within intimate and family relationships could fall under domestic violence or intimate partner abuse. However, narcissistic individuals have distinct deceitful characteristics that make their abusive patterns unique compared to non-narcissistic abusers. Hence, not every domestic violence perpetrator is narcissistic but narcissistic abuse within family and intimate relationships is domestic violence.

Although the majority of State courts do not include the word “narcissistic abuse” as a criterion in their definition of domestic violence, the literature review showed much overlap that concluded for narcissistic abuse to align with domestic violence. However, the state courts or law enforcement are not criminalizing hidden abuse such as coercive control and narcissistic abuse.

In conclusion, there is a gap in the awareness and advocacy of narcissistic abuse (within family and intimate relationships) being acknowledged as domestic violence in the

mental health field, clinical practice, policy making, court system, law enforcement, and the public at large. This lack of acknowledgement and advocacy in the domestic violence field has caused tremendous life-changing clinical and legal problems for victims and survivors of narcissistic abuse. For instance, because such hidden abuse is not acknowledged as domestic violence, perpetrators are not being criminalized in the larger system; which then leads to the invalidation and reinforcement of the cycle of trauma and abuse on victims and survivors.

This needs assessment recommends for clinicians to become familiar with agencies and resources that address and provide services helpful to the needs of victims and survivors of narcissistic abuse such as harm reduction and safety strategies and programs, child protective services, adult and child welfare services, legal resources familiar with narcissistic abuse, financial support tactics and agencies, and domestic violence resources and support. Due to the gaps and discrepancies in the delineation of narcissistic abuse (within family and intimate relationships) as domestic violence, it is recommended for clinicians to practice their executive core competence of conducting empirical research (AAMFT, 2004) to suggest the distinctions between different forms of abuse and to collect evidence to legitimize narcissistic abuse. Additionally, it is recommended for clinicians to practice their executive core competence as critiquing the existing limited literature and assessing the quality of current research studies, program evaluation, and professional and popular publications (AAMFT, 2004) regarding domestic violence and hidden or narcissistic abuse. Additionally, Critiquing the current publications and resources can suggest for improvement of clinical practices despite limitations in literature and law.

The next steps for closing this gap can include for clinicians to initiate and develop advocacy, training, and direction for professionals to capitalize the few state laws (e.g., California) that have reformed from the violent-incident model and acknowledge emotional abuse as a recurring and long-term incident of coercive control that can be counted a charged crime. Another beneficial next step in order to close the gap can include advocating or conducting a small-scale pilot project (i.e. one county/municipality) for a test case.

Licensed Marriage and Family Therapists

According to the American Association of Marriage and Family Therapy (AAMFT), marriage and family therapists (MFTs) are recognized as the five core mental health professions, along with psychiatrists, clinical psychologists, clinical social workers and psychiatric nurse specialists (2022). As MFTs are recognized by the U.S. Department of Health and Human Services and Health Resources and Services Administration to treat individuals, couples and families (AAMFT, 2022), they are one of the main lines of contact for consumers of mental health services. Especially due to their focus on understanding symptoms and diagnoses within interactions, relationships, and environmental and familial systems (AAMFT, 2022), MFTs should have sufficient competence in treating relational issues such as relational trauma.

Since COAMFTE has been the most standard and recognized national accreditation, this study focused on exploring the efficacy of COAMFTE accredited MFT program and therapists. Although the core competency and educational system for marriage and family therapists are known, what is not known is how sufficient the

programs are for therapists to treat special populations. For example, although personality disorders, such as narcissistic personality disorder (NPD), are taught in assessment and psychopharmacology courses via DSM-5, MFT master's degree courses are not designed to focus on the treatment of special populations. Additionally, the literature review showed for DSM-5 to not include the full manifestation of NPD and does not include a diagnosis specific to victims and survivors of narcissistic abuse.

The COAMFTE-approved curriculums showed a lack of training or information on people in relationships with individuals high in narcissism or narcissistic personality disorder. Additionally, it is difficult to assess if Domestic Violence or intimate partner violence courses and professors teach about narcissistic abuse and its impact on others since domestic violence does not include "narcissistic abuse" in its definition. Moreover, professional and popular publications have shown that narcissistic abuse can occur in all relationships, including but not limited to parent-child, intimate relationships, friendships, work-environment relationships, and even politician-civilian dynamics (Durvasula, 2015). Therefore, even if narcissistic abuse is explained in different terms, such as coercive control or psychological abuse in domestic violence courses, the full manifestation of narcissistic abuse in all relational dynamics would be misrepresented.

Therefore, MFTs would naturally miss the opportunity to learn about the victims and survivors of narcissistic abuse. Moreover, with the introductory level and board overview of narcissistic personality disorder covered in COAMFTE accredited master's level MFT programs, marriage and family therapists may need to continue higher education and training to enhance their knowledge and clinical skills in narcissism and the impact of narcissism on victims and survivors. One problem with this is that if a

marriage and family therapist has been taught limited information from their trusted MFT programs, recognizing and becoming aware of their lack of knowledge and clinical skills can be far-fetched. Awareness of lack of knowledge and clinical skills might have to spark due to experience with clients, coming across professional and popular publications such as books and articles, social media, colleagues or other professionals, post-graduate and specialty workshops or training, etc.

In conclusion, there is a gap in acknowledgement, education, and training of narcissistic abuse in academia. Academic and clinical programs, including MFT programs and the DSM-5, have not sufficiently covered the identification, needs, assessments, and treatment of victims and survivors of narcissistic abuse.

This needs assessment recommended specific required knowledge and clinical skills, assessment, and treatment practices mentioned in chapter 5 that can guide LMFTs in treating victims and survivors of narcissistic abuse beyond their academic program. It is recommended for clinicians to inform their clinical practice by immersing themselves in the limited existing literature, highly specialized supervision, multifaceted continuing education courses and trainings, and alternative available professional and popular publications focused on narcissism, narcissistic abuse, and the symptoms common to the victims and survivors of narcissistic abuse.

The next steps that can assist in closing the gap can include for the development of academic curriculum that includes courses focused on clients impacted by narcissistic abuse. Another step that can assist in closing the gap can include for expert clinicians to advocate for inclusion of narcissistic abuse in academic programs and/or provide structured supervision or consultation groups for interns and/or pre-licensed clinicians.

Current Training on Narcissistic Abuse

Upon searching Google for narcissistic abuse training, the search engine provides a collection of YouTube Videos, Podcasts, Continuing Education workshops and trainings, and professional and popular publications such as books, articles, uncertified and unaccredited training and workshops. Most of these professional and popular publications seem to target the victim and survivor of narcissistic abuse rather than giving therapeutic direction for professionals treating this population; however, professionals can benefit from the information by enhancing their expertise about this population. Generally, there are abundant resources and trainings that are targeted at common mental illnesses and symptoms. As mentioned, individuals that have suffered from narcissistic abuse experience a variety of physical and psychological symptoms and illnesses, including but not limited to depression, anxiety, PTSD, Complex PTSD, neurological issues, medical issues, eating disorders, substance abuse, suicidality, self-harm, sleep disorders (Howard, 2019; Leedom, 2019; Day et al., 2020). Since these symptomologies and disorders are common to other mental illnesses and are experienced by a variety of clients with different mental health concerns, clinicians can increase their knowledge and clinical skills by gaining additional training on the aforementioned issues. Although there do not seem to be sufficient standardized one-stop resources for clinicians to become proficient in the needs, assessments, and treatment of narcissistic abuse, there seem to be helpful resources covering the aforementioned symptoms and disorders commonly experienced by individuals suffering from mental health issues.

In addition to their academic degree, mental health professionals must complete continuing education courses to receive their license renewal. There are some available and accessible continuing education courses and trainings offered through US accredited

agencies focused on narcissistic abuse recovery. Recently, there has been a slight increase in some Continuing Education (CE) sources and trainings accredited by well-known programs, such as Pesi.com, that offer workshops, conferences, and training courses focused on the narcissistic dynamic and narcissistic abuse. Such CE courses have been a valuable addition to educating clinicians; however, there is still a need for additional affordable and comprehensive educational resources. Additionally, compared to the complex needs of victims and survivors of narcissistic abuse and the lack of teachings in the academic curriculum, the number of the available, accessible, and acceptable trainings and courses for clinicians seem to be limited in quantity, comprehensiveness, and consistency and cohesiveness among training models.

In addition to the limited availability of educational and treatment resources focused on narcissistic abuse, accessibility to such resources can also become a barrier for clients and clinicians. The dearth of resources can also lead to limited availability and accessibility to services for clients. Additionally, the lack of academic and empirical research and support has led to barriers to the acceptability of services for clients and clinicians. Moreover, such resources are very costly, creating a barrier to the acceptability of the services. Additionally, as previously mentioned, victims and survivors of narcissistic abuse have experienced various abusive encounters, including financial abuse or financial struggles; therefore, they might not be able to afford mental health professionals who have spent much money on their own training and thus charge higher session fees; making such resources inaccessible.

In conclusion, there is a gap between the need for evidence-based and comprehensive training specifically focused on narcissistic abuse recovery and its availability, accessibility, and acceptability.

This needs assessment recommends for clinicians to collectively network in order to develop accessible and affordable evidence-based clinical training models and certification programs for clinicians and supervisors, screening and scaling tools for therapy quality and therapist competency, and evidence-based and standardized treatment models and programs focused on narcissistic abuse that includes the strategies and tools mentioned in chapter 5.

In order to further close the gap, the next steps can include clinical trials and program evaluation for current available continuing education trainings in order to measure the strengths and areas of growth of the programs.

Terminology and Conceptual Framework

People go through learning and growth as they interact and make meaning of their lives and experiences; learners can be motivated by community reward, inner drive, and psychological self (Vygotsky, 1978). Social constructivism showed that language is the basis of learning due to its support in activities such as reading and writing and communicating, reasoning and reflecting (Vygotsky, 1978). As such, Vygotsky formed three main concepts explaining: cognitive development and learning culture is significant in learning, language is the root of culture, and individuals learn and develop within their role in the community (Vygotsky, 1978).

Some of the methods therapists can learn clinical knowledge and competency are through their academic experience, supervision, continuing education units (CEUs), and post-graduate training. As social constructivism suggests, culture and language and interaction play a role in learning; therefore, therapists can also improve their knowledge and clinical skills by joining the communities and colleagues who are more knowledgeable in the field of narcissism and narcissistic abuse. However, there seems to be a dearth of sufficient availability, accessibility, and acceptability of such supportive and educational community resources for clinicians treating victims and survivors of narcissistic abuse.

In addition, professional and popular publications such as books written by experienced mental health professionals have increased awareness of terms such as narcissistic abuse, the narcissistic abuse cycle, narcissistic dynamic, gaslighting, flying money, grey rocking, love bombing, hoovering, narcissistic supply, and narcissistic family system to voice a common language in describing such antagonistic relational dynamics (Durvasula, 2014). Moreover, social constructivism suggests that individuals are active participants in creating their knowledge and most learning occurs in social and cultural settings (Schreiber & Valle, 2013). Thus, gathering communities that are knowledgeable in the terminology and treatment of narcissism and narcissistic abuse, despite limited academic materials, can spark a culture of learning through discussions and interactions within groups and communities. In other words, cognitive functions and understandings can be changed based on social interactions and collaboration. Therefore, the understanding of narcissism and narcissistic abuse can change based on safely facilitated collaboration and interactions between experts in the field of narcissism,

clinical providers, and higher education authorities and policy makers. The social negotiation can create change in the competency of clinicians, clients, and the education system.

In conclusion, there is gap in having an official comprehensive and standardized clinical terminology that describes the full manifestation of narcissism and narcissistic abuse. There is also a gap in available and accessible educational communities for clinicians to gather, consult, and brainstorm.

This needs assessment recommends for clinicians to increase their awareness and understanding of narcissistic-related clinical and informal terminologies available on professional and popular publications. Moreover, due to the advantages and disadvantages of informal terminologies, it is also recommended for clinicians to practice their professional core competence of contributing to the development of new knowledge (AAMFT, 2004) by collaborating with other experts in the field to develop an official and standardized glossary of narcissistic related terms.

In order to close the gap of the lack of a DSM diagnosis specific for victims and survivors of narcissistic abuse, the next step can include for clinicians and appropriate professionals to collaborate in creating a diagnosis and criteria for victims and survivors of narcissistic abuse. In combination with training and collaboration with appropriate organizations, the creation of a diagnosis could address a real barrier to essential identification, documentation, and interventions that can dramatically improve the care response to victims and survivors of narcissistic abuse. Additionally, a proposal for adding a new diagnosis of for victims of narcissistic abuse in the DSM can be submitted to the American Psychiatric Association, when required evidence have been concluded.

Limitations

This needs assessment is a primary research that is innovative; the researcher aimed to answer questions that had not been academically or empirically investigated before, in order to address gaps and needs that had not been yet defined. Primary research refers to research that involves collecting original data that has not yet been provided in the field (Gratton & Jones, 2010). Due to the scarce empirical research focused on victims and survivors of narcissistic abuse, the researcher had to gather information first-hand rather than relying on available information in databases specific to the population. For instance, the impact of narcissistic abuse was not directly investigated and collected from empirical research focused on that population. Therefore, the researcher had to use alternative research topics/populations and professional and popular publications to present the necessary information. The scarce background empirical and evidence-based research on narcissistic abuse may have caused limitations in information validity and consistency throughout this paper. For instance, researcher had to personally evaluate and select professional books over others that provided dissimilar perspectives on the related topic, without the sources having been supported by evidence or research.

When conducting thematic data analysis, the researcher becomes the instrument for analysis, coding, and identifying, analyzing, organizing, describing, and reporting themes found within a data set (Braun & Clarke, 2006). One important step in thematic analysis is to ensure reliability and validity of the themes, suggesting an outside coder to develop new set of codes and themes in order to compare and evaluate the identified themes created by the researcher (Miles & Huberman, 1994). Although a second coder is recommended to ensure validity and reliability of thematic analysis (Creswell & Poth, 2018), researcher was only able to seek a reviewer (not a coder) due to the substantial

number of transcribed lengthy interviews. Thus, the limitation in this needs assessment is the absence of an outside coder and reviewer creating a second set of themes, reducing the reliability and validity of the themes created by the researcher. However, an outside reviewer evaluated researcher's codes and themes and provided feedback without creating a second set of themes for comparison purposes. This needs assessment missed the opportunity of a second set of outside themes that would have informed of any conflicting results, if there were any (Miles & Huberman 1994; Hosmer 2008). To address the limitation, the independent reviewer (experienced in thematic analysis) reviewed the transcripts, codes, and themes in the early and late stages of data analysis, in order to provide an objective review of the study and analysis process and highlight the study's strengths and weaknesses (Creswell & Poth, 2018). To ensure transparency and minimize bias, the independent reviewer was not involved in the data collection process or interviews in order ensure a fresh outside perspective. The reviewer asked precise questions about the methods, meanings, and interpretations and provided feedback on addition, deletion, and modification of codes and themes. Therefore, inspite of the lack of a second coder, the researcher was still better informed of any conflicting results with respect to any codes or themes that were suggested to be added or removed by the independent reviewer (Miles & Huberman 1994; Hosmer 2008).

Another limitation includes the interview methodology; due to the 60-90-minute-long interview including on the spot questions, there could have been a chance for participants to experience interview fatigue. Additionally, the long list of questions and the nature of interviews could have limited organized and well-thought-out answers. In other words, participants might naturally not remember all of the concepts they would

want to share within their answer; therefore, the data might exclude important information that was forgotten to be expressed.

Another limitation includes the small pool of 14 participants. The 14 interviews might have been too small to achieve thematic saturation; limiting the discovery of the fullness of relationships between themes (Green and Thorogood 2004). Thematic saturation in qualitative research occurs when the same themes are repeated as interviews increase and researchers stops finding new themes, ideas, opinions, or patterns (Green and Thorogood 2004). In this case, further observations and analysis would have to occur in order to reveal no new themes and achieve thematic saturation.

Future Directions

Being a primary and innovative research, this needs assessment has answered questions that had not been academically or empirically investigated before, in order to address gaps and needs that had not yet been defined. Thereof, this needs assessment has become a pipeline of long-term strategy imperative for continued development of new knowledge, services, and unexpected discoveries that spur even more new service ideas to be explored and brought to fruition. Based on the dearth between the required knowledge and clinical skills and the available resources focused on victims and survivors of narcissistic abuse, this needs assessment provided recommendations in areas of clinician's required knowledge, clinical skills, and clinical resources in addressing the needs, assessment, and treatment of victims and survivors of narcissistic abuse. The limitations suggest for future empirical research on the construct of narcissistic dynamic and abuse, it's impact, and it's lasting effects on adults and children in different forms of narcissistic relationships including but not limited to parent-child, intimate, and

professional relationships. Such fundamental research could be a stepping stone to developing policies, evidence-based program development and evaluation, as well as a standardized diagnosis, assessment, and evidence-based treatment models and trainings focused on victims and survivors of narcissistic abuse.

In order to close the systemic gaps, further findings and development of research and services can be expanded to all stakeholders, policy makers, agencies, and professionals (e.g., physical and mental health professionals, law enforcement, legal and court system, and supportive service agencies such as domestic violence programs) that are of service to victims and survivors of narcissistic abuse.

The next step for the domestic violence field can include for researchers, service providers, advocates, policymakers, and the public health and criminal justice systems to further investigate and modify the language, definitions, and classification of all forms of interpersonal abuse, including family and domestic violence, in criminal justice and social service provision sphere order to advance the field and improve the national responses to domestic violence.

Relevance and Application to the Field

According to the American Association of Marriage and Family Therapy (AAMFT), marriage and family therapists (MFTs) are recognized as the five core mental health professions, along with psychiatrists, clinical psychologists, clinical social workers and psychiatric nurse specialists (2022). As MFTs are recognized by the U.S. Department of Health and Human Services and Health Resources and Services Administration to treat individuals, couples and families (AAMFT, 2022), they are one of the main lines of contact for consumers of mental health services. Especially due to their

focus on understanding symptoms and diagnoses within interactions, relationships, and environmental and familial systems (AAMFT, 2022), MFTs should have sufficient competence in treating individuals, couples, and families with relational issues such as relational trauma and narcissistic abuse. Research has shown that therapists have a critical role in the therapy process and change; the therapist may often be the central figure in positive and negative therapeutic change (Blow et al., 2007; Wampold, 2001). Therefore, it is important to ensure and improve the quantity, quality, comprehensiveness, and consistency of educational and clinical resources available to therapists who treat vulnerable populations including but not limited to victims and survivors of narcissistic abuse. Moreover, it is important to evaluate and improve the therapy quality and therapist competency available to victims and survivors of narcissistic abuse.

Identifying the needs, assessments, and treatment of victims and survivors of narcissistic abuse was helpful in identifying the systemic gaps in academia, clinical practice, program development and evaluation, and available sources focused on victims and survivors of narcissistic abuse. This needs assessment played a role in the fundamental therapeutic recommendations for addressing the needs, assessment, and treatment of victims and survivors of narcissistic abuse. Identifying the viewpoints and expertise of clinicians who have knowledge and clinical skills in narcissistic abuse recovery can be a stepping stone in the development of further research, diagnosis, assessment, treatment, training and program development, and policy change focused on narcissistic abuse. This needs assessment plays a role in increasing awareness and advocacy as well as reducing stigma and systemic traumatization regarding narcissism,

narcissistic abuse, and it's devastating impact on individuals and the public at large. Therefore, this innovative needs assessment can spark further progress and systemic change in areas of academia, policy making, clinical practice, legal field and court system, law enforcement, and the public at large.

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APPENDIX A
RECRUITMENT EMAIL

Hello [Point of Contact],

My name is Sadaf Shalchian and I am a doctoral student within the Department of Counseling and Family Sciences at Loma Linda University. The Principal Investigator, Dr. Lena Lopez Bradley, Assistant Professor at Loma Linda University, and I are seeking participants for my doctoral project research study titled, “Clinician’s Recommendations in Treating Victims and Survivors of Narcissistic Abuse” This study has been approved by the Loma Linda University IRB (#000000).

We are inviting mental health clinicians in the United States of America to partake in a one-on-one Zoom interview to understand the needs, assessments, and treatment of victims and survivors of narcissistic abuse. Narcissistic abuse refers to any form of abuse inflicted by a narcissist including but not limited to emotional, physical, sexual, or financial abuse. The aim of this needs assessment is to identify the knowledge and clinical skills recommended by clinicians who treat victims and survivors of narcissistic abuse, in order to identify some needs, assessments, and treatment practices that can guide LMFTs in treating this population.

If you agree to participate in this study you will take part in a 60 to 90-minute confidential and recorded virtual Zoom interview scheduled at your earliest convenience. This is not an evaluation of your knowledge, but a valuable opportunity to add to the body of research focused on helping victims and survivors of narcissistic abuse and the therapists that treat them. Participants will be paid a lump sum of \$50

for attending the interview. Premature withdrawal from the interview process will not reduce the compensation amount.

The criteria to participate in this study includes the following:

- You are a clinician currently practicing and licensed in a State in the United States of America for one of the following degrees:
 - Licensed Professional Clinical Counselor (LPCC)
 - Licensed Clinical Social Worker (LCSW)
 - Licensed Marriage and Family Therapist (LMFT) holding a Masters or Doctorate in Marriage and Family Therapy (DMFT)
 - Clinical Psychologist holding a Doctorate in Philosophy (PhD) or Psychology (PsyD)
- You are a clinician who has competent, proficient, or expert level of knowledge and clinical skills in treating victims and survivors of narcissistic abuse.
- You have treated or are currently treating at least 6 primary narcissistic abuse cases within the past year of practice.

Please feel free to share this information with other clinicians if someone you know meets the above criteria.

If you have any questions, comments, or concerns, you may reach out to the following;

- Lena Lopez Bradley, Ph.D. – Principal Investigator, llopezbradley@llu.edu
- Sadaf Shalchian, AMFT, Student Investigator, SShalchianPourkhaljan@students.llu.edu

If you are interested in participating, please respond to this email within 1 week by completing the following:

- 1) Click on this Qualtrics Link (Insert Hyperlink) in order to
 - a. Complete and Sign Informed Consent
 - b. Complete Demographic Questionnaire
- 2) Email Student Investigator at SShalchianPourkhaljan@students.llu.edu with any questions.

Thank you for your consideration.

Sincerely,

Sadaf Shalchian, Associate Marriage and Family Therapist
Student Investigator for Research Study
DMFT Candidate – Marital and Family Therapy Department of Counseling and Family Sciences
School of Behavioral Health | Loma Linda University
E-mail: SShalchianPourkhaljan@students.llu.edu

APPENDIX B

RECRUITMENT FLYER



LOMA LINDA UNIVERSITY

Participants needed for research on Narcissistic Abuse

Are you a mental health clinician who provides treatment to victims and survivors of Narcissistic Abuse?

Your knowledge and clinical skills in the needs, assessment, and treatment of victims and survivors of narcissistic abuse are highly valuable and needed in research.

You may be eligible to participate in a one-on-one 60-90 minute Zoom Interview.

Purpose

We are inviting mental health clinicians in the United States of America to partake in a one-on-one Zoom interview to understand the needs, assessments, and treatment of victims and survivors of narcissistic abuse. Narcissistic abuse refers to any form of abuse inflicted by a narcissist including but not limited to emotional, physical, sexual, or financial abuse. The aim of this needs assessment is to identify the knowledge and clinical skills recommended by clinicians who treat victims and survivors of narcissistic abuse, in order to identify some needs, assessments, and treatment practices that can guide LMFTs in treating this population.

You May Qualify If You

- You are a clinician currently practicing and licensed in the United States of America for one of the following degrees:
 - LPCC
 - LCSW
 - LMFT
 - DMFT
 - PhD or PsyD in Clinical Psychology
- Must have graduated from accrediting commissioning bodies approved by the state of licensure of where you are currently practicing
 - You are currently providing clinical treatment for victims and survivors of narcissistic abuse
 - You are a clinician who has competent, proficient, or expert level of knowledge and clinical skills in treating victims and survivors of narcissistic abuse
- You have treated or are currently treating at least 6 primary narcissistic abuse cases within the past year of practice.

If you agree to participate in this study you will take part in a 60 to 90-minute confidential and recorded virtual Zoom interview scheduled at your earliest convenience. This is not an evaluation of your knowledge, but a valuable opportunity to add to the body of research focused on helping victims and survivors of narcissistic abuse and the therapists that treat them. Participants will be paid a lump sum of \$50 for attending the interview. Premature withdrawal from the interview process will not reduce the compensation amount.

If you or someone you know are interested in participating, please contact:
Sadaf Shalchian, AMFT, DMFT Candidate at
SShalchianPourkhaljan@students.llu.edu

APPENDIX C

INFORMED CONSENT



LOMA LINDA UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH

Loma Linda University Department of Counseling and Family Sciences

TITLE: Clinician's Recommendations in Treating Victims and Survivors of Narcissistic Abuse

SPONSOR: Loma Linda University
Department of Counseling and Family Sciences

PRINCIPAL INVESTIGATOR: Dr. Lena Lopez Bradley, Ph.D., LMFT
llopezbradley@llu.edu

STUDENT Sadaf Shalchian Pourkhaljan, AMFT, DMFT Candidate

INVESTIGATOR: SShalchianPourkhaljan@students.llu.edu

Dear Recipient,

We would love to have you as a part of our study and would like to inform you of what you can expect of this process prior to committing. We are interested in understanding therapeutic practices in the treatment of victims and survivors of narcissistic abuse. This consent form will provide you with the necessary information to understand the purpose of conducting this study. This form will describe what you will need to do to participate and any known risks and benefits you may experience.

The study should take you around 60 to 90 minutes to complete. Your participation in this research is voluntary. You will be paid a lump sum of \$50 for attending the interview. You have the right to withdraw at any point during the study; there will be no penalty or loss of benefits to which you are otherwise entitled if you choose not to participate or discontinue participation.

You will be asked to participate in a scheduled virtual interview to answer question regarding your knowledge and clinical skills in treating victims and survivors of narcissistic abuse. You will also be asked to complete a demographic questionnaire and informed consent. If selected for participation in this study, you will get instructions to sign-up for an interview slot at your earliest convenience.

WHY IS THIS STUDY BEING DONE?

There is not a significant emphasis in the treatment of victims and survivors of narcissistic abuse in COAMFTE accredited Masters level Marriage and Family Therapy programs (COAMFTE, 2017). Therefore, it is important to better understand the knowledge and clinical skills that LMFTs may need in order to treat victims and survivors of narcissistic abuse.

The aim of this needs assessment is to identify the knowledge and clinical skills recommended by clinicians who treat victims and survivors of narcissistic abuse, in order to identify some needs, assessments, and treatment practices that can guide LMFTs in treating this population. The goal of this study is to use a qualitative thematic analysis to conduct a 60-90-minute virtual interview with 10 to 15 clinicians who identify as having competent, proficient, or expert level of knowledge and clinical skills in treating victims and survivors of narcissistic abuse, in order to provide recommendations for LMFTs. The purpose of this needs assessment is to gain guidance from clinicians who treat victims and survivors of narcissistic abuse, in order to create therapeutic recommendations that could enhance the competency of LMFTs who treat this population. Furthermore, this study can also be a stepping stone in encouraging further research, official diagnosis development, program development and training, academic courses and focus, and higher education in narcissistic abuse.

You will be invited to participate in this study if you meet the criterion and report to have competent, proficient, or expert level of knowledge in treating victims and survivors of narcissistic abuse (based on the provided Dreyfus model of skill acquisition). The information you provide alongside other participants will be used to create recommendations on the needs, assessment, and treatment practices of victims and survivors of narcissistic abuse.

HOW WILL I BE INVOLVED?

Participation in this study involves the following:

- *Identify if you are qualified for the study based on the mentioned criteria*
- *Sign-up for interview at the earliest convenient time*
- *Complete informed consent form and demographic questionnaire*
- *Participate in the virtual interview for about 60 to 90 minutes*
- *Receive a 50\$ check within 2 weeks after the interview*

WHAT ARE THE REASONABLY FORESEEABLE RISKS OR DISCOMFORTS I MIGHT HAVE?

This study poses no greater risk to you than what you routinely encounter in day-to-day life. Some of the foreseeable risks or discomforts of your participation may include experiencing negative emotions about yourself or the study, in the case in which you might not know an answer or might feel unable to provide clinical recommendation. Other discomforts might include boredom or fatigue due to the 60-90-minute duration of the interview. Please keep in mind that this study is not an evaluation of your competency.

All records and research materials that identify you will be held confidential. Any published document resulting from this study will not disclose your identity without your permission. Information identifying you will only be available to the study personnel.

The virtual interview will be recorded, stored, transcribed, and organized in a password protected device with exclusive exposure to the study personnel. We will de-identify all transcribed interviews with a pseudonym so that no personal information will be identifiable. We will delete the recordings immediately after transcribing all the video and audio recordings. We plan to keep participants' contact information and transcribed interviews in separate files and confidential on a HIPAA compliant cloud, OneDrive, through Loma Linda University.

WILL THERE BE ANY BENEFIT TO ME OR OTHERS?

Although you may not personally or directly benefit from this study, you will be involved in an innovative research that may make a change in the treatment of victims and survivors of narcissistic abuse. Through offering your knowledge and clinical skills, you might play a role in encouraging a larger pool of like-minded colleagues that you can collaborate with in order to provide appropriate care for victims and survivors of narcissistic abuse. This study can help mental health professionals, including LMFTs, in improving their knowledge and clinical skills of the needs, assessment, and treatment of victims and survivors of narcissistic abuse. Therefore, providing your knowledge and clinical skills can become a part of a larger systemic change in the quality of treatment of victims and survivors of narcissistic abuse.

WHAT ARE MY RIGHTS AS A SUBJECT?

Your participation in this study is entirely voluntary. You may refuse to participate or withdraw once the study has started. Your decision whether or not to participate or terminate at any time will not affect your compensation agreement. You do not give up any legal rights by participating in this study.

If at any time you feel uncomfortable, you may refuse to answer questions.

WHAT COSTS ARE INVOLVED?

There is no cost to you for participating in this study.

WILL I BE PAID TO PARTICIPATE IN THIS STUDY?

Participants will be paid a lump sum of \$50 for attending the interview. You have the right to withdraw at any point during the study; there will be no penalty or loss of benefits to which you are otherwise entitled if you choose not to participate or discontinue participation.

If you receive \$600 or more from Loma Linda University for taking part in this research study or a combination of studies in one tax year, you will be sent a 1099 form as required by IRS.

WHO DO I Contact IF I HAVE QUESTIONS?

If you wish to contact an impartial third party not associated with this study regarding any questions about your rights or report a complaint you may have about the study, you may contact the Office of Patient Relations, Loma Linda University Medical Center, Loma Linda, CA 92354, phone (909) 558-4647, e-mail patientrelations@llu.edu

If you have any questions, concerns, or complaints about this study, please feel free to contact the Student Investigator, Please email Sadaf Shalchian Pourkhaljan, AMFT, DMFT Candidate at sshalchianPourkhaljan@students.llu.edu. You may also contact the Principle Investigator, Dr. Lena Lopez Bradley, Ph.D., LMFT at llopezbradley@llu.edu.

SUBJECT'S STATEMENT OF CONSENT

By clicking the button below, you acknowledge:

- I have read the contents of the consent form and have listened to the verbal explanation given by the investigator.
- Your participation in the study is voluntary.
- You are 18 years of age.
- You are aware that you may choose to terminate your participation at any time for any reason.
-
- My questions concerning this study have been answered to my satisfaction.
- Signing this consent document does not waive my rights nor does it release the investigators, institution or sponsors from their responsibilities.
- I may email Sadaf Shalchian at sshalchianPourkhaljan@students.llu.edu if I have additional questions or concerns.
- I hereby give voluntary consent to participate in this study.

I understand I will be given a copy of this consent form after electronically signing it.

Signature of Subject

Printed Name of Subject

Date

STUDENT'S INVESTIGATOR'S STATEMENT

I have reviewed the contents of this consent form with the person signing above. I have explained potential risks and benefits of the study.

Signature of Investigator

Printed Name of Investigator

Date

APPENDIX D

DEMOGRAPHICS QUESTIONNAIRE

Thank you for your interest in this research study. Prior to conducting the interview, the researchers are interested in knowing some of your demographics. Your answers will remain confidential and secure.

What is your full name? (For Compensation Purposes)

What is your full address? (For Compensation Purposes)

What is your age?

- 18- 30 years old
- 31- 43 years old
- 44- 56 years old
- 57- 69 years old
- 70- 82 years old

What is your gender?

- Male
- Female

What is your ethnicity or race?

- White
- Spanish
- Latino
- Black or African American
- Native American
- Asian or Pacific Islander
- Others, please specify []

What is your marital status?

- Single, never married
- Divorced
- Married
- Widowed
- Separated

What is your employment status?

- Part-time
- Full-time
- Retired
- Others, please specify []

What is your highest degree or level of education?

- Bachelor's Degree
- Master's Degree
- Doctoral Degree
- Others, please specify []

Which of the following Degrees are you currently licensed in?

- Licensed Professional Clinical Counselor (LPCC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT) holding a Master's degree
- Licensed Marriage and Family Therapist (LMFT) holding a Doctorate in Marriage and Family Therapy (DMFT)
- Clinical Psychologist holding a Doctorate in Philosophy (PhD)
- Clinical Psychologist holding a Doctorate in Psychology (PsyD)
- Clinical Psychologist holding a Doctorate in Clinical Forensic Psychology (PsyD)
- Others, please specify []

What state are you licensed in?

What national, regional, and/or specialized accreditation applies to your academic programs?

What is your theoretical orientation as a Clinician? If none, please indicate

How many years have you been practicing as a clinician?

- 0-3
- 4-7
- 8-11
- 12+

How many years of experience do you have in treating victims and survivors of narcissistic abuse?

- 0-3
- 4-7
- 8-11
- 12+

How many narcissistic abuse cases have you successfully treated in the past year of your clinical practice?

- 0-3
- 4-7
- 8-11
- 12+

How have you supported your professional development and competence in treating victims and survivors of narcissistic abuse?

- Completed related academic courses
- Read ample amount of related anecdotal sources such as books, journals, articles, etc.
- Read and reviewed ample amount of related empirical resources and research
- Attended ample amount of related conferences, workshops, or structured trainings

- Instructed ample amount of related conference presentations, structured trainings, or workshops
- Published related books
- Published related blogs, articles, research studies
- Have treated or are currently treating at least 6 primary narcissistic abuse cases within the past year of practice.
- Others, please specify []

What professional setting(s) are you providing mental health services for victims and survivors of narcissistic abuse?

- Private practices
- Schools
- Universities/Colleges
- Correctional facilities
- Mental health facilities
- Hospitals
- Community centers
- Others, please specify []

How would you identify your knowledge and clinical skills in treating victims and survivors of narcissistic abuse? (see the following for definitions)

- Novice
- Advanced Beginner
- Competent
- Proficient
- Expert
- Other, Please describe []

Dreyfus model of skill acquisition

- **Novice:** No prior background in treating the population; therefore, follows direct protocols and others in the field. Uses analytic reasoning and rules to link cause and effect.
- **Advanced beginner:** has seen and practiced treating the population; however, still has limited situational perception. Able to sort through information and rules to decide what is relevant on the basis of past experience. Able to mentally organize and synthesize presenting problems and comprehend them into a succinct, unified explanation of the problem by using analytic reasoning and pattern recognition.
- **Competent:** Having consistent and repeated encounter with the population in the clinical setting, while being able to identify and assess patterns and presenting problem accurately. Uses analytic and nonanalytic reasoning to recognize efficient and accurate diagnosis and patterns. Has emotional buy-in on the population which leads to an appropriate level of responsibility. Still requires reliance on analytic reasoning while treating complex or uncommon problems.

- **Proficient:** Has vast experience in treating the population. Has a systemic view of the situation and can easily perceive deviations from normal patterns. Responds to cases intuitively and is capable of working effectively in unfamiliar context in treating this population.
- **Expert:** Has highest level of performance in treating this population. Thoughts, feelings, and actions align into intuitive problem recognition and intuitive situational responses and management while treating the population. Perceptive in discriminating features that do not fit a recognizable pattern.

APPENDIX E

ELIGIBILITY INVITATION EMAIL

Dear [Name of the Participant]

It is our honor to welcome you to be a part of our study. You have been selected due to reporting a high level of knowledge and clinical skills in the needs, assessment, and treatment of victims and survivors of narcissistic abuse. This population is very important to me and I am truly grateful for the opportunity to interview you in hopes of advocating for victims and survivors of narcissistic abuse and the mental health professions that treat them.

This email is to instruct you in scheduling your upcoming 60-90 minute interview.

In order to schedule your interview please do one of the following within the next week:

1. Call Student Investigator and Researcher, Sadaf Shalchian at (949)424-3547 to schedule an appointment
2. Please email back with providing your availability for the next month. It is recommended that you provide at least 5 available 2 hour spots; researcher will try to accommodate the earliest appointment.

After your interview is scheduled, a Zoom Invitation Link will be provided.

If you need to cancel, reschedule, or withdraw please inform the researcher as early as possible.

If you have any questions or concerns, please do not hesitate to contact me

Your participation is greatly appreciated

Sincerely,

Sadaf Shalchian, Associate Marriage and Family Therapist
Student Investigator for Research Study
DMFT Candidate – Marital and Family Therapy Department of Counseling and Family
Sciences
School of Behavioral Health | Loma Linda University
(949)424-3547

APPENDIX F

ZOOM LINK INVITATION EMAIL

Dear [Name of the Participant]

Thank you for scheduling your interview. Please download the Zoom App on your device prior to the scheduled time. Please ensure that you are in an uninterrupted and private space with excellent Wi-Fi connection. The Following is a HIPAA Compliant zoom link; the interview will be recorded. If you have questions about the steps taken to keep confidentiality and security of the data, please refer back the consent form or contact me with any further questions.

If you need to cancel, reschedule, or withdraw please inform the researcher as early as possible.

If you have any questions or concerns, please do not hesitate to contact me

Sadaf Shalchian is inviting you to a scheduled Zoom meeting.

Topic: Research Study

Join Zoom Meeting

<https://us02web.zoom.us/j/3960168375?pwd=TDVMT3pnZk9Bd0tjVXVtSXl4SU5OZz0>

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Meeting ID: XXXXXXXX

Passcode: XXXXXX

Your participation is greatly appreciated

Sincerely,

Sadaf Shalchian, Associate Marriage and Family Therapist
Student Investigator for Research Study
DMFT Candidate – Marital and Family Therapy Department of Counseling and Family
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School of Behavioral Health | Loma Linda University
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APPENDIX G

INTERVIEW QUESTIONS

Research Question: What do clinicians who treat victims and survivors of narcissistic abuse consider as the needs, assessments, and treatment of this population?

The aim of this needs assessment is to identify the knowledge and clinical skills recommended by clinicians who treat victims and survivors of narcissistic abuse, in order to identify some needs, assessments, and treatment practices that can guide LMFTs in treating this population.

Clinician's Needs and Resources

1. What specific clinical skills and knowledge do clinicians need in order to be proficient in providing therapy to victims and survivors of narcissistic abuse?
 - a. How can they increase their proficiency in treating victims and survivors of narcissistic abuse?
 - b. What are some available resources to improve their clinical skills and knowledge
 - c. Are there specific graduate and post-graduate training resources available for clinicians to improve their proficiency?
2. What are the steps for clinicians to specialize in narcissistic abuse recovery?
3. Is there a community of clinicians who treat victims and survivors of narcissistic abuse?
 - a. Is there a referral system available for clinicians who treat victims and survivors of narcissistic abuse?

Assessment

4. What are some ways a clinician can assess and identify victims and survivors of narcissistic abuse in individual therapy?
 - a. In couples' and family therapy?
 - b. In group therapy?
5. When assessing victims and survivors of narcissistic abuse, what are some common terminology to identify and describe the narcissistic dynamic?
6. What specific presenting problems do clinicians need to look for in order to identify victims and survivors of narcissistic abuse?

7. What are some useful assessments to guide identification and diagnosis of victims and survivors of narcissistic abuse?
 - a. What are the strengths and limitations of these assessments
8. What are some common diagnoses that victims and survivors of narcissistic abuse are diagnosed with? Are those accurate/ inaccurate.

Treatment

9. What are some effective theories and modalities for treating victims and survivors of narcissistic abuse – pathological love relationships.
10. What are some common clinical needs of victims and survivors of narcissistic abuse that clinicians need to be aware of in order to conceptualize a treatment plan?
 - a. What does a common treatment plan entail in treating victim and survivor of narcissistic abuse
11. What are some effective interventions for treating victims and survivors of narcissistic abuse?
12. What are some management of risks and crises common to victims and survivors of narcissistic abuse?

APPENDIX H

DREYFUS MODEL OF SKILL ACQUISITION: DEFINITIONS CRITERION

Dreyfus model of skill acquisition

- **Novice:** No prior background in treating the population; therefore, follows direct protocols and others in the field. Uses analytic reasoning and rules to link cause and effect.
- **Advanced beginner:** has seen and practiced treating the population; however, still has limited situational perception. Able to sort through information and rules to decide what is relevant on the basis of past experience. Able to mentally organize and synthesize presenting problems and comprehend them into a succinct, unified explanation of the problem by using analytic reasoning and pattern recognition.
- **Competent:** Having consistent and repeated encounter with the population in the clinical setting, while being able to identify and assess patterns and presenting problem accurately. Uses analytic and nonanalytic reasoning to recognize efficient and accurate diagnosis and patterns. Has emotional buy-in on the population which leads to an appropriate level of responsibility. Still requires reliance on analytic reasoning while treating complex or uncommon problems.
- **Proficient:** Has vast experience in treating the population. Has a systemic view of the situation and can easily perceive deviations from normal patterns. Responds to cases intuitively and is capable of working effectively in unfamiliar context in treating this population.
- **Expert:** Has highest level of performance in treating this population. Thoughts, feelings, and actions align into intuitive problem recognition and intuitive situational responses and management while treating the population. Perceptive in discriminating features that do not fit a recognizable pattern.