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Recognising Narcissistic Abuse and the Implications for Mental Health Nursing Practice.

Abstract

Emotional and psychological abuse are components of what are now more commonly accepted as aspects of domestic violence in addition to physical assault. Narcissistic abuse formulations of domestic violence are lesser known concepts and not recognised in UK health care in general, nor commonly in UK mental health services and by default mental health nursing. The effects on the individual who has experienced narcissistic abuse can be fatal or extremely debilitating, long lasting and individual recovery can be a complex process. This article will argue that the language and formulation of narcissistic abuse should be at the forefront of the multidisciplinary team's, and in particular mental health nurses' knowledge in order that victims can be directly supported or signposted to support to enable timely interventions and in-depth understanding.

Introduction

In the UK with regards to domestic violence, narcissistic abuse is a largely unfamiliar term and not used in everyday language. This article aims to examine the complexities and manifestations of narcissistic abuse against a background of current approaches to domestic violence, with particular reference to the UK. In addition, a discursive exploration will occur on how mental health nurses are in a central position to recognise narcissistic abuse and support victims.

Narcissistic abuse involves the harm of individuals often through manipulative psychological communication by someone considered to have narcissistic traits. However its definition and meaning remains unclear and confusing often to those who may be unknowingly experiencing it. Arabi (2017) states the lack of attention and validation given to this form of abuse may be due to its covert and insidious nature. There is also a lack of research to support narrative accounts of narcissistic abuse. Adding to the ambiguity is the use of language connected to narcissistic abuse and the presumed meaning of the word 'narcissist'. The word 'narcissist' in everyday language conjures an image of someone who is overly concerned with vanity and their own needs. In societal portrayals this has moved to viewing a narcissist as someone who is self-obsessed and concerned with their own power and position, especially in the workplace, whereby there is a cultural focus on self-admiration (Twenge & Campbell, 2009). However, with regards to personality type, a 'narcissist' has been defined as someone exhibiting traits of narcissistic personality disorder (NPD) or pathological narcissism with reference to specific criteria (Levy, Ellison, & Reynoso, 2011). The criteria of NPD as outlined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), Fifth Edition (American Psychiatric Association, 2013) is presented in Box 1. A summary of the key features of NPD focus upon grandiosity, a need for admiration and a lack of empathy (Ambardar, 2018). The term 'pathological narcissism' focusses upon two themes of dysfunction which include narcissistic grandiosity and narcissistic vulnerability (Pincus & Lukowitsky, 2010). Although the criteria of NPD have been defined and used across clinical and empirical literatures, the effects of a narcissist's behaviour on victims (which can include partners, family members, friends and colleagues) remains an under discussed phenomenon which can leave victims without recognition of the source of their distress and without the help and support they require. It has been reported that victims frequently can be left with trauma experiences such as post-traumatic stress disorder (PTSD), complex post-traumatic stress disorder (C-PTSD) (Schneider, 2018) and damaged neurological processes (Bremner, 2008; Sherin & Nemeroff, 2011). PTSD and C-PTSD will be outlined and explored in this article whilst identifying the

consequences for the victim which can include isolation (Herman, 2015), severe depression (Campbell, 2002) and can lead to suicide (LeBouthillier, McMillan, Thibodeau, & Asmundson, 2015). A detailed understanding and recognition of the signs of a narcissistic abuse victim would enable victims to gain support and intervention as soon as possible.

A Note on Terminology and Focus

To denote the individual who has experienced narcissistic abuse, the words 'victim', 'target' and 'survivor' will be used interchangeably dependent on the context of the experience being referred to. For the purpose of this article, women are being discussed as the victims of narcissistic abuse, though it is recognised that men can also be victims and women can also be narcissistic abusers. It is currently anecdotally reported that more women suffer narcissistic abuse than men and more men than women have been identified as having traits of NPD/pathological narcissism (Stinson, et al., 2008). However, these statements are not conclusive and are questionable due to the covert nature of narcissism and the complexity both within presentations of narcissism and the identification of narcissistic abuse. Statistical evidence identifies more women (1 in 4) than men (1 in 6) suffer domestic violence (Department of Health, 2017) of which narcissistic abuse could be further identified as one manifestation. Narcissistic abuse experiences of female victims will be focussed upon within this article, although some female experiences identified may be applicable to male victims. This article refers to the 'helping professions' which includes any health or social care practitioner; therapist and counsellor; and staff who work with women's issues and domestic violence. The terminology of domestic abuse and domestic violence are used interchangeably.

A background to the recognition and response to domestic violence/abuse within the UK

In previous years, domestic violence was discussed more commonly in terms of physical assault which can be argued mirrored a more straightforward process for prosecution, as the damage was visible and more easily evidenced. Terminology which was once used such as 'battered woman' yet again placed an emphasis on physical injury and did not support those in the helping professions to also consider more invisible signs of abuse and injury (Shipway, 2004). A contemporary outlook on abuse both legally and from the helping professions recognises non-physical aspects incorporating emotional and psychological abuse as key components, with women reporting that these aspects of abuse are often more damaging to them than physical aspects (Tolman, 1992; Baldry A, 2003; Lawrence, Yoon, & Ro, 2009). With regards to criminal prosecution it has been reported that specialist police officers can lack the skills to tackle domestic violence effectively which may involve recognising patterns of dangerous behaviour. This is especially apparent when there is no overt physical violence but where psychological intimidation and controlling behaviour may be evident and can equally lead to fatal outcomes (HMIC, 2014). The Department of Health (2017) state that domestic abuse is a serious health and criminal concern and that health professionals are in a prime position to identify and interject domestic violence by providing further support and safety. However in order to do this professionals need training on identifying aspects of abuse, early identification and interventions. A study involving 2,500 women engaging in domestic violence services reported that prior to receiving this specialist help, just under half the women had seen a GP an average of 5.3 times and one in five had attended Accident and Emergency Departments as a result of the abuse (Safe Lives, 2012).

The definition of domestic violence from the Home Office (2013, page 4) is stated as:

“any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial, emotional.”

In addition, research and legislation highlights the recognition of the term 'coercive control' (Laing, Humphreys, & Cavanagh, 2013; Legislation.gov.uk, 2018) and the path of its course which may or may not include physical violence (Stark, 2007; Johnson M, 2008). Coercive control is a patterned structure of abuse incorporating intimidation, isolation and control (Stark, 2007). It can include threatening and controlling behaviour, psychological abuse and manipulation, constantly checking up on someone, taking control of an individual's finances and constant criticism (Victim Support, 2018). It is complex in its detection as often the abuse is very individualised to the personal dynamics of the relationship involving the perpetrator and victim (Stark, 2013). Coercive control is a criminal offence under the Serious Crime Act 2015 (Legislation.gov.uk), however there have been problematic change processes identified, specifically with regards to shifts required in police culture which make the prosecution of coercive controlling behaviour complex. Because evidence of physical injury indicates a clear boundary which has been crossed and is assessed on a continuum of severity, referred to as the violent incident model (Stark, 2012), this manner of risk assessing harm to a victim often does not account for the reality of what may be classified as low level abusive behaviours, but which in fact have led to domestic homicides (Weiner, 2017). This classification may trivialise abuse women are experiencing because it has been categorised as low level violence through an incident specific lens (Stark, 2012). A recent study by Brennan, Burton, Gormally, & O'Leary (2018) also concluded that factors such as lack of definitional clarity, limited resources and service providers' experiences of competing demands lead to coercive control being not comprehended as a course of conduct and influenced a possible abuse of discretion which lead to discounting mechanisms or failures to comprehensively address possible coercive control instances. This study highlights the need for an increased consideration of power and control dynamics within relationships and how this may improve domestic abuse responses by frontline services. Although these factors may continue to be a challenge to the recognition of non-physical domestic violence,

organisations such as Women's Aid campaign to make coercive control understood and to provide support and advice to victims (Women's Aid, 2018).

What is narcissistic abuse?

Historically the term 'narcissistic abuse' derived from descriptions of parent to child emotional abuse (Ferenczi, 1984, Miller, 1995) but has developed to describe emotional and psychological abuse within adult to adult relationships which follows a cycle of behaviour and contains particular characteristics. There is not a universally agreed definition of narcissistic abuse which may be due to its complexity across differing relationships it may occur within, e.g. intimate partner, family, friends and working relationships. In the US it is estimated that narcissistic abuse affects over 158 million people (Bonchay, 2018), however due to its lack of recognition in the UK there are no statements on its prevalence. For the purpose of this article, narcissistic abuse within intimate partner relationships will be focused upon, though it is recognised narcissistic abuse occurs across other relationships. The target/victim of a narcissist is in some way meeting a key need for them within the relationship, and therefore the target's presence in the narcissist's life is important (or was, if the relationship is terminated). There is a pattern of narcissistic abuse which includes specific behaviours throughout the beginning, middle and ending of an intimate relationship. Typically, at the beginning of the relationship, the narcissist selects a partner with an empathetic nature whom they over shower with affection and attention at a rapid pace and within a short time frame (often referred to as 'love-bombing' in survivor accounts). This behaviour firmly and quickly makes a deep impression on the victim and facilitates a strong bond with the narcissist as the victim is only seeing a false representation of their new partner (the narcissist). This false representation may stem from both a purposeful construction of how they want to be viewed by their new partner, but may also be driven by unconscious processes which have gained momentum throughout their childhood experiences and embedded in to their personality construct. The narcissist also often chooses a

partner who has something they will find useful or who will inflate their self-esteem either through admiration or by association; i.e. the narcissist may view their new partner as a trophy partner with special qualities who will also elevate the narcissist's sense of self because they have secured a relationship with them. Once the narcissist has hooked the partner in to this idealised false image of themselves and the victim is fully immersed in the relationship, the devaluation stage will begin. In this stage the narcissist's true personality emerges whereby they will begin to devalue their partner through such tactics as belittling remarks which gain momentum as time progresses, leading to using communication techniques to destroy their partner's sense of self. This can also include ignoring behaviours and making public comments to humiliate their partner (though others present may not see this and the significance of what has been said which may be personal to the victim). Narcissists are fully aware how their comments and behaviours will attack their partner's sense of self and the humiliation which will be experienced. Vaknin (2003, page 21) states: *"The narcissist does not suffer from a faulty sense of causation and is able to accurately predict the outcomes of his actions...but he doesn't care."* It is theorised this behaviour may also be driven from the narcissist's construct that at the beginning of the relationship they valued their partner's qualities to meet their own needs but as time progresses they begin to feel threatened by them and inferior (Arabi, 2017). The next stage 'discarding of current partner' will often move on to seeking a new partner through having an affair/affairs and the end result is often an overlapping relationship(s) whilst denying this to their current partner. At the same time insidious abuse techniques are employed such as 'gas lighting' which involves making subtle hints and cryptic conversations resulting in the victim questioning their own judgements about their reality. For example even though the victim's judgments may be based on clear evidence their narcissistic partner is having an affair, the narcissist may conjure lies and deceptions very skilfully which make the victim confused and open to further manipulation, self-doubt and questioning their own interpretations of experiences.

The narcissist will often blame their partner and directly say any relationship problems have been caused by them including the narcissist's adulterous behaviour. The narcissist will never take any

accountability for their own behaviour and the decisions they have made. If the partner uncovers the truth of the narcissist's behaviour and openly discusses this, this may result in what is referred to as 'narcissistic rage' whereby the narcissist will employ any tactic to psychologically harm or destroy the current partner, including spreading rumours about the partner/victim, making up dishonest accounts of the victim but implanting a grain of truth somewhere in their story to make it appear believable to friends and family. This has been described as a manifestation of the narcissist's anger, aggression and destructiveness in the pursuit of revenge (Kohut, 1972). The narcissistic abuser will then present themselves as the victim. They may have financially abused their partner and often they will give the silent treatment to the victim so the victim cannot get any closure on the unanswered questions of why they have been treated in this way. The narcissist will then start this pattern of a relationship all over again with a new partner, often describing themselves as a victim who has been in a relationship with a 'deranged person.' In the love bombing stage, the narcissist will often repeat the same flattering communication strategies and state exactly the same things to the new partner as they did to their previous partner at the beginning of the relationship stating they have found their soulmate (again). The previous partner observing this will experience not only distress but a deep sense of betrayal and feel like a disposable object believing their relationship experience and the duration of it was not genuine as key aspects of it are being repeated with the new partner. The narcissist will often bring in their new partner within a 'triangulation' process to repeat the (dishonest) accounts they have formulated about their last partner so that the last partner experiences bullying and abuse not only from the narcissist ex-partner but now from their new partner as well, who has been brainwashed with false accounts and seduced with professions of love.

As already stated, although the characteristics of emotional and psychological abuse are now more commonly recognised within descriptions of what domestic violence may entail, what is helpful

about the formulation of narcissistic abuse is that its components and language furthermore provide a detailed identification of abusive behaviours and the drivers behind these with direct reference to this type of abuser's psychology. The main drivers behind a narcissistic abuser's devastating behaviours are integral to the construction of their personality which focuses on entitlement beliefs and a superior self-image. It does not matter in the least to them how their behaviour may affect others. Their only concern is that their needs are met (at whatever cost to anyone else). The narcissistic abuser is defined as an individual capable of inflicting a range of abusive behaviours on their target, (some have already been discussed). The key abusive behaviours and their utilisation in the stages of an intimate relationship have been summarised in Box 2 and are frequently recounted in the narrative descriptors and self-reports of narcissistic abuse. As discussed, a narcissistic abuser has been categorised as someone who may have/or fit a classification of NPD within a psychiatric diagnosis but again it is argued there is complexity within identifying the traits of a narcissist as their presentations may span a spectrum of behaviours, for example they may not be an overt attention seeking individual full of admiration for themselves but may present as an unassuming individual who is covertly holding strong self-entitlement beliefs.

Although abuse may have been occurring covertly or subtly within the duration of a relationship with a narcissist, it is often when the relationship is threatened or terminated either by the abuser or the victim that the abuser increases their strategies to strip away the victim's sense of self and reality and erode and re-invent occurrences which have happened in the past during the relationship. This is to the abuser's advantage, most often to enable moving on to the next target/victim. Often, a victim may only realise they have suffered abuse at the end of the relationship because the strategies used have been insidious and only become heightened and visible in the discarding stage of the relationship. The narcissistic abuser's mind-set concludes that their target is no longer meeting their primary needs, or 'supply' as it is often referred to. Supply has been described as the stimulation needed by the narcissist to feed their self-esteem needs. It is an addiction which drives them and is at the root of their decisions and behaviour (Vaknin, 2019). The

abuser may in addition conclude they have no control over the victim anymore as the victim may be considering terminating the relationship. The abuser concludes therefore their victim can be 'destroyed' through the psychological discreditation techniques discussed, and then discarded. The abuser may intermittently try to draw the victim back in to the relationship, termed 'hoovering' for further attention and supply for their own self-esteem and entitlement beliefs.

When describing the characteristics of narcissistic abuse, it has been identified that gaining an understanding of this type of abuse is difficult, because if it has not been experienced personally, the abusive techniques and psychological and emotional damage they cause is difficult to imagine. To support readers' understanding, two anonymised survivors' reflective statements of experiences of aspects of narcissistic abuse are presented in Box 3 and Box 4. These personal reflective statements demonstrate experiences of key abusive strategies reflected in the available literature on narcissistic abuse which have accumulated from survivor accounts. These include some of the behaviours of narcissistic abuse outlined in Box 2. It is significant to note that some of these behaviours can be isolated and used by abusive individuals who may not have a diagnosis/suspected NPD and may be employed for other reasons such as immaturity and life stress in response to an isolated event. In contrast, narcissistic abuse entails patterns of similar abuse which can be tracked with multiple targets through a number of relationships.

It is important to state here that the experiences of victims are not connected to 'sour grapes' or dissatisfaction and grief due to the ending of a relationship. Their experiences are those of targeted manipulation and pathological dishonesty by the abuser who as stated will often incorporate a small detail of truth in to their fabricated accounts of the victim, to make their false narrative believable and in consequence more damaging to the victim.

So why does the narcissistic abuser do what they do and what about their victims?

There are differing explanations which address the reasons why narcissistic abusers inflict their abusive behaviours. Using the diagnostic criteria of NPD, the individual exhibiting narcissistic personality disorder traits outlined in the DSM V (American Psychiatric Association, 2013) focuses on the abuser's difficulties with self-identification and self-functioning and the search for continuous external self-validation which may have arisen from childhood development stages (Thomaes, Bushman, De Castro, & Stegge, 2009). Other key identifiers include deficits in interpersonal functioning, including inability to empathise with others and using superficial intimacy as a means of meeting their own self-esteem needs. It is identified that narcissistic abusers experience low self-esteem but also a sense of entitlement and their behaviour as such centres around their addiction for self-esteem (Thomaes, Bushman, De Castro, & Stegge, 2009).

Bushman (2017) however states that after conducting 30 years of research, he believes it is a myth that narcissistic aggressive and violent people experience low self-esteem and that they are more likely to believe they are superior to others and lash out when they do not receive the respect they feel entitled to. This has been referred to as 'narcissistic injury' which describes the process of when a narcissist's highly inflated view of themselves has been threatened and they respond with aggression which detracts from facing a negative appraisal of themselves (Baumeister & Boden, 1996). When discarding a partner, they are ultimately discarding parts of themselves they are dissatisfied with by not addressing the realities which may be being presented to them. This also gives them a sense of power and control and enjoyment of the effects they are having on someone else.

A psychoanalytic perspective views the development of a narcissist occurring in early childhood. Kernberg (1975) states that narcissists' primary concern is their image and that they cannot differentiate between their imagined image and their true sense of self, resulting in the actual self-image being lost. Lowen (1997) further elaborates on this view by stating that the basic disturbance of a narcissist is that they do not base their actions on feeling and the greater the denial of

feeling, the more narcissistically disturbed an individual is as their investment is in self-image not their true sense of self.

Like other disorders, narcissism is identified as occurring on a spectrum and at the most severe end of the spectrum is malignant narcissism that can co-occur with anti-social behaviour and psychopathy (Kernberg, 1998; Hart & Hare, 1998; Ronningstam, 2009). This dangerous form of a narcissist has been described as using people to satisfy their own needs then casting them aside when they're done (Malkin, 2015). It is a malignant narcissist's behaviours which can often be identified in features of narcissistic abuse whereby a multitude of diversionary tactics can be used to distort the reality of victims and avoid any accountability (Arabi, 2017).

Victim Experiences

In identifying the literature to answer; how A effects B and how B has been affected by what A has done; although there appears a raft of information on the diagnosis of NPD, in comparison there is little research activity and evidence on the abuse experiences and effects on an individual connected to someone containing the traits of a narcissistic abuser. Accumulated knowledge on the experiences of someone involved with a narcissist has accrued from victims telling their own stories about their abuse. However, there are recent progressions in promoting the awareness of narcissistic abuse and the United States in particular has developed survivor organisations which are rich sources of information and support networks for abuse victims.

Many abuse victims struggling with their experiences and unable to make sense of what has happened to them have come across social media information and online communities quite by accident, i.e. Facebook support pages which illustrate what the features of narcissistic abuse are. Consequently the person who thought they were the only person to have experienced these phenomena are amazed to see there are many others who describe similar experiences and abuse

patterns. Social media resources can be the ultimate breakthrough in making sense of personal abuse experiences, but the concerning factor is if someone does not have access to social media or use the internet, they may never begin to obtain some enlightenment that what they have experienced is not specific to them and most importantly it is not their fault. This is opposite to the message often enforced by their abuser.

Victims may be confused and disorientated from what they have experienced, questioning their own sense-making of situations and consequently they remain in a cycle of reflecting on their experiences, unable to process what has happened to them. Louis de Canonville (2019) raises some interesting and vital discussions around how the needs of victims of narcissistic abuse are recognised. She discusses how the term 'narcissistic victim syndrome' captures the key presentations of abuse victims who may access a therapist or health care professional. The key emotions of a victim, she says, are often characterised by shock, anger, fear and guilt with co-occurring experiences of PTSD and C-PTSD. PTSD involves reliving experiences, avoiding behaviour and increased arousal usually from a single traumatic event and C-PTSD primarily refers to the experiences and features of many traumatic events over an extended period of time (Resick, et al., 2012).

Louis de Cannonville (2019, para 24) identifies that features of trauma associated with narcissistic abuse will emerge as a cluster from the victim's account of their mental health, to include *"avoidance behaviour, loss of interest, feeling detached, sense of a limited future, sleeping or eating difficulties, irritability, hypervigilance, easily startled, flashbacks, hopelessness, psychosomatic illnesses, self-harming and thoughts of suicide"*. There will also be other key processes occurring both for the victim and within the abusive relationship which will influence the course of the relationship and experiences of distress and confusion. One such process is referred to as 'trauma bonding' and refers to the disparity of experiences the victim absorbs from the abuser. For example,

within the hostile behaviour there are moments of seeming love and kind gestures from the abuser which reignites the victim's attachment to them.

This has been compared to Stockholm Syndrome taken from experiences of kidnap victims, which pertains to victims experiencing direct threats, were isolated, had opportunity to 'escape' whilst being held captive but did not, and showed sympathy with captors once no longer being held captive (Namnyak, et al., 2008). Both trauma bonding and Stockholm syndrome are viewed as survival techniques because positive connections make the victim feel closer to the abuser and hence safer within the relationship they are attempting to survive within or recover from. This is one explanation to the question which asks why abuse victims stay within an abusive relationship; because both trauma bonding and Stockholm syndrome are viewed as psychological survival attempts.

In addition, these concepts connect to the theory of 'cognitive dissonance' whereby there is an inconsistency between an individual's actions and attitudes which leads to psychological discomfort (Festinger & Carlsmith, 1959). The individual will then either modify their attitudes or avoid a situation in an attempt to regain the comfort and equilibrium. Women in abusive relationships may have high levels of dissonance as they may experience a very negative attitude to the relationship but may be unable to leave it. They may then change their attitude to be more positive towards the relationship or abuse which could involve subconscious mechanisms, in order to reduce the dissonance experienced. If this occurs the woman may be in a much more dangerous situation still experiencing the same abuse, but her attitudes have changed over time and she feels more comfortable in the relationship because of the reduced cognitive dissonance (Dare, Guadagno, & Muscanell, 2013). Within narcissistic abuse, cognitive dissonance may especially be apparent for the victim during the devaluation stage, because the abuser may be exhibiting negative behaviour that the victim is trying to incorporate in to their view of their partner, which does not match the overly attentive, complimentary behaviour which occurred at the beginning of the relationship. The victim

is then left in a position where interpretations and beliefs about their partner are mismatched and confused.

When do individuals on the narcissistic spectrum present to health care services/the helping professions and would their disorder be recognised?

Arabi (p. 28, 2017) states “...the full extent of narcissistic abuse is not taught in any psychology class or diagnostic manual, though these manipulative techniques can be found in numerous books by experts about narcissism...and survivor accounts.” Louis de Canonville, a psychotherapist specialising in narcissistic abuse in Ireland states that speaking to her fellow psychotherapist colleagues in Ireland, she can confidently say that therapists do not know enough about the effects of narcissism on victims. She further states that NPD primarily sits within the domain of psychiatrists, psychologists and mental health services because the narcissistic individual would be presenting with a problematic mental health problem causing them some vulnerability (Louis de Canonville, 2018). Other scenarios may involve that narcissists present to a mental health service as a result of particular risks from their behaviour and descriptions of mental health distress which would action a mental health referral and interventions. But how common is the diagnosis of NPD and would individuals be easily diagnosed with this disorder? Where narcissistic abuse is more widely recognised, prevalence rates of NPD in the US is estimated as 0.5% of the general population and in 2-16% of those seeking support from a mental health professional (Torgerson, 2005) . The prevalence rates for the United Kingdom are unclear. It has been stated that individuals displaying or diagnosed with NPD and associated features do not present with high distress and problematic behaviours to mental health services, and those that do present, express failure in achievement and romantic relationships (Campbell, 1999; Campbell, 2001). This can be surmised because they often are very successful in finding ‘supply’ to meet their needs in the forms of victims who are often intimate partners, family members, friends or work colleagues to maintain their self-esteem and

entitlement identifications. Their behaviours are harmful to others and not usually centred in self-harm. If at any point their needs are not met, it is possible they may present to mental health services with accounts of depression and anxiety or suicidal thoughts, but NPD individuals often remain covert, often non-diagnosed in their personality disorder/maladaptive behaviour and not seeking any treatment unless it feeds their own self-image (Masterson, 1988). If the narcissist is a malignant narcissist with features of psychopathic – sociopathic behaviour, they may be diagnosed/identified when their behaviour becomes problematic in terms of criminal behaviour or they progress to commit a serious offence (Gerberth & Turco, 1997). It is important to consider the aforementioned identification of individuals with NPD traits, as without recognition of their features and why they may or may not present for help, those they abuse will be even less considered.

It could be argued that the societal process of NPD mirrors the interpersonal relationship between abuser and victim. NPD remains a covert, invisible abuse happening within society without an outward recognition of its presence influencing domestic violence and its prevalence. Furthermore, because those on the narcissistic spectrum often remain covert and undiagnosed, the consideration of how they may be seriously harming those around them remains unaddressed within healthcare services.

How could the increased recognition of narcissistic abuse support the personal recovery of the abused individual presenting to mental health care services?

Understanding the formulations of both the patterns and individual features of narcissistic abuse which have been described in this article could improve healthcare professionals' awareness of this particular presentation of domestic violence. In the UK, fitting the features of narcissistic abuse within the criteria of coercive control (a recognised psychological abuse framework) would support the helping professions to identify the profile of the abuser who is on the narcissism spectrum and

provide a focussed indication of what the abuse victim could be experiencing, indicating questions for further assessment and support required.

Not causing further harm to the victim is another key consideration and without the awareness of the features of narcissistic abuse, a GP or other healthcare professional may advise on a generic intervention indicated for relationship difficulties, such as couple's therapy. To advise on this as a helpful intervention may cause further harm to the narcissistic abuse victim, because abusers on the narcissistic spectrum can use couple's therapy to continue such behaviours as pathological lying and gas lighting, yet again causing more psychological damage and further trauma to the victim (Arabi, 2017). If the therapist/professional is not experienced in the concept of narcissistic abuse and narcissism, they may not realise the abuser is attempting to use the therapist in a triangulation dynamic to inflict more psychological abuse upon the victim with the abuser falsely portraying a caring and considerate image of themselves. The narcissistic abuser would not be using the therapy as intended but to execute more abuse and to elevate their self-esteem.

These considerations also apply to mental health services and their assessment approaches and therapeutic interventions. To have a thorough awareness of both the behaviours involved in the narcissism spectrum and narcissistic abuse will assist in the exploration and identification of an individual's presenting difficulties. A hypothetical example may be that a victim of narcissistic abuse may have either left or have been discarded from a romantic relationship amongst very severe and distressing covert psychological abuse used on them. They have been referred to a crisis mental health team because they have expressed suicidal intent to their GP. They are assessed by mental health nursing staff who after interviewing the woman are confused about her account of her experiences as she does not seem to be able to clearly explain what has happened to her. She has talked about her ex-partner turning her family and friends against her and leaving her for another woman and that she feels suicidal because lies have been posted over Facebook publically about her and her character has been obliterated. She wonders if her ex-partner is partly right in that she has

brought it on herself, because she knows she has not been very attentive to him over the past six months as she has suffered from ill health. The woman explains she has repetitive thoughts about things he has said to her and hears him saying negative things in her head which some of her family now agree with and also blame her, and that she can't take it anymore. The woman says she cannot concentrate on anything and cannot face going to work. She now feels her life is worthless because she is not valued by anyone. She says she cannot get over how her partner could just walk away and cut off all contact with her whilst also spreading lies about her. She wakes up every day with intense anger and sadness. The woman begins to ring the crisis team nursing staff frequently because she is now in an isolative position and cannot cope with the flash backs and feelings of hopelessness. The crisis team assessors are still formulating their thoughts about the support the woman can access and be given but are wondering if the woman's responses derive from a personality problem. They cannot find any concrete evidence about some of the things the woman is telling them.

The above example may read as quite a crude example of narcissistic abuse, but often all of the details of narcissistic abuse cannot be disclosed or determined by a professional in a few meetings within a short space of time. There are many barriers to formulating a full picture of an individual's experiences of narcissistic abuse and what has happened to them: The victim as a result of the trauma they have experienced may be confused, may have subconsciously separated themselves from their experiences (dissociation) and the trauma may have effected their ability to speak about their experiences as research has shown trauma can affect the part of the brain concerned with speech and memory (Bremner, 2008). Sometimes an individual's experiences sound so far-fetched, even to themselves, they again find it incredibly difficult to articulate and make sense of them in order to speak to others about them. All of these factors should be taken in to consideration by any health care professional, but particularly by members of the multi-disciplinary mental health team, in which mental health nurses often provide a lead assessment role. In the above example of a woman being assessed by mental health nurses within a crisis mental health service, the woman may be presenting with behaviours associated with a personality problem but is in fact presenting

with behaviours primarily associated with recent trauma. The experience of betrayal may be the most prominent feeling the woman is turning over in her mind. Cleary, Wilson, & Jackson (2018) state that as nurses we encounter people who have experienced betrayal from those they have trusted in a range of different relationships, which may include experiences of domestic violence. It is possible that as healthcare professionals we may cause further trauma and betray those we are trying to help by the language we use to pathologise their experiences of trauma and by this we are associating the problem with the victim/survivor rather than with the event they have experienced (Freyd 2013, Cleary, Wilson, & Jackson 2018). Within clinical responsibilities, mental health nurses often contribute to safeguarding and MARAC (Multi Agency Risk Assessment Conferences) processes. Their formulations and presenting their knowledge of an individual experiencing domestic abuse are important to the development of action plans with other agency representatives to support the victim's safety (Safe Lives, 2018). Recognising the signs of narcissistic abuse would greatly help in identifying more accurate and relevant formulations.

There are a range of personal recovery avenues proposed for someone who has experienced narcissistic abuse including an appropriately trained therapist. However, the initial validation of an abuse victim's experiences can be the most important factor in beginning their journey of recovery. To have a helping professional listen to you and recognise the features of the abuse you are describing after being told by the abuser you are the problem, could be the difference in surviving narcissistic abuse and not surviving it. The helping professions collectively are built upon an ethos of utilising therapeutic skills and values to support distressed individuals to move forward with their lives. Within mental health nursing, Rogers' (1957) core conditions of congruence, unconditional positive regard and a demonstration of empathetic understanding remain the foundation of building the therapeutic relationship between professional and client. Therapeutic skills such as effective listening, acknowledgement and validation of the individual's experiences can support the abused individual to change negative perceptions of themselves and their situation. Within mental health nursing practice the therapeutic use of self as a conscious process involves the use of the nurse's

personal qualities and knowledge in order to alleviate distress in the 'patient' (Travelbee, 1971). This again is a powerful change agent when considering the narcissistic abuse victim who has just experienced a relationship which has been built upon mistruths and misplaced trust. The nurse/helping professional will offer a relationship which is genuinely putting the victim's best interests and needs at the centre of their communication and offers of support may serve to counteract and neutralise some of the very distressing emotions which have been experienced by the victim. In addition, incorporating a Strengths-based approach (Rapp, 1997; Saleebey, 2002) when supporting a narcissistic abuse victim may further assist them in regaining their sense of self by identifying where they sit currently; what they have achieved and enjoyed in the past; and what they would like to aim for in the future. This is essential for the abused individual, because the narcissistic abuser has often attempted to strip away their very essence of 'personhood' including their positive attributes. Supporting the individual through a Strengths-based lens draws out the positive resources an individual has access to in their life and within themselves, with the helping professional playing a key role as guiding facilitator. This can provide an essential framework for supporting the abused individual to move from a dark, confusing, isolative place to a rediscovered hopeful future step by step.

Reflective Discussion and Summary

There is a lack of public health recognition on how others are affected by the pathology of individuals demonstrating a severe personality disorder which hold the features of a lack of conscience and inability to show empathy (Brown, 2010). The context of this article has only touched the tip of the iceberg in highlighting the complexities around both the psychological profiles of individuals who sit across the spectrum of narcissism and the intimate partners they abuse. However, the key arguments of why the recognition of these phenomena are vitally important have been articulated and applied to both mental health service recognition and arguments have been

put forward for why mental health nurses are in a professionally suitable position to recognise narcissistic abuse and to utilise specific skills and therapeutic approaches in supporting the recovery of abuse victims.

The features of narcissistic abuse share some parallels and similarities to alternative descriptions of domestic violence and notably to those described in coercive control patterns. The language around coercive control is now more commonly used both in social care, within the police force and criminal prosecutions in the UK. Along with coercive control, building awareness of the features of narcissistic abuse has the potential to enrich the understanding around emotional and psychological abuse and widen the knowledge and recognition of abuser profiles who may be identified as holding a personality within the narcissistic spectrum/pathological narcissism. It is proposed that there needs to be a move towards building a robust body of evidence through research to develop further understanding around those holding narcissistic traits who abuse; narcissistic abuse processes and the support and treatment of victims. In addition, suicide has been identified as a risk and outcome for victims but there is not currently any research to refer to within this area, although specific cases have been identified (Arabi 2017). However, just because there is a lack of current research and evidence around the formulation and consequences of narcissistic abuse, as a concept it should not be discredited. The voices of narcissistic abuse survivors are reaching out to others, clearly articulating their experiences, trying to educate others and providing support to those who have been through similar experiences. This should be taken as a solid foundation to build further on this evidence from those who have experienced this abuse directly. This can be compared to how the recovery movement in mental health and its body of research has flourished. The recovery philosophy incorporating values and beliefs about the very personal experiences of those experiencing mental health problems and listening to personal accounts about what can help individuals with their aspirations in life and building meaningful life experiences had its origins from survivor movements and inspired care providers to take on these values and build upon research in this area (Davis & Walker, 1997). It is proposed that a multi-faceted approach of 1) facilitating

education to increase the recognition of narcissistic abuse; 2) healthcare professionals utilising their therapeutic skills when supporting a narcissistic abuse victim and 3) building upon the narrative accounts of narcissistic abuse through further research; points to a hopeful and successful way forward in achieving the delivery of increased meaningful support to victims.

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