International Journal of Science and Research (IJSR)
ISSN: 2319-7064
Impact Factor 2025: 7.089

A Study on the Psychological, Physical, and Boundary Impact on Close Relationship Survivors of Narcissistic Personality Disorder

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Abstract: ***Narcissistic Personality Disorder (NPD) is usually studied through the person who holds the diagnosis, while the people closest to that person, their children and their partners, are rarely examined. This study investigated the psychological, physical, and boundary-related impact of close relationships with people diagnosed with, or showing, narcissistic traits, among adults in urban India. A quantitative, cross-sectional, correlational design was used within a larger mixed methods project. Survivors were analysed as two groups, adult children of a narcissistic parent and survivors of a narcissistic intimate partner, and a group of practising clinicians provided observational data. Participants completed a socio-demographic sheet, the Patient Health Questionnaire-15 (PHQ-15), the International Trauma Questionnaire (ITQ), and the Empowerment and Boundaries Assessment (EBA). Data were analysed using descriptive statistics, Cronbach's alpha, independent-samples comparisons, chi-square analysis, and Spearman correlations. Adult children of a narcissistic parent reported significantly higher somatic burden and higher trauma symptoms than partner survivors, and met criteria for Post-Traumatic Stress Disorder or Complex Post-Traumatic Stress Disorder far more often. Boundary functioning was broadly similar across the two groups and differed only on the social and relational domain. Physical and psychological harm were strongly correlated, and weaker boundaries accompanied higher trauma. Clinician observations pointed the same way. All measures showed good to excellent internal consistency. These findings describe the burden survivors carry across mind and body; they indicate association rather than clinical causation.***

Keywords: Narcissistic abuse; Complex trauma; Somatic symptoms; Psychological boundaries; Help-seeking; India

1. Introduction

Discussions of Narcissistic Personality Disorder usually centre on the person who carries the diagnosis. The people who live closest to that person, however, often bear the heaviest and most lasting cost, and they rarely appear in the clinical record. This study places two such groups at the centre: adult children of narcissistic parents and survivors of narcissistic intimate partnerships. The harm these survivors carry tends to build over time. Repeated invalidation, manipulation, and alternating idealisation and devaluation can leave a person with lasting anxiety, a weakened sense of self-worth, and a pattern of symptoms that closely resembles Complex Post-Traumatic Stress Disorder (C-PTSD).

NPD is an enduring pattern of grandiosity, a strong need for admiration, and limited empathy, classified within the Cluster B personality disorders (American Psychiatric Association, 2013). It presents in two broad forms. Grandiose narcissism is open and visible, expressed through entitlement and dominance. Vulnerable narcissism is quieter, working through sensitivity, grievance, guilt, and emotional withdrawal. Both cause real harm, yet established criteria lean towards the grandiose presentation, which leaves those harmed by covert or vulnerable parents and partners without a clear path to recognition or care (Malkin, 2015).

Narcissistic abuse refers to the cumulative relational harm that follows long exposure to a person with narcissistic traits. It is not a formal diagnostic category, which is part of why survivors present with the consequences of relational trauma while carrying no diagnosis that names what happened to them.

Psychological Impact and Complex Trauma

Complex trauma provides the central clinical lens for this harm (Herman, 1992). The distinction between single-incident trauma and the cumulative trauma of a prolonged, abusive relationship is reflected in the ICD-11 model of PTSD and C-PTSD (World Health Organization, 2019), which is operationalised in the International Trauma Questionnaire (Cloitre et al., 2018). Survivors commonly report chronic anxiety, disturbed identity, emotional dysregulation, and difficulty trusting themselves and others.

Physical and Somatic Impact

The harm does not stay in the mind. It also settles in the body, in tiredness that rest does not ease, in headaches that become routine, and in a nervous system that has lost its sense of safety. This mind and body link is well described in the trauma literature (van der Kolk, 2014), yet the physical side of narcissistic abuse is rarely examined alongside the psychological.

Boundary Functioning and Empowerment

A defining feature of narcissistic abuse is the erosion of personal boundaries. Boundary collapse is the mechanism through which control is established and maintained, and its restoration is central to recovery. Boundary functioning has only recently become measurable for this population through the Empowerment and Boundaries Assessment

(Sindhu et al., 2025), which places the present study in a position to test it directly.

The Indian Context

The study is set in urban India, where expectations around endurance, family duty, and loyalty shape whether survivors recognise their experience as harmful and whether they seek help for it. National figures indicate that emotional spousal violence is common yet widely under-reported (International Institute for Population Sciences & ICF, 2021). The present work therefore examines perceived psychological, physical, and boundary impact together, and considers how the cultural setting surrounds them.

2. Literature Survey

The literature on narcissistic abuse is interdisciplinary, spanning clinical psychology, trauma studies, and health psychology. It is organised here by theme.

Recognition and Conceptualisation of Narcissistic Abuse

- **Howard (2019).** Documented that narcissistic abuse is poorly recognised in clinical settings and set out the implications for mental health practice, arguing that survivors are frequently missed.
- **Green and Charles (2019).** In a qualitative analysis of survivors of narcissistic partners, reported a consistent erosion of self-worth, persistent fear, and covert abuse that went unnamed.
- **Malkin (2015).** Framed narcissism as a spectrum running from healthy self-confidence to pathological grandiosity, locating sustained relational harm at the extreme end.
- **Braiker (2004).** Described covert manipulation that operates through guilt, withdrawal, and quiet invalidation rather than open aggression, a pattern typical of narcissistic relationships.

Psychological Impact and Trauma

- **Herman (1992).** Distinguished the cumulative trauma of prolonged relational abuse from single-incident trauma and defined the features of complex trauma that fit narcissistic abuse most closely.
- **Cloitre et al. (2018).** Developed the International Trauma Questionnaire, a brief self-report measure aligned to the ICD-11 model of PTSD and Complex PTSD.
- **Reyna (2024).** In a mixed methods study of 500 participants, found that 78 per cent reported symptoms consistent with C-PTSD and 82 per cent reported significant anxiety.
- **Karakurt and Silver (2014).** Reported that emotional abuse in intimate relationships is strongly associated with poorer mental health, independent of physical violence.

Physical and Somatic Impact

- **van der Kolk (2014).** Showed how unresolved trauma is held in the body through chronic stress and physiological dysregulation, linking relational harm to physical symptoms.
- **Vaisanen (2025).** Concluded, in a literature review, that narcissistic abuse produces both psychological and physical effects that are frequently missed in healthcare settings.
- **Sruthi (2025).** In a case study from Kerala, documented anxiety, depression, chronic headaches, and fibromyalgia in a survivor of prolonged narcissistic abuse.
- **Bonomi et al. (2009).** Found that non-physical intimate partner violence, on its own, was associated with higher healthcare use and costs, underlining the bodily toll of emotional abuse.

Boundary Functioning and Empowerment

- **Sindhu et al. (2025).** Constructed and developed the Empowerment and Boundaries Assessment, the first tool designed specifically to measure boundary-setting and empowerment in survivors of narcissistic abuse.
- **Sindhu et al. (2026).** Reported the standardisation of the EBA, establishing its reliability and validity in survivors of narcissistic abuse.
- **Malhotra et al. (2026).** In a correlational study, examined emotional, cognitive, and behavioural boundaries in survivors, linking boundary functioning to related clinical constructs.
- **Zimmerman (1995).** Provided the empowerment framework that underpins the construct, distinguishing intrapersonal, interactional, and behavioural components of psychological empowerment.

Theoretical Foundations

- **Kohut (1971).** Proposed that unmet needs for affirmation and a stable idealised figure produce a fragile, compensatory self, which also explains the deep unmet needs of children of narcissistic parents.
- **Carnes (1997).** Described trauma bonding, in which intermittent reward and punishment create a strong attachment to the person causing harm, explaining why survivors find it hard to leave.
- **McBride (2008).** Described the lasting shame and identity confusion reported by adult daughters of narcissistic mothers.

The Indian Context

- **Mishra et al. (2025).** Revisited Kohut's self psychology and reviewed emerging treatment options for NPD within Indian psychiatric practice.
- **Barwal and Sharma (2025).** In a study of Indian women, found that vulnerable narcissism was significantly associated with moral disengagement and revenge-seeking behaviour.
- **Ameen et al. (2025).** Argued that the narcissistic abuse cycle deserves dedicated clinical and research attention, noting the near absence of treatment studies.

3. Problem Definition

Despite a growing awareness of narcissistic abuse, few studies examine adult children of narcissistic parents and intimate partner survivors together, as distinct but related groups, and fewer still do so in the Indian urban context. Physical harm is rarely studied alongside psychological harm within a single design, and boundary functioning has only recently become measurable. The problem this study addresses is therefore twofold: what psychological,

physical, and boundary-related impact survivors report, and whether these differ between the two survivor groups. The study does not claim to establish clinical causation.

4. Methodology / Approach

4.1 Research Design

A quantitative, cross-sectional, correlational design was used, forming the quantitative strand of a larger mixed methods project. The survey method was chosen because the study examined reported impact and the relationships among variables without manipulating any treatment. A qualitative strand of semi-structured interviews addressed the cultural dimension of recognition and help-seeking and is reported separately.

4.2 Participants and Sampling

The target population was adults, eighteen years and above, who had experienced a close relationship with a parent or an intimate partner showing narcissistic patterns. A sample of 83 survivors was obtained through non-probability purposive and snowball sampling, comprising 58 who answered in relation to a narcissistic intimate partner and 25 who answered in relation to a narcissistic parent. A separate group of 16 practising mental health clinicians provided observational data on affected clients. Inclusion required a relationship of at least one year experienced as emotionally harmful, controlling, or invalidating. Participants in acute crisis or unable to give informed consent were excluded.

4.3 Data Collection Procedure

An online survey was used to collect data. The form was shared through community and practitioner networks. Participants were informed about the study and gave consent before completing the questionnaire. Responses were voluntary, anonymous, and kept confidential. The data were then coded and set up for analysis.

4.4 Tools Used

The socio-demographic section recorded age, gender, marital status, education, occupation, the relationship in question, and its duration. The PHQ-15 measured physical symptom burden across fifteen items rated from 0 to 2. The ITQ measured ICD-11 post-traumatic and complex post-traumatic stress across eighteen items rated from 0 to 4, with an item counted as endorsed at a rating of 2 or higher, and yielded a diagnostic classification. The EBA measured boundary functioning across emotional, behavioural, cognitive, and social or relational domains in twenty-five items rated from 1 to 5, with one reverse-keyed item, where higher scores indicate stronger boundaries. Partner-worded and parent-worded forms were combined into one score per respondent.

4.5 Data Analysis

Responses were converted to numeric scores and the instruments scored following their manuals. Descriptive statistics, including frequency, percentage, mean, and standard deviation, were computed. Cronbach's alpha assessed internal consistency. Differences between the two groups were tested with independent-samples comparisons (Welch t), cross-checked with the Mann-Whitney U test because several variables departed from normality. The association between group and trauma classification was tested with the chi-square test, and relationships among the measures were examined with Spearman correlations.

5. Results and Discussion

5.1 Participant Profile

Most survivors were women (86.1 per cent). The largest age group was 35 to 44 years (57.8 per cent), followed by 18 to 24 years (33.7 per cent). In education, 46.8 per cent held an undergraduate degree and 40.3 per cent a postgraduate degree or above. By relationship type, 37.3 per cent answered for an intimate partner, 30.1 per cent for a parent, and 32.5 per cent for both, answering the remaining sections for the relationship that affected them most.

5.2 Reliability

Internal consistency was good to excellent across all measures, as shown in Table 1.

Table 1: Internal consistency of the study measures.

Measure	Cronbach's α
PHQ-15 (physical symptoms)	.90
ITQ (12 symptom items)	.96
EBA total	.97
EBA subscales	.71 to .97

5.3 Group Differences

Table 2 reports the descriptive statistics and the group comparisons. Somatic symptom burden was significantly higher among adult children of a narcissistic parent than partner survivors, $t = -5.56$, $p < .001$, with a large effect ($d = 1.11$), supporting the physical-impact hypothesis. Total trauma symptoms were also higher in the parent group, $t = -3.36$, $p = .001$ ($d = 0.70$), as were PTSD symptoms, $t = -5.20$, $p < .001$ ($d = 1.15$), supporting the psychological-impact hypothesis. Disturbances in self-organisation did not differ ($p = .404$). Total boundary scores did not differ ($p = .431$); among the domains, only social and relational boundaries differed, $t = -3.25$, $p = .002$ ($d = 0.70$), being somewhat stronger in the parent group, so the boundary hypothesis was partially supported. Figure 1 shows the group means on the psychological and physical measures.

Table 2: Descriptive statistics and group comparisons for the study variables.

Variable	Partner M (SD)	Parent M (SD)	t	p	d
PHQ-15 somatic total	9.82 (7.27)	17.13 (3.93)	-5.56	< .001	1.11
ITQ PTSD symptoms	6.80 (6.41)	13.65 (4.44)	-5.20	< .001	1.15
ITQ DSO symptoms	9.84 (8.04)	11.21 (5.36)	-0.84	.404	0.18
ITQ total symptoms	15.98 (13.71)	24.79 (8.09)	-3.36	.001	0.70
EBA total	75.83 (26.56)	79.38 (10.32)	-0.79	.431	0.15
EBA Emotional	19.00 (5.64)	18.20 (2.48)	0.90	.373	0.16
EBA Behavioural	17.50 (5.26)	18.35 (2.23)	-0.97	.335	0.18
EBA Cognitive	18.59 (7.78)	21.43 (5.07)	-1.89	.064	0.40
EBA Social/Relational	20.83 (7.99)	25.92 (5.60)	-3.25	.002	0.70

Note. DSO = disturbances in self-organisation. A negative t indicates a higher mean in the parent group. d is Cohen's d. Mann-Whitney U tests produced the same pattern of significance.

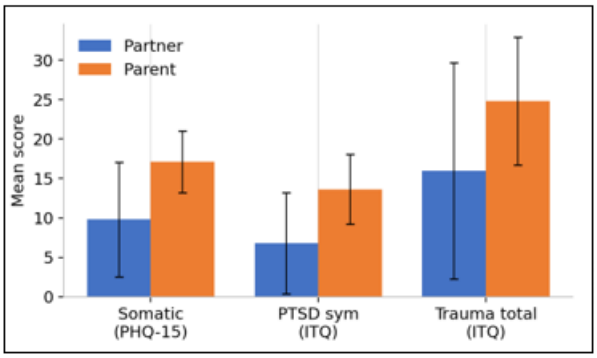

Figure 1: Mean somatic, PTSD, and total trauma scores by group

5.4 Trauma Classification

A chi-square test showed a significant association between group and trauma classification, $\chi^2(2) = 14.20$, $p = .001$. Within the parent group, 40.0 per cent had no diagnosis, 24.0 per cent met criteria for PTSD, and 36.0 per cent for Complex PTSD. Within the partner group, the figures were 81.0, 5.2, and 13.8 per cent. Adult children of a narcissistic parent therefore met criteria for PTSD or Complex PTSD far more often (60 per cent) than partner survivors (19 per cent). Figure 2 displays this distribution.

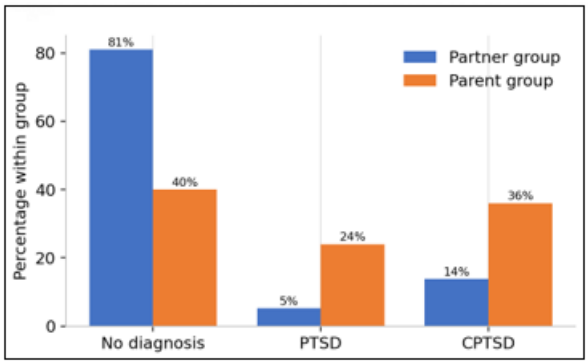

Figure 2: ICD-11 trauma classification by group (per cent within group).

5.5 Correlation Findings

Physical and psychological harm were strongly related. Greater somatic burden accompanied greater trauma symptoms ($\rho = .76$, $p < .001$). Boundary functioning was negatively related to trauma ($\rho = -.29$), indicating that weaker boundaries accompanied higher trauma symptoms. Table 3 reports the correlation matrix.

Table 3: Spearman correlations among the study variables

Variable	1	2	3	4	5
1. PHQ-15	—				
2. ITQ PTSD	.83	—			
3. ITQ DSO	.70	.72	—		
4. ITQ total	.76	.87	.94	—	
5. EBA total	.02	-.12	-.26	-.29	—

Note. EBA is keyed so that higher scores indicate stronger boundaries.

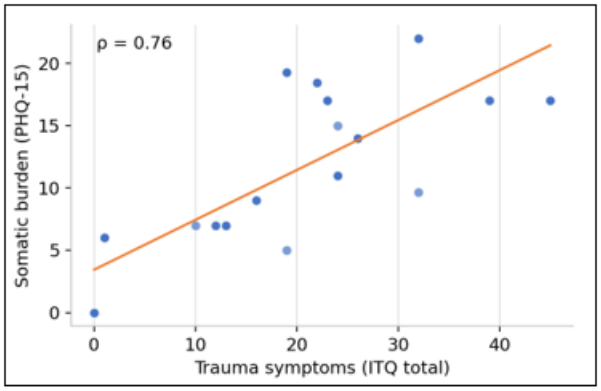

Figure 3: Scatterplot of trauma symptoms (ITQ total) against somatic burden (PHQ-15), showing the positive correlation ($\rho = .76$).

5.6 Clinician Observations

Clinicians rated how frequently they observed each symptom in affected clients, from 0 (never) to 4 (very often). Their ratings were high across all three domains (physical M = 2.83, psychological M = 2.90, boundary M = 2.74) and matched the survivor pattern, with sleep disturbances, avoidance of reminders, and acting out of fear among the most frequently observed.

6. Discussion

The findings confirm that narcissistic abuse leaves a mark that can be measured across mind and body, and that adult children of narcissistic parents carry a particularly heavy share of it. This is consistent with accounts of complex trauma as the build-up of prolonged relational harm (Herman, 1992) and with the mind and body link that van der Kolk (2014) described. The strong association between somatic and trauma symptoms is a reminder that survivors may first present to medical rather than psychological services, and that their physical complaints deserve attention.

Boundary functioning was similar across groups at the level of the total score and differed only on the social and relational domain, which suggests that boundary impact is uneven and is better read domain by domain than through a single total. The clinician data provided an independent, professional check on the survivors' accounts and pointed the same way across all three domains. As all measures are self-reported, the relationships describe association rather than clinical causation.

7. Conclusion

People who have lived in close relationships with narcissistic individuals carry real and mounting harm across mind and body, and adult children of narcissistic parents appear to carry the most. Physical and psychological harm were closely linked, boundaries differed only on the social and relational domain, and clinician observations supported the survivor pattern. The measures were highly reliable. The findings support the case for clear recognition of these survivors, for assessment that covers the physical, psychological, and boundary domains together, and for culturally sensitive, survivor-centred care.

8. Future Scope

Future studies should use larger and more balanced samples with longitudinal or controlled designs. A dedicated cultural and help-seeking measure would allow the cultural dimension to be tested directly rather than only qualitatively. Mixed-method work could explore survivor experiences in greater depth, and intervention studies could test whether boundary-focused therapy improves outcomes.

9. Limitations

The study is cross-sectional and relies on self-report, so the findings describe association rather than causation. The two survivor groups were unequal in size, which limits the comparison. The quantitative survey did not include a standalone cultural or help-seeking measure. Participants may have used other supports alongside the relationships they described, so factors beyond the abuse itself may have contributed to their reports.

Author Note

Sneha Mohammed is with the Department of Psychology, Centre for Distance and Online Education, Jain (Deemed-to-be) University, Bengaluru. This manuscript is based on a Master of Science dissertation completed under the supervision of Asst. Prof. Evangeline Supriya. Correspondence concerning this article should be addressed to Sneha Mohammed, Department of Psychology, Jain (Deemed-to-be) University, Bengaluru, Karnataka, India (email: sneha20mach@gmail.com). The authors report no conflicts of interest and received no specific funding for this work. The Empowerment and Boundaries Assessment was used with the written permission of its author, Dr. Amita Puri. All participants gave informed consent, and the study followed standard ethical guidelines for research with human participants.

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